BRIDGES TO BETTER

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GROUNDWORK FOR BUILDING SURVIVOR-CENTERED SYSTEMS

Final Evaluation Report of the Quality Improvement Center on Domestic Violence in Child Welfare (QIC-DVCW)

APRIL 2023

QIC Domestic Violence in Child Welfare

Advancing an Adult & Child Survivor-Centered Approach

SUBMITTED TO THE CHILDREN'S BUREAU

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ABOUT THE REPORT

Title

Bridges to Better: Groundwork for Building Survivor-Centered Systems. Final Evaluation Report of the Quality Improvement Center on Domestic Violence in Child Welfare (QIC-DVCW)

Authors

Juliana Carlson, Ph.D.
School of Social Welfare
University of Kansas

Nancy Jo Kepple, Ph.D.
School of Social Welfare
University of Kansas

Becci Akin, Ph.D.
School of Social Welfare
University of Kansas

Chi Connie Park, Ph.D.
Senior Research Associate
James Bell Associates, Inc.

Joanna DeWolfe, M.S.
Senior Research Associate
James Bell Associates, Inc.

Tien Ung, Ph.D.
Associate Director of Impact and Learning
Futures Without Violence

Shellie Taggart
Project Director, QIC-DVCW
Futures Without Violence

Submitted to:

Julie Fliss, Federal Project Officer
Child Welfare Specialist
Office on Child Abuse and Neglect
Children's Bureau
Administration for Children and Families
U.S. Department of Health and Human Services

Key QIC-DVCW Staff

Futures Without Violence
Tien Ung, Ph.D., Associate Director of Impact and Learning
Shellie Taggart, Project Director, QIC-DVCW
Lonna Davis, Director, Children and Youth Team

University of Kansas School of Social Welfare
Juliana Carlson, Ph.D., Principal Investigator
Nancy Jo Kepple, Ph.D., Co-Principal Investigator
Becci Akin, Ph.D., Co-Principal Investigator

Funder

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Tien Ung, Ph.D.
Associate Director of Impact and Learning

Shellie Taggart
Project Director, QIC-DVCW

TABLE OF CONTENTS

About The Report i

Title i

Authors i

Submitted to: i

Key QIC-DVCW Staff i

Funder i

Funding Disclaimer i

Suggested Citation i

Acknowledgements ii

Table of Contents iii

List of Tables vii

List of Figures xii

List of Abbreviations xvi

Executive Summary xvii

Adult & Child Survivor-Centered Approach: Actuating collaborative, cross-sector, trauma-informed DV practice in child welfare xvii

Enabling Collaborative, Cross-Sector, Trauma-Informed DV Practice & Systems Change xviii

Studying the impacts, mechanisms, and costs of collaborative, trauma focused, DV specific systems change xix

Section 1. Introduction and Background on the QIC-DVCW 1

Report Organization 1

Background 1

Importance of this work 1

Intervention: An Adult & Child Survivor-Centered Approach 2

Guiding Principles 2

Protective Factors for Survivors 4

Relational and Systemic Accountability 6

Implementing the Approach with Implementation Science 8

Implementation Outcomes 9

Implementation Strategies Using the Active Implementation Frameworks 10

Terminology/Definitions 13

Project 13

Project intervention and comparison sites 13

Domestic violence 14

Section 2. QIC-DVCW and the Demonstration Projects 15

Structure and Population 15

QIC-DVCW Partnerships 15

Site Selection 15

Demonstration Projects and Partners 16

Massachusetts Project 16

Illinois Project 17

Allegheny County, Pennsylvania Project 18

Memoranda of Understanding 19

QIC-DVCW Teams 19

Implementation Activities 22

Stakeholder and partner engagement 22

Institutional Analysis and Community Mapping 22

Approach Training 23

Coaching of supervisors and managers 23

Judicial leadership 24

Collaboration and Equity 24

Services 25

Communications and evaluation support 25

Section 3. Evaluation Design & Methods 27

Evaluation Design 27

Three Studies: Implementation, Outcomes, and Cost 27

Research Questions 27
Human Subject Institutional Review Board (IRB) 31
Certificate of Confidentiality 31
Registered as Clinical Trial 32
Methods: By Data Source 32
Project Sampling Frame: Managing Project Roster for Fidelity Checklist, Self-Survey, & Family Survey 32
Drivers Assessment 32
Fidelity Checklists 34
Final Coaching Assessment 35
Centering Racial Equity in Collaboration Survey 38
Key Informant Interviews 42
Universal Stages of Implementation Completion 45
Self-Survey 47
Caseworker Self-Survey 48
CW Supervisor Self-Survey 52
Community Partner Self-Survey 53
Family Survey – DV Case Specific 56
Adult Survivor Field Survey 66
Adult Survivor Interviews 74
Strong Fathers Focus Groups 78
Case Record Review 80
Administrative Data 83
Methods: Cost Study 83

Section 4. Results: Implementation Study 87

Research Question: To What Extent Did the Approach Spread to Sites? 87
Research Question: How Did Implementation Drivers Change? 89
Drivers Assessment Completion 89
Research Question: How Did Fidelity to the Approach Change? 96
Fidelity Completion and Consent Status 96
Research Question: How Long Did It Take to Implement the Approach and How Complete was Implementation? 99
Research Question: What Contributed and Inhibited Successful Implementation of the Approach? 101
Key Informant Interviews 101
What Supported the Implementation of the Approach? 101
What got in the Way of the Implementation of the Approach? 104
Environmental Barriers 104
Barriers Related to Technical Assistance 106
Coaching Focus Groups 110
Perceptions of Supervision Change 112
Perception Of Coaching Related Barriers 113

Section 5. Results: Outcomes Study 116

Research Question: How Did Service Delivery Outcomes Change? (Consequent Practice Behaviors) 116
1.B.1. Enhanced Child Welfare Practice 116
1.B.2. Enhanced Community Partner Practice 144
1.B.3. Enhanced Cross-Organization Communication & Collaboration 154
Research Question: How Did Child Outcomes Change? 171
2.A.1. Were there significant differences between the intervention and comparison sample in measures of child survivor safety? 171
2.A.2. Were there significant differences between the intervention and comparison sample in child permanency? 177
2.A.3. Were there significant differences between the intervention and comparison sample in child well-being? 188

Research Question: How Did Adult Survivor Outcomes Change? 194

2.B.1. Were there significant differences between the intervention and comparison sample in adult survivor safety and stability? 194

2.B.2. Were there significant differences between the intervention and comparison sample in adult survivor well-being? 203

Research Question: How Did Person Who Uses Violence Outcomes Change? 209

2.C.1. Were there significant differences in PUV blaming adult survivor and justification for violence between the intervention and comparison sample? 210

2.C.2. Were there significant differences in PUV positive beliefs, attitudinal, & behavioral change between the intervention and comparison sample? 212

2.C.3. Were there significant differences in person using violence well-being & supports between the intervention and comparison sample? 216

Section 6. Results: Cost Study Cross Site 220

Summary of Costs Across Locales 220

Overview of QIC-DVCW Resources and Supports 220

Overview of total costs and costs per household for intervention and comparison sites by locale. 220

Costs by cost category for intervention and comparison sites by locale. 221

Labor allocation by service activity across locales 222

Section 7. Massachusetts Project Report 223

Implementation Study 223

Research Question: To What Extent Did the Approach Spread to Sites? 223

Research Question: How Did Implementation Drivers Change? 224

Research Question: How Did Fidelity to the Approach Change? 225

Fidelity Completion and Consent Status 225

Outcome Study 227

Child Outcomes 227

2.A.1 Child Safety 227

2.A.2. Were there significant differences between the intervention and comparison sample in child permanency? 232

Cost Study 242

Total cost and cost per household 243

Summary of costs by cost category 243

Key cost drivers 244

Labor allocation by service activity 245

Section 8. Illinois Project Report 247

Implementation Study 247

Research Question: To What Extent Did the Approach Spread to Sites? 247

Research Question: How Did Implementation Drivers Change? 248

RQ: How Did Fidelity to the Approach Change? 249

Fidelity Completion and Consent Status 249

Outcome Study 251

Child Outcomes 251

2.A.1 Child Safety 251

2.A.2. Were there significant differences between the intervention and comparison sample in child permanency? 258

Section 9. Allegheny County, PA Project Report 271

Implementation Study 271

Research Question: To What Extent Did the Approach Spread to Sites? 271

Research Question: How Did Implementation Drivers Change? 272

Research Question: How Did Fidelity to the Approach Change? 274
Fidelity Completion and Consent Status 274
Outcome Study 275
Child Outcomes 275
2.A.1 Child Safety 275
2.A.2. Were there significant differences between the intervention and comparison sample in child permanency? 280
Cost Study 290
Service characteristics 290
Total cost and cost per household 290
Summary of costs by cost category 290
Key cost drivers 291
Labor allocation by service activity 292
Section 10. Discussion and Application of Results 294
Implementation Study 294
What factors are associated with successful implementation and sustainability of an adult and child survivor-centered approach? 294
Summary of Implementation Outcomes 294
Factors that Contributed or Inhibited Successful Implementation 296
Application of the Implementation Study Results 297
Outcomes Study 298
Service Delivery Outcomes 298
Child Outcomes 304
Child Safety 304
Child Permanency 305
Child Well-Being 306
Adult Survivor Outcomes 306
Persons Using Violence Outcomes 308
Cost Study 309
Monitoring Agency Operations 309
Developing Comprehensive Budgets for Sustainability or Expansion 309
Conducting an Economic Evaluation of the Approach 310
Section 11. Evaluation Strengths & Limitations 311
Evaluation Strengths 311
Project Collaboration & Data Sharing 311
Design and Methods Overall 311
Spotlighted Safety & Trauma-Informed Practices 311
Prioritized Partner Level Collective Process & Decision Making 312
Evaluation Limitations 312
Time and Covid-19 Limitations 312
Sample & Uptake of Research Participation Limitations 312
Measurement Limitations 313
Cost Study Limitations 313
Section 12. Implications for Future Work 315
Center lived experience of survivors of family violence to address adult survivor well-being, design meaningful and relevant action plans, and assess efforts to eliminate dynamics of DV. 316
Empower and embolden middle management and frontline staff as leaders. 317
Keep equity in focus 318
Establish innovation as a habit of mind and create sustainable infrastructure for its ongoing application in practice 318
Center the power of language and relationships 320
Go slow, be intentional, and expect and engage pivots to steward truly transformational systems change 320
Conclusion 321
References 322

List of Tables

Table 1. Active Implementation Frameworks Used by Implementation Teams and Connection to Evaluation 11

Table 2. Final Coaching Assessment Sample Demographic Characteristics (N=44) 36

Table 3. (Collaboration Survey) Respondent Characteristics by Data Collection Time Point 39

Table 4. Key Informant Interviews Demographic Characteristics (N=26) 43

Table 5. Summary of the Universal Stages of Implementation Completion Tool 47

Table 6. (Self Survey) Eligible Sample by Provider Role across all Partner Sites 48

Table 7. (Self-Survey) Child Welfare Sample Baseline Differences in Demographic Characteristics between Intervention & Comparison 49

Table 8. (Self-Survey) Child Welfare Sample Baseline Differences in Training/Employment Experiences between Intervention & Comparison 50

Table 9. Community Partner Sample Baseline Differences in Demographic Characteristics between Intervention & Comparison 54

Table 10. (Self-Survey) Community Partner Sample Baseline Differences in Training/ Employment Experiences between Intervention & Comparison 55

Table 11. (Family Survey) Eligible Cases by Eligibility & Complete Status 58

Table 12. (Family Survey) Non-Eligible Cases by Reason Provided by Caseworker 58

Table 13. (Family Survey) Survey Completion by Project Site, Intervention Group, and Data Collection Time 59

Table 14. (Family Survey) Proportion of Cases Identifying Child, Adult Survivor, and Person who Uses Violence (PUV) 60

Table 15. (Family Survey) Demographics for Focal Child & Adult Survivor 60

Table 16. (Family Survey) Demographics & Characteristics for Person who uses Violence 62

Table 17. (Family Survey - Caseworker Report) Case Characteristics for Cases with Both T1 and T2 reported 63

Table 18. (ASFS) Overall Sample Disposition and Response Rate 68

Table 19. Distribution of Eligible & Complete Adult Survivor Field Surveys by Sites 68

Table 20. (ASFS) Adult Survivor Demographics by Intervention & Comparison Groups 68

Table 21. (ASFS) Person who Uses Violence Demographics by Intervention & Comparison Groups 69

Table 22. (ASFS) Focal Child Demographics by Intervention & Comparison Groups 70

Table 23. (Adult Survivor Interviews) Distribution of Adult Survivor Interviews by Sites 75

Table 24. (Adult Survivor Interviews) Adult Survivor Interview Demographics by Intervention & Comparison Groups 75

Table 25. (Adult Survivor Interviews) Person who Uses Violence Demographics by Intervention & Comparison Groups 76

Table 26. (Adult Survivor Interviews) Focal Child Demographics by Intervention & Comparison Groups 77

Table 27. (Strong Fathers) Involvement in Types of Groups 79

Table 28. Case Record Review Family Demographics by Intervention & Comparison 80

Table 29. Case Record Review Case Characteristics by Intervention & Comparison 81

Table 30. Crosswalk of Implementation Study's Research Questions, Implementation Outcomes, and Data Source 87

Table 31. Cross-Project Spread: Percent of Eligible People Who Participated in Training, Coaching, and Fidelity Checklist by Site 88

Table 32. Driver Assessment Survey Completion Rates by Year and Site 89

Table 33. Drivers Assessment Domain and Item Average Scores by Year 93
Table 34. Drivers Assessment Domain Average Scores by Site & Time 95
Table 35. Fidelity Checklist Completion and Consent Status by Site 96
Table 36. Fidelity Checklist Average Number Completed per Caseworker by Site and Consent Status 97
Table 37. Fidelity Checklist Average Scores by Domain, Site, and Year 98
Table 38. Implementation Phase Duration and Proportion Completed by Project Site 100
Table 39. (Self Survey) Linear Mixed Model using Intent-to-Treat Child Welfare Sample Comparing Average Protective Factor Practice Behaviors between T2 and T4 116
Table 40. (ASFS) Adult Survivor Ratings of Child Welfare Caseworker Practice Behaviors with Adult & Child Survivors 118
Table 41. (CRR) Documentation of Adult Survivor Strengths and Risks within the Case File 119
Table 42. (Self Survey) Linear Mixed Model using Intent-to-Treat Child Welfare Sample Comparing Average RSA Practice Behaviors between T2 and T4 120
Table 43. (ASFS) Adult Survivor Ratings of Child Welfare Caseworker Practice Behaviors associated with RSA Framework 122
Table 44. (CRR) Identification and Engagement of PUV by Intervention Group 123
Table 45. (CRR) Protective Order by Intervention Group & Source of Initiation 124
Table 46. (Family Survey) Caseworker Estimate of Frequency of PUV Risk Towards Adult Survivor in the Past 6 Months 127
Table 47. (CRR) Reason for Case Opening by Intervention Group 128
Table 48. (CRR) Documentation of Type of Violence by Intervention and Comparison Group 128
Table 49. (Family Survey) Caseworker Estimate of PUV Meetings 129
Table 50. (Family Survey) Caseworker PUV meetings relative to AS meetings 130
Table 51. (CRR) Types of Service Referrals by Study Group & Adult Family Member 138
Table 52. (CRR) Protective Order by Intervention Group & Source of Initiation 139
Table 53. (Self Survey) Linear Mixed Model using Intent-to-Treat Sample Comparing Equity-oriented Practice Behavior and Average Preparation to Engage in Equity & Collaborative Practice between T2 and T4 140
Table 54. (ASFS) Adult Survivor Ratings of CW Caseworker Practice Behaviors associated with Equity & CW-Partner Communication & Collaboration in Case Activities 141
Table 55. (Self Survey) Linear Mixed Model using Intent-to-Treat Child Welfare Sample Comparing Average Collaborative Practice Behaviors between T2 and T4 142
Table 56. (ASFS) Composition of Providers Serving Adult Survivor Respondents 144
Table 57. (Self Survey) Linear Mixed Model using Intent-to-Treat Community Partner Sample Comparing Average Protective Factor Practice Behaviors between T2 and T4 144
Table 58. (ASFS) Adult Survivor Ratings of Community Partner Practice Behaviors with Adult & Child Survivors 146
Table 59. (Self Survey) Linear Mixed Model using Intent-to-Treat Community Partner Sample Comparing Average RSA Practice Behaviors between T2 and T4 147
Table 60. (ASFS) Adult Survivor Ratings of Community Partner Practice Behaviors associated with RSA Framework 148
Table 61. (Self Survey) Linear Mixed Model using Intent-to-Treat Sample for the Community Partner Sample Comparing Equity-oriented Practice Behavior and Average Preparation to Engage in Equity & Collaborative Practice between T2 and T4 149

Table 62. (ASFS) Adult Survivor Ratings of Community Partner Practice Behaviors associated with Equity & CW-Partner Communication and Collaboration 151

Table 63. (Self Survey) Linear Mixed Model using Intent-to-Treat Community Partner Sample Comparing Average Collaborative Practice Behaviors between T2 and T4 152

Table 64. (Collaboration Survey) Average Collaboration Score Regressed on Time* (N = 165 cases with complete data) 157

Table 65. (Collaboration Survey) Descriptive Statistics of Items, Organized by Domains 165

Table 66. Cross-Project Baseline Characteristics of Index Children with Substantiated Referrals between 2019-2021 by Intervention Site, Comparison Site, and Other Sites within States 173

Table 67. Cross-Project Recurrence of Maltreatment between 2019-2021 by Intervention Sites, Comparison Sites, and Other Sites Within States 174

Table 68. Cross-Project Baseline Characteristics of Index Children with Identified Co-occurring Maltreatment & Domestic Violence between 2019-2021 by Intervention and Comparison Groups 175

Table 69. Cross-Project Recurrence of Maltreatment & Domestic Violence between 2019-2021 for Co-occurring Sample by Intervention and Comparison Groups 176

Table 70. Adult Survivors Ratings of Child Safety and PUV Parenting 177

Table 71. Cross-Project Child Demographics Associated with Unique Foster Care Episodes by Intervention Sites, Comparison Sites, and Other sites within Each State 178

Table 72. Cross-Project Foster Care Episode Characteristics by Intervention Sites, Comparison Sites, and Other sites within Each State 180

Table 73. Cross-Project Estimated Proportion of Foster Care Episodes that Resulted with Children being Reunified with Families by Site and Time Period 183

Table 74. Cross-Project Likelihood of Experiencing Placement Stability by Duration in Foster Care by Intervention Site, Comparison Site, and Other Sites within States 185

Table 75. Cross-Project Estimated Probability of a Child Experiencing Placement Stability by Duration in Foster Care and Entry Cohort by Intervention Site, Comparison Site, and Other Sites within States 187

Table 76. (ASFS) Adult Survivor Ratings of Child Outcomes 189

Table 77. (Family Survey) Part 1. Child Social and Emotional Abilities 190

Table 78. (Family Survey) Part 2. Child Social and Emotional Abilities 191

Table 79. (Family Survey) Child Emotional and Social Development, and Physical Health 193

Table 80. (Family Survey – Caseworker Report) Focal Child Number of Meaningful Adult Relationships 194

Table 81. (Family Survey – Caseworker Reports) Level of Risk PUV Poses to AS 195

Table 82. (Family Survey) AS Observations of PUV Behavior Change 195

Table 83. (ASFS) Adult Survivor Experiences of Violence by Intervention & Comparison Groups 196

Table 84. (ASFS) Adult Survivor Experiences of PUV Use of Systems Coercion by Intervention & Comparison Groups 197

Table 85. (ASFS) Adult Survivor Frequency of PUV Use of Other Coercive Behavior by Intervention & Comparison Groups 198

Table 86. (ASFS) Adult Survivor Socio-economic Factors by Intervention & Comparison Groups 199

Table 87. (ASFS) Adult Survivor Current Living Situation & Relationship Status by Intervention & Comparison Groups 199

Table 88. (Family Survey – Caseworker Report) Caseworkers' Perceptions of AS Protective Factors 200

Table 89. (ASFS) Adult Survivor Empowerment by Intervention & Comparison Groups 202

Table 90. (Family Survey – Caseworker report) Caseworkers' Perceptions of AS Social, Cultural & Spiritual Connections by Intervention and Comparison Groups 204

Table 91. (ASFS) Adult Survivor Well-being Outcomes by Intervention & Comparison Groups 205

Table 92. (Family Survey) Caseworkers Perceptions of AS Resilience & Growth Mindset by Intervention and Comparison Groups 206

Table 93. (Family Survey) Caseworkers Perceptions of AS Social & Emotional Abilities by Intervention and Comparison Groups 208

Table 94. (Family Survey-Caseworker Report) CW Observed a Change in PUV Behaviors by Intervention & Comparison Groups 213

Table 95. (Family Survey) AS Described PUV Behavior Change 213

Table 96. (ASFS) PUV-Child Relationship 215

Table 97. Massachusetts Spread: Percent of Eligible People Who Participated in Training, Coaching, and Fidelity Checklist by Site 224

Table 98. Massachusetts Drivers Assessment Domain Average Scores 225

Table 99. Massachusetts Fidelity Checklist Completion and Consent Status 226

Table 100. Massachusetts Fidelity Checklist Average Number Completed per Caseworker by Consent Status 226

Table 101. Massachusetts Fidelity Checklist Average Scores by Domain and Year 227

Table 102. Massachusetts Baseline Characteristics of Index Children with Identified Maltreatment between 2019-2021 by Intervention Site, Comparison Site, and Other Sites within State 228

Table 103. Massachusetts Recurrence of Maltreatment between 2019-2021 by Intervention Site, Comparison Site, and Other Sites within State 229

Table 104. Massachusetts Baseline Characteristics of Index Children with Identified Co-occurring Maltreatment & Domestic Violence between 2019-2021 by Intervention and Comparison Groups 230

Table 105. Massachusetts Recurrence of Maltreatment between 2019-2021 for Co-occurring Sample by Intervention and Comparison Groups 231

Table 106. Massachusetts Child Demographics Associated with Unique Foster Care Episodes by Intervention Site, Comparison Site, and Other Sites within State 232

Table 107. Massachusetts Foster Care Episode Characteristics by Intervention Site, Comparison Site, and Other Sites within State 234

Table 108. Massachusetts Interrupted Time Series Analysis of Child Removal Rates per 100 Children by Project Sites comparing Trends during Pre-intervention, Post-intervention, and Post-Covid Time Periods 235

Table 109. Massachusetts Estimated Proportion of Foster Care Episodes that Resulted with Children being Reunified with Families by Time Period and by Intervention Site, Comparison Site, and Other Sites within State 237

Table 110. Massachusetts Likelihood of Experiencing Placement Stability by Duration in Foster Care by Intervention Site, Comparison Site, and Other Sites within State 239

Table 111. Massachusetts Estimated Probability of a Child Experiencing Placement Stability by Duration in Foster Care and Entry Cohort by Intervention Site, Comparison Site, and Other Sites within State 241

Table 112. Summary Cost Metrics for Massachusetts Intervention and Comparison Sites, July 1, 2020 – June 30, 2021 244

Table 113. Crosswalk of Implementation Study's Research Questions, Implementation Outcomes, and Data Source 247

Table 114. Illinois Spread: Percent of Eligible People Who Participated in Training, Coaching, and Fidelity Checklist 248

Table 115. Illinois Drivers Assessment Domain Average Scores 249

Table 116. Illinois Fidelity Checklist Completion and Consent Status by Site 249

Table 117. Illinois Fidelity Checklist Average Number Completed per Caseworker by Site and Consent Status 250

Table 118. Illinois Fidelity Checklist Average Scores by Domain, Site, and Year 250

Table 119. Illinois Baseline Characteristics of Focal Children with Identified Maltreatment between 2019-2021 by Intervention Site, Comparison Site, and Other Sites within State 251

Table 120. Illinois Recurrence of Maltreatment between 2019-2021 by Intervention Site, Comparison Site, and Other Sites within State 252

Table 121. Illinois Baseline Characteristics of Index Children with Identified Co-occurring Maltreatment & Domestic Violence between 2019-2021 by Intervention and Comparison Groups 256

Table 122. Illinois Recurrence of Maltreatment between 2019-2021 for Co-occurring Sample by Intervention and Comparison Groups 257

Table 123. Illinois Child Demographics Associated with Unique Foster Care Episodes by Intervention Site, Comparison Site, and Other Sites within State 258

Table 124. Illinois Foster Care Episode Characteristics by Intervention Site, Comparison Site, and Other Sites within State 259

Table 125. Illinois Interrupted Time Series Analysis of Child Removal Rates per 100 Children by Project Sites comparing Trends during Pre-intervention, Post-intervention, and Post-Covid Time Periods 261

Table 126. Illinois Estimated Proportion of Foster Care Episodes that Resulted with Children being Reunified with Families by Time Period and by Intervention Site, Comparison Site, and Other Sites Within State 262

Table 127. Illinois Likelihood of Experiencing Placement Stability by Duration in Foster Care 268

Table 128. Illinois Estimated Probability of a Child Experiencing Placement Stability by Duration in Foster Care and Entry Cohort 269

Table 129. Crosswalk of Implementation Study's Research Questions, Implementation Outcomes, and Data Source 271

Table 130. Allegheny County, PA Spread: Percent of Eligible People Who Participated in Training, Coaching, and Fidelity Checklist by Site 272

Table 131. Allegheny County, PA Drivers Assessment Domain Average Scores 273

Table 132. Allegheny County, PA Fidelity Checklist Completion and Consent Status by Site 274

Table 133. Allegheny County, PA Fidelity Checklist Average Number Completed per Caseworker Consent Status 274

Table 134. Allegheny County, PA Fidelity Checklist Average Scores by Domain and Year 275

Table 135. Allegheny County, PA Baseline Characteristics of Index Children with Identified Maltreatment between 2019-2020 by Intervention Site, Comparison Site, and Other Sites within State 276

Table 136. Allegheny County, PA Recurrence of Maltreatment between 2019-2020 by Intervention Site, Comparison Site, and Other Sites within State 277

Table 137. Allegheny County, PA Baseline Characteristics of Index Children with Identified Co-occurring Maltreatment & Domestic Violence between 2019-2021 by Intervention and Comparison Groups 279

Table 138. Allegheny County, PA Recurrence of Maltreatment between 2019-2021 for Co-occurring Sample by Intervention and Comparison Groups 279

Table 139. Pennsylvania Child Demographics associated with Unique Foster Care Episodes 281

Table 140. Pennsylvania Foster Care Episode Characteristics 282

Table 141. Allegheny County, PA Interrupted Time Series Analysis of Child Removal Rates per 100 Children by Project Sites comparing Trends during Pre-intervention, Post-intervention, and Post-Covid Time Periods....283

Table 142. Pennsylvania Estimated Proportion of Foster Care Episodes that Resulted with Children being Reunified with Families by Site and Time Period....285

Table 143. Pennsylvania Likelihood of Experiencing Placement Stability by Duration in Foster Care.287

Table 144. Pennsylvania Estimated Probability of a Child Experiencing Placement Stability by Duration in Foster Care and Entry Cohort....289

Table 145. Summary Cost Metrics for Allegheny County, PA Intervention and Comparison Sites, July 1, 2020 – June 30, 2021....291

Table 146. Summary of Implementation Study Findings by Implementation Outcome....294

Table 147. Summary of Implementation Facilitators and Inhibitors by Implementation Driver....296

Table 148. Summary Enhanced CW Practice 1.B.1.1 Results....299

Table 149. Summary Enhanced CW Practice 1.B.1.2. Results....299

Table 150. Summary Enhanced CW 1.B.1.3. Results....300

Table 151. Summary Enhanced CW Practice 1.B.1.4.-1.B.1.5. Results....300

Table 152. Summary Community Partner 1.B.2.1-1.B.2.3. Results....301

Table 153. Summary Community Partner 1.B.2.4.-1.B.2.6. Results....301

Table 154. Summary Cross-Organization CW-Partner 1.B.3.1.-1.B.3.3. Results....302

Table 155. Summary CW-Partner 1.B.3.4-1.B.3.6. Results....303

Table 156. Summary 2.A.1. Child Safety Outcome Results....305

Table 157. Summary 2.A.2. Child Permanency Outcomes Results....305

Table 158. Summary 2.A.3. Child Well-being Outcomes Results....306

Table 159. Summary Adult Survivor Safety & Stability Outcome Results....306

Table 160. Summary Adult Survivor Well-being Outcome Results....307

Table 161. PUV Results Summary by Data Source....308

List of Figures

Figure 1. Implementation Science Formula for Success....9

Figure 2. Conceptual Model for Implementation Research....10

Figure 3. Active Implementation Frameworks Selected to Guide the QIC-DVCW....11

Figure 4. Implementation Drivers....13

Figure 5. QIC-DVCW Organization Chart....26

Figure 6. Research Questions....27

Figure 7. Analytic Outcome-Based QIC-DVCW Logic Model with Proctor's Implementation Framework Applied....28

Figure 8. Logic Model of the QIC-DVCW....30

Figure 9. Logic Model Expansion on Child & Adult Outcomes....31

Figure 10. (Collaboration Survey) Respondents Type of Organization by Data Collection Time Point....41

Figure 11. Service Delivery Characteristics and Cost Categories Included in the BAT....85

Figure 12. Implementation Driver Domains Mean Scores by Year....91

Figure 13. Leadership Driver Items Average Scores by Year....92

Figure 14. Competency Driver Items Average Scores by Year....92

Figure 15. Organization Driver Items Average Scores by Year....93

Figure 16. Fidelity Checklist Scores by Domain and Year....99

Figure 17. Average Duration of Universal Sites that Achieved Competency Compared to QIC-DVCW Project Sites 100

Figure 18. (Self Survey) Estimate of Protective Factor Practice Behaviors from T2 to T4 for Intent-to-Treat Child Welfare Samples by Project Sites 117

Figure 19. (Self Survey) Estimate of RSA Practice Behaviors from T2 to T4 for Intent-to-Treat Child Welfare Samples by Project Sites 121

Figure 20. (Self Survey) Estimate of Preparation to Actively Practice Equity Practices from T2 to T4 for Intent-to-Treat Child Welfare Samples by Project Sites 141

Figure 21. (Self Survey) Estimate of Collaborative Practice Behaviors from T2 to T4 for Intent-to-Treat Child Welfare Samples by Project Sites 143

Figure 22. (Self Survey) Estimate of Protective Factor Practice Behaviors from T2 to T4 for Intent-to-Treat Community Partner Samples by Project Sites 145

Figure 23. (Self Survey) Estimate of RSA Practice Behaviors from T2 to T4 for Intent-to-Treat Child Welfare Samples by Project Sites 148

Figure 24. (Self Survey) Estimate of Equity-oriented Practice Behaviors from T2 to T4 for Intent-to-Treat Community Partner Sample by Project Sites 150

Figure 25. (Self Survey) Estimate of Preparation to Actively Practice Equity Practices from T2 to T4 for Intent-to-Treat Community Partner Sample by Project Sites 151

Figure 26. (Self Survey) Estimate of Collaborative Practice Behaviors from T2 to T4 for Intent-to-Treat Community Partner Sample by Project Sites 153

Figure 27. (Collaboration Survey) Change in Average Collaboration Score by Data Collection Time Point 155

Figure 28. (Collaboration Survey) Highest Scoring Collaboration Items for 2021 (alongside 2019 and 2020 scores) 156

Figure 29. (Collaboration Survey) Lowest Scoring Collaboration Items for 2021 (alongside 2019 and 2020 scores) 156

Figure 30. Cross-Project Maltreatment Recurrence Rate by Group Between 2019 and 2021 by Intervention Sites, Comparison Sites, and Other Sites Within States 174

Figure 31. Cross-Project Maltreatment Recurrence Rate for Children Exposed to Domestic Violence and Identified by the Child Welfare System Between January 1, 2019 and September 30, 2021 176

Figure 32. Cross-Project Reunification Rates by Intervention, Comparison Sites and Other Sites within the State comparing FC Entry Cohorts 2014-2018 and 2019-2021 184

Figure 33. Cross-Project Probability of Placement Stability by Entry Cohort by Intervention Site, Comparison Site, and Other Sites within States 185

Figure 34. Cross-Project Estimated Probability of a Child Experiencing Placement Stability by Duration in Foster Care and Entry Cohort by Intervention Site, Comparison Site, and Other Sites within States 187

Figure 35. Comparison of Cost per Household Served by Locale, July 1, 2020 – June 30, 2021 221

Figure 36. Distribution of Costs by Cost Category for Intervention and Comparison Sites, July 1, 2020 – June 30, 2021 222

Figure 37. Massachusetts Maltreatment Recurrence Rate for Children Served between 2019-2021 by Intervention Site, Comparison Site, and Other Sites within State 229

Figure 38. Massachusetts Maltreatment Recurrence Rate for Children Exposed to Domestic Violence and Identified by the Child Welfare System Between January 1, 2019 and September 30, 2021 232

Figure 39. Massachusetts Interrupted Time Series Analysis of Child Removal Rates per 100 Children by Project Sites Comparing Trends during Pre-intervention, Post-intervention, and Post-Covid Time Periods 236

Figure 40. Massachusetts Reunification Rates comparing FC Entry Cohorts 2014-2018 and 2019-2021 by Intervention Site, Comparison Site, and Other Sites within State 238

Figure 41. Massachusetts Probability of Experiencing Placement Stability by Entry Cohort by Intervention Site, Comparison Site, and Other Sites within State 239

Figure 42. Massachusetts Estimated Probability of a Child Experiencing Placement Stability by Duration in Foster Care and Entry Cohort by Intervention Site, Comparison Site, and Other Sites within State 241

Figure 43. MA Intervention and Comparison Site Operational Cost, Households Served, and Cost Per Household (July 1, 2020 – June 30, 2021) 243

Figure 44. Staff Roles and Number of FTEs for Massachusetts Intervention and Comparison Sites, July 1, 2020 – June 30, 2021 245

Figure 45. Labor Allocation Across Key Activities for Massachusetts Intervention and Comparison Sites, July 1, 2020 – June 30, 2021 246

Figure 46. Illinois Maltreatment Recurrence Rate for Children Served between 2019-2021 by Intervention Site, Comparison Site, and Other Sites within State 253

Figure 47. Illinois Maltreatment Recurrence Rate by Racial/Ethnic Identification for Children Served between 2019-2021 by Intervention Site, Comparison Site, and Other Sites within State 255

Figure 48. Illinois Maltreatment Recurrence Rate for Children Exposed to Domestic Violence and Identified by the Child Welfare System between January 1, 2019 and September 30, 2021 257

Figure 49. Illinois Interrupted Time Series Analysis of Child Removal Rates per 100 Children by Project Sites comparing Trends during Pre-intervention, Post-intervention, and Post-Covid Time Periods 261

Figure 50. Illinois Reunification Rates Comparing FC Entry Cohorts 2014-2018 and 2019-2021 by Intervention Site, Comparison Site, and Other Sites within State 263

Figure 51. Illinois Reunification Rates for Children entering Foster Care due to Neglect during Pre-Intervention (2014-2018) and Post-Intervention (2019-2021) Time Periods by Intervention Site, Comparison Site, and Other Sites within State 264

Figure 52. Illinois Reunification Rates for Children experiencing Neglect and who were identified as Black and not Latino/a during Pre-Intervention (2014-2018) and Post-Intervention (2019-2021) Time Periods by Intervention Site, Comparison Site, and Other Sites within State 265

Figure 53. Illinois Reunification Rates for Children experiencing Neglect and who were identified as Latino/a and Any Race during Pre-Intervention (2014-2018) and Post-Intervention (2019-2021) Time Periods by Intervention Site, Comparison Site, and Other Sites within State 266

Figure 54. Illinois Probability of Experiencing Placement Stability by Entry Cohort by Intervention Site, Comparison Site, and Other Sites within State 267

Figure 55. Illinois Estimated Probability of a Child Experiencing Placement Stability by Duration in Foster Care and Entry Cohort 269

Figure 56. Allegheny County, PA Maltreatment Recurrence Rate by Intervention and Comparison Sites between 2019 and 2020 277

Figure 57. Allegheny County, PA Maltreatment Recurrence Rate for Young Children Experiencing Neglect and by Intervention and Comparison Groups 278

Figure 58. Allegheny County, PA Maltreatment Recurrence Rate by Initial Maltreatment Type for Children Exposed to Domestic Violence and Identified by the Child Welfare System Between January 1, 2019 and September 30, 2021 280

Figure 59. Allegheny County, PA Interrupted Time Series Analysis of Child Removal Rates per 100 Children by Project Sites comparing Trends during Pre-intervention, Post-intervention, and Post-Covid Time Periods 284

Figure 60. Pennsylvania Reunification Rates Comparing FC Entry Cohorts 2014-2018 and 2019-2021 by Intervention Site, Comparison Site, and Other Sites within State 285

Placement Stability by Entry Cohort 286

Figure 62. Pennsylvania Estimated Probability of a Child Experiencing Placement Stability by Duration in Foster Care and Entry Cohort 288

Figure 63. Allegheny County, PA Intervention and Comparison Site Operational Cost, Households Served, and Cost Per Household (July 1, 2020 – June 30, 2021) 290

Figure 64. Summary Cost Metrics for Allegheny County, PA Intervention and Comparison Sites, July 1, 2020 – June 30, 2021 292

Figure 65. Labor Allocation Across Key Activities for Allegheny County, PA Intervention and Comparison Sites, July 1, 2020 – June 30, 2021 293

List of Abbreviations

Abbreviation	Meaning
AC (or AC, PA)	Allegheny County, Pennsylvania
AC CYF (or AC, PA CYF)	Allegheny County, Pennsylvania Office of Children, Youth and Families
AS	Adult survivor
ASFS	Adult Survivor Field Survey
ASI	Adult Survivor Interview (qualitative)
Approach	Adult & Child Survivor-Centered Approach
BAT	Budget Assistance Tool
CP	Community partner
CRR	Case Record Review
CW	Child welfare
DV	Domestic violence
DVIP	Domestic Violence Intervention Program (IL)
DVU	Domestic Violence Unit (MA)
FS	Family survey (DV case specific)
IL DCFS	Illinois Department of Child and Family Services
KU	University of Kansas (evaluation partner of the QIC-DVCW)
PF	Protective factors
PI	Principal investigator
MA DCF	Massachusetts Department of Children and Families
PUV	People who use violence and coercion
RSA	Relational and systemic accountability
Self-survey	Caseworker self-survey, supervisor self-survey or community partner self-survey
TA	Technical assistance
Uni-SIC	Universal Stages of Implementation Completion
Worker	Child welfare agency caseworker
QIC-DVCW	Quality Improvement Center on Domestic Violence in Child Welfare

EXECUTIVE SUMMARY

The Quality Improvement Center on Domestic Violence in Child Welfare (QIC-DVCW), led by Futures Without Violence (FUTURES), was funded in 2016 by the Children's Bureau at the Administration for Children and Families, Department of Health and Human Services. The three goals of the 5-year effort were: 1) to actuate more collaborative, trauma-informed domestic violence (DV) practice in child welfare (CW), 2) to enable transformative, cross-sector, DV related systems change, and 3) to study the impacts, mechanisms, and costs of DV-focused systems change. To effectively meet the goals of this project, FUTURES partnered with the Center for the Study of Social Policy, Latinos United for Peace and Equity at Caminar Latino, the National Council of Juvenile and Family Court Judges, the Center for Health & Safety Culture, and the University of Kansas School of Social Welfare (KU) who designed and implemented the associated research study.

This Executive Summary highlights results from the research study, along with actionable insights from navigating complex cross-sector systems change during an unexpected global pandemic. Relevant findings to be shared and discussed include **improvements in child safety and permanency outcomes, adult survivor experiences of child welfare,** and **enhanced practice and collaboration** within and among child welfare and partnering organizations and agencies.

Adult & Child Survivor–Centered Approach: Actuating collaborative, cross–sector, trauma–informed DV practice in child welfare

The QIC-DVCW Program Team[1] in collaboration with its partners, DV survivors, frontline CW professionals, and DV advocates codified an approach to practice to be implemented at a systems level across multiple local community institutions serving DV impacted children and their families: Public child welfare agencies, juvenile and family dependency courts, and community-based organizations caring for DV survivors and intervening with people who use violence in their intimate relationships (i.e., abusive partners). This evidence-informed approach, named the Adult & Child Survivor-Centered Approach (the Approach), stems from over 30 years of practice wisdom, community know-how, the lived experiences of impacted people, and a rigorous synthesis of what we know about child development, the neurophysiology of healing, and the science of trauma and resilience. Practice wisdom and lived experience have uncovered the pitfalls and opportunities at the intersection of DV and child welfare practice, to include what we now know and understand about the racialized and gendered impacts of systems on families and communities.

Three QIC-DVCW Projects implemented the Approach reaching approximately 500 professionals across Massachusetts, Illinois, and Pennsylvania. Professionals included frontline CW staff and their supervisors and managers, domestic violence advocates and service providers, professionals working with abusive partners, behavioral health providers, attorneys for parents and children, and dependency court judges and probation officers, all serving DV-impacted and child welfare-involved families who are disproportionately Black, Indigenous and Latino/a.

The Approach was intentionally designed to be adaptable to local contexts. Unlike a model that prescribes specific practices or steps to be deployed, often with unmodifiable, detailed sequencing, the Approach is a process by which professionals at all levels of practice can seek to better understand, serve, and help child welfare-involved and DV-impacted families. The Approach is a beacon of information and knowledge providing guidance and direction for how to engage, connect, and partner with DV survivors

[1] The QIC-DVCW Program Team was composed of ten expert practitioners with 15 - 35+ years of experience working in child protection, domestic violence, or with people who use violence.

and their abusive partners. It informs assessment of and case planning with DV-impacted families, emphasizing survivor driven solution design that meets the needs of both child and adult DV survivors. The Approach consists of six principles and two frameworks.

The six principles act as goal posts for professionals to evaluate the quality and impact of their responses, decisions, and actions associated with DV identification, assessment, and response in families where DV and child maltreatment co-exist. In brief, the six principles are:

- **Collaboration**: Collaboration among multiple partners and at multiple levels is essential to meet the safety, mental health, basic needs, healing, and well-being of families experiencing DV.
- **Connectedness**: Improving outcomes for child and adult survivors who are involved in the child welfare system requires that their safety, healing, and well-being are addressed interdependently and not at the expense of one another.
- **Planning with Survivors**: DV survivors know the most about their own circumstances, the danger they are in, what helps, and what does not. Survivors' knowledge, perspectives and experiences should drive case/service planning and interventions.
- **Unique Strengths and Challenges:** Case planning, interventions, and court orders should be flexible, individualized, build on family members' strengths, support parent-child relationships, and address the family's unique contexts, challenges, and barriers to meaningful help.
- **Equity:** Addressing racial, gender, and economic disparities are essential to addressing the roots and negative impacts of DV and child maltreatment related trauma for child and adult survivors in order to meet the needs of families.
- **Healing and Well-being:** Individuals in families experiencing DV can and do heal, including adult and child survivors and people who use violence and coercion.[2] Promoting trauma-informed service delivery and case planning helps families get and stay on a trajectory of health and well-being ensuring positive outcomes.

The two practice frameworks offer strategies to promote resilience, healing, and accountability, specifically:

- To build five protective factors that reduce the negative impacts of violence and advance the well-being of both adult and child survivors, including safer and more stable conditions; social, cultural and spiritual connections; resilience and a growth mindset; nurturing parent-child interactions; and social and emotional abilities and,
- To utilize the power of relationships as well as the authority of systems to hold abusive partners accountable for the use of violence and coercion, and to provide meaningful support for them to change.

Enabling Collaborative, Cross-Sector, Trauma-Informed DV Practice & Systems Change

Project sites worked in partnership with the KU research team to facilitate data collection and embark on a robust learning journey that explored four primary **research questions:**

1. What is the impact of a survivor-centered approach on adult and child survivor safety, child permanency, and child and family well-being?
2. For which families, and in which social contexts, does the survivor-centered approach improve these outcomes?

[2] People who use violence and coercion are referred to in some systems as batterers, perpetrators or DV offenders. The QIC-DVCW chose to use person-centered language to attempt to convey that violence is a choice, and that some people who use violence and coercion can and do change. In this report, authors occasionally use the phrase "abusive partner" for the ease of the reader.

3. What factors are associated with successful implementation and sustainability of an adult and child survivor-centered approach?

4. What are the costs associated with implementation and maintenance of an adult and child survivor-centered approach, and how does that compare with "business as usual"?

To answer these questions, three studies were conducted: an **outcomes study**, an **implementation study**, and a **cost study**.

To ensure consistent rollout of the Approach, at each Project's intervention site(s) the QIC-DVCW Program Team provided (1) training on the Approach for staff at all levels among collaborating partners situated at child welfare, the courts, community-based DV organizations, and battering intervention programs (BIPs), (2) two years of monthly coaching of supervisors and managers of direct service staff in those same systems and (3) targeted and responsive technical assistance (TA) to cross-sector implementation and management teams.

The decision by the QIC-DVCW Management Team[3] to build and support supervision and managerial excellence with the Approach was deliberate and based on prior tacit wisdom and child welfare research that meaningful practice and transformational system change comes from frontline supervisors and middle management. It is this level of infrastructure where innovation is endorsed, enabled, and shepherded, where primary decisions and solutions are designed, authorized, and implemented, and where there is less turnover enabling conditions to facilitate lasting changes. We designed our Approach on the premise that increased critical thinking, intentional support, and targeted skills at the management level would have a positive impact on collaborative, creative problem solving in direct practice with children and families, a significant influence on team and organization level policy changes, and, in turn, change "business as usual" across sectors writ large.

Studying the impacts, mechanisms, and costs of collaborative, trauma focused, DV specific systems change

The three studies that form the backbone of the research were collaboratively designed to provide an integrated and comprehensive picture of what was done, how it was done, and what impact it had on the experiences of families, practice, and cross-sector systems change - to include assessing the cost of doing business in this way. The studies employed a quasi-experimental, longitudinal, mixed methods design that included common measurement of constructs and multiple data collection methods including surveys, interviews, focus groups, administrative data, case record reviews, and implementation tracking. When feasible, the research question types included three kinds of comparisons: sites (intervention and comparison), project (three projects), and time. Data from each source was analyzed and cross-referenced with other data sources to provide a robust view of complex system change. Power analyses were completed across all three studies. Data analysis involved descriptive statistics, baseline equivalency when relevant, multivariate statistics, and thematic coding.

While the Approach represents a level of systems change that can take years to reach its full effect, within a few years of active implementation results from the impact, implementation, and cost studies found **positive child outcomes, improved child welfare and community partner practice and collaboration, and increased equity practices**. Across the two projects who were able to provide cost study data, the **cost of the intervention per household was up to $1187 less than current practice**. What follows are brief highlights of impactful findings. A full review and discussion of all the findings across the three studies is provided in the body of the report.

1. **Child safety and permanency improved at the individual project level.**

   - In the Allegheny County, Pennsylvania Project:

[3] The QIC-DVCW Management Team was comprised of key leaders from the partner organizations: the Center for the Study of Social Policy, Latinos United for Peace and Equity-Caminar Latino, the Center for Health and Safety Culture, the National Council of Juvenile and Family Court Judges, the Evaluation Team at the University of Kansas, and a retired child welfare director with 30+ years of experience in the field.

- Child maltreatment recurrence rates were lower where the approach was utilized, specifically for children under 10 years of age who had an initial allegation of neglect,
- For families experiencing co-occurring DV and neglect, there was a 149 percent higher likelihood of maltreatment recurrence in comparison sites than in implementation sites, and
- There was a decrease in foster care removal rates in implementation sites while they increased in comparison sites.

- In the Illinois Project:
  - Reunification rates of children with parents rose at implementation sites, specifically for children identified as either Black and not Latino/a or as Latino/a and any race, and
  - Youth served by intervention sites and who were in foster care for two or more years were more stable.

2. **Across all three projects adult survivor experiences varied. Almost all survivors interviewed felt they were held accountable for their abusive partner's behaviors and/or feared losing their children, while almost half of survivors also had some positive experiences.**

   - Most survivors had some difficult experiences with child welfare caseworkers.

     "I would say it was more so terrifying because they were trying to, like, take the kids away from me and the domestic [abuse] didn't come because I was abusing the kids. They came from a domestic relationship with the kids' father. It was more so terrifying because I didn't want to lose my kids at all."

   - Of adult survivors interviewed, 13 out of 31 also reported some helpful experiences with child welfare caseworkers.

     "...you could tell that she really does want to help out actually. You can spot the difference when someone's just doing their job, because it's their job. And from her, I didn't get that. I got like, 'Wow. She's really interested in wanting to know everything.' You could tell that she wants the best interest, not only for me, but for my kid as well."

     "What really stands out to me, I think, would be the second time around, we got the same caseworker, and she's completely changing their approach. She said, whereas before like they don't feel like we're a high-risk family, so we would just get the one-month phone call in - and anyway, the second time around she said she's gotten her supervisor involved. And her supervisor is a man, so she has him in the conversation with my son's dad. She just feels like he just - he never would answer the phone before, and they would just not really do anything about it, as long as I answered, and they had contacted me it was fine. But they didn't - so now, they're kind of approaching it in a more, like, aggressive way, I guess."

   - More than half of adult survivors interviewed (19 out of 31) believed that child welfare, and specifically their caseworkers, doubted their love for or protection of their children. Instead, they reported, caseworkers viewed them as choosing to stay in the relationship over their children's safety.

     "...they just continue to see me as - I don't know, I guess just this monster. And I guess, what their biggest thing is they - I feel like, how they view it is that I don't love my children, because I couldn't stop using or I couldn't leave their father. And, my thing is, it has nothing to do with my love for my children. I love them very much. I had everything to do with the fact that I

didn't love myself enough and that's where they're wrong."

- While the qualitative interviews were solely focused on the survivors' experience with child welfare and did not inquire into the survivor's experience of abuse or their relationship, overwhelmingly adult survivors discussed the abuse they endured at the hands of their partner and their care and concern for their children. In the Adult Survivor Field Survey, survivors in the intervention offices were more likely to rate their trauma symptoms as more severe in number and frequency than those in comparison offices. Almost all of the 31 survivors interviewed feared and understood that being a survivor of domestic violence meant being at risk of or losing their children.

3. **Child welfare caseworkers at intervention sites were more inclined to recognize indicators of protection and resilience among adult DV survivors.**

- Caseworkers at intervention sites demonstrated greater awareness of adult survivors' capacities and protective actions, including survivors:
  - Identifying strategies to counter the negative impact of domestic violence on their children,
  - Expressing confidence that they can achieve positive goals,
  - Recognizing tough or bad situations as temporary, and
  - Persevering even when they encounter challenges.

4. **Communication and collaboration between staff within teams and across sectors improved.**

- CW workers, advocates, professionals serving people who use violence, supervisors, lawyers, and judges communicated and collaborated among themselves, with each other, and across settings. Communication and collaboration improved at the organizational and practice level.

"I feel like people held risk more, there were situations where I felt like, in a different office with a different group of people, they would have taken custody of these kids. And in [the intervention] offices, I was in conversations where we easily could have made the argument in court that we needed to [remove] kids, but they really wanted to try to do a different approach with the adults before feeling like that was our only course of action."

"There has been an uptick in group thinking, group consultations, that involve far more people than usually it would, in the past, it might be a social worker and supervisor asking to consult with [DV experts]. There have been a lot of cases in the [de-identified] intervention offices where it was the [de-identified higher level administrators], the supervisor and the social worker, and maybe the response team, there's like nine people in this conversation, problem solving. So, I think that goes, and there were also some community providers that were in some of those meetings. So, the use of sort of a collaborative thinking on cases together, I think increased."

"When I think about outcomes on cases, again, I just think there was probably more and deeper collaborative efforts and conversation between service providers, between our staff, and between – and [child welfare agency] staff on cases… And I think that as a result of this effort, maybe more people were comfortable stepping into that like uninvited consultant role."

5. **Child welfare and community partner mindsets about DV shifted and practices improved.**

   - Evidence of the use of shared principles and application of frameworks to practice emerged from the implementation study results in the adoption of Approach language contributing to positive changes in mindsets, case planning, and decision-making.

     "...it's changing our language. You know, it's not the batterer, it's not the victim. And I would take that into supervision, because I think it really, those terms are so negative, and it really biases how you look at the survivor and the person who uses violence very differently."

     "I have been in area clinical meetings where people have discussed their concerns about DV. Serious concerns in terms of whether or not, the person who uses violence poses a risk to the children or not, and that the planning has been very thoughtful. And that I've seen some of those cases closed because people have been able to really stabilize."

   - Child welfare staff also reported improvements in accountability practice behaviors.

     "...now I see the person that uses violence different[ly] than just the file that I'm reading, and I tell people that he's no longer that record that I pulled out, and he's more than just that. So that shaped the way I see people that use violence."

     "And then we have seen more fathers be involved, that's one of the things that I personally didn't expect, but more fathers have been involved, they have been engaged."

   - Community partners increased their utilization of protective factor practice behaviors. Regardless of whether survivors were served by intervention or comparison offices, adult survivors report experiencing DV advocates' approach and practice being more aligned with the Approach compared to those of child welfare workers.

6. **Improvements in equity-focused goal setting, measuring equity, strengthening staff preparedness to engage in equity-focused practices, and enhancing equity practices emerged as positive impacts.**

   - As part of this effort, Latinos United for Peace and Equity collaborated with the University of Kansas Evaluation Team and Futures Without Violence to develop a Centering Racial Equity in Collaboration Survey. At the time of implementation in 2019, no instrument existed (to the research and project team's knowledge) that infused racial equity into the assessment of collaboration across organizational partnerships.

   - Participants across the sites described ways their projects identify and work to alleviate race and gender inequities.

   - Over the course of the study, an upward trend and significant treatment effect was observed for how well-prepared respondents felt to actively engage in equity practice, which correlated with how highly participants scored themselves on their equity practice behaviors.

   - An upward trend was observed in equity practice behaviors – more willingness to deal with conflict openly and respectfully, enhanced awareness of cultural impositions, and a willingness of those in power to compromise – enabling engagement and trust-building with marginalized groups.

   - Analysis of qualitative group interviews with project participants suggests that coaching and implementation teams played a positive and contributing role to these equity results.

"...the racial equity discussions, really for me, seem to have a strong focus in our coaching sessions. And I think, reinforced that we already knew [was] really important, but we tend to fall away from them when they're not in focus... And recognizing you have to have a network, and you have to have partners, even though we felt like - you're getting the work, you can't do it alone."

7. **Practice frameworks offer criteria beyond compliance and its derivatives - such as cooperation, treatment completion, parental agreeableness or attitude - to assess parental fitness, focusing more on the nature and quality of services being provided**.

"...these cases are involved in the court, the decisions that judges are able to make, based upon the quality, the social workers write like court reports for the judge and providing a lot of that detail around the resiliency factors and their engagement in these community-based treatment programs. It really helps the court and the judge, you know, with the goal of obviously keeping children, you know, in their homes and in their communities. So, it completely impacts you know, all of our practice... the decrease of assumptions and the quick judgment and ultimately making those assessment decisions was really slowed down."

"So just having one of the judges mentioned once that now when [they] see the person that uses violence, [they are] also looking at more, and what else can we connect this person, and how can they – how can we better serve the family, not just this is what I'm here to do, we're thinking about the entire family. So having a judge, having people in power, saying this is how this is helping us make a lot of things easier. So now we don't have the distrust, well if you go to the district court, most likely this is what's going to happen, and now you can say actually, if you go to [de-identified] Court, they're trying to make a push to be able to see the entire family. [Being] able to talk to and hear what the family need[s], and hear what advocates are the recommendations that the advocates are having. So, I think just being with each other, I think made that connection even stronger."

Launching and implementing this work during the beginning of a global pandemic had its challenges, and also made clear that innovation can and does happen. Some of the mechanisms that enabled significant practice change on a grand scale involved having shared ways of seeing, thinking, communicating, and doing across system actors directly involved. Participants at the intervention sites protected space and shifted the nature of practice conversations to align priorities and focus case actions on addressing trauma, promoting healing and well-being, enabling equity-focused decision making, promoting protective factors, and enhancing accountability. What follows are ten actionable insights around which further systems change efforts can be launched and evaluated based on both the findings from the research and the lessons learned from scaffolding cross-sector systems change during a global pandemic.

Actionable insight 1 > Professionals serving families who experience domestic violence can decrease risk and strengthen families by reducing stress and burden. Battering intervention groups increased their focus on emotional regulation skills with participants to help prevent violence. DV advocates began asking survivors on Zoom calls general questions about stressors and burdens on families, and then responded to specific needs, such as organizing community volunteers to help children with homework to provide adults much-needed respite. Child welfare caseworkers took food and personal protective equipment to families' homes and asked what other resources they needed.

Actionable insight 2 > Collaboration among team members and across systems leads to

innovative resource allocations that enhance safety by building protective factors. For example, a budget manager advocated with colleagues for the purchase of plane tickets to allow a survivor and her children to flee to a relative's home in another state rather than petition the court for custody.

Actionable insight 3 > Collaboration between partners (child welfare staff, DV programs, abusive partner programs, judges, attorneys and other court staff) and with families enable the use of benchmarks beyond compliance (and its derivatives such as cooperativeness, parental attitude, motivation, awareness, or remorse for example) to assess case progress and adjudicate court involved families. After being trained, a judge included in his annual visit to child welfare offices an explanation of his new Approach-aligned expectations, and shared the specific questions he would be asking caseworkers and lawyers in DV cases. A judge who joined the project late requested specific TA on how to talk to people who use violence to better engage them in a conversation about changing behaviors that were harming their children.

Actionable insight 4 > Promoting protective factors and enabling relational and systemic accountability are trauma-informed strategies that are demonstrative of reasonable efforts on behalf of families where child maltreatment and DV co-occur. A domestic violence advocate who accompanied an investigator on a home visit opened avenues of accountability for the father by engaging with him around his love for his child. Together the advocate and investigator convinced the father to re-install a license plate on the car so the mother and child could find a safer place to live. Without the advocate, the child would have been removed and the mother would have remained unsafe.

Actionable insight 5 > Listening to, partnering with, and supporting adult and child survivors as well as abusive partners to improve their experiences and life conditions helps to orient service and intervention design and case management towards safety, healing, trauma, building resilience, and well-being. A caseworker who described a young, previously violent father as overwhelmed and depressed sought out free time at a local music studio to provide a creative outlet for him. Instead of asking, "Why aren't we removing these children who have been exposed to DV?" some staff asked, "What else can we try to keep these children out of foster care?"

Actionable insight 6 > Survivors can be seen and engaged beyond their victimization status and people who use violence beyond their aggression. Changing terminology from victim to survivor, and abuser or batterer to person using violence, shifted child welfare and community partner mindsets, prompting new perspectives on survivor resilience, outreach and engagement with abusing partners, how to help families, and whether change is possible.

Actionable insight 7 > Creating regular and intentional space for child welfare staff and partnering agencies strengthens individual and team readiness to define an equity agenda and improve equity driven practices. Following George Floyd's murder, supervisors and managers used the coaching space to grieve, process, and reflect on how to address the racism of the child welfare system, described as metaphorical "chokeholds" on Black, Indigenous, and Latino/a families. Similarly, implementation teams intentionally developed their capacity to talk openly about race and then designed or expanded local strategies such as equity leadership development across agencies, inviting new partners into the work and strengthening their use of data to take action on disparities in practice.

Actionable insight 8 > Meaningful change at the practice and systems level requires both active support for critical thinking, and utilization of enforceable and concrete practice protocols for engagement, assessment and planning. Coaches spent time in cohorts reviewing basic child welfare DV practice guidance that supervisors had not previously been trained on and with which they were not familiar. Both supervisors and managers identified the critical need for practical tools and on-going efforts to build staff skills for a nuanced and contextual assessment of risk due to DV, as well as critical inquiry and analysis, without which they tend more towards all or nothing thinking as well as more narrow problem framing and problem solving. Judges also play a role. One participant reported that "the judges in [our project site] have

really seen this as an opportunity to go back to child welfare and say you're not doing your jobs, this, that and the other when you bring these cases to court. And I think part of that is because they have been involved in this and learned more about what should be done."

Actionable insight 9 > The presence of domestic violence in child welfare cases provokes an immediate knee jerk response that is not centered on children, and too often has direct, negative impacts on children's well-being. A supervisor who transferred from one office to an intervention office participated in an extended DV case staffing focused on creative ways to support the family. She questioned why the child was not simply being removed as usual, noting that it was standard practice in her previous office.

Actionable insight 10 > Caseworkers are critical to holding people who use violence, and not survivors, accountable for the harm they cause. Almost all adult survivors interviewed felt that their partners were 'given a pass' by child welfare. More than half expressed the belief that their caseworker doubted their love for or protective actions for their children because of their continued involvement in their relationship with their partner. In addition, in about one third of case records reviewed there was no documentation of specific tactics of DV used by the abusive partner. Where such documentation did exist, it was focused on incidents of physical abuse — meaning that the full range of harmful and controlling behaviors, and the impact on children's safety and well-being — went unnoticed, unexplored, or undocumented.

CONCLUSION

Collaboration with other agencies and partnering with survivors and families is at the heart of the Approach. Within a system as complex as child welfare, partnering with families regularly takes a back seat to bureaucratic requirements and timelines. Results from the implementation study and coaching indicate systemic norms informed by legal standards and governmental requirements constrain full and sustainable implementation of a survivor-centered approach and practice on the frontlines. Leaders have a key role to play in shifting mindsets from crisis management as the driving response framework, liability navigation as a key consideration in decision making, and compliance oversight as the overarching assessment of case progress. Partnering with survivors and families requires investing time in building relationships marked by respect and cultural humility, supporting survivor safety and well-being through changing circumstances, building upon the strengths and resilience that allow people to survive DV and child welfare involvement, and providing what parents really need to do their best for their children. Collaboration makes new human and material resources available to help families and to provide a mirror and accountability for the child welfare system's disproportionate and harmful impact on Black, Native and Latino/a families. Sharing power and resources, enabling leaders in multiple agencies and committing to truth-telling are essential ingredients of authentic collaboration.

Survivors and families experiencing domestic violence know more about their own lives than child welfare or any system ever will. Children and their families deserve our best thinking, our most innovative design, fair and just problem solving, and a sustained and authentic commitment to collaborative, trauma-informed, organizational learning and continuous quality improvements of the public systems and non-profit landscape. The Quality Improvement Center on Child Welfare and Domestic Violence was exactly that – a bold investment in cross-sector systems change aimed at improving our abilities to recognize and effectively respond to and, whenever possible, prevent domestic violence.

SECTION 1. INTRODUCTION AND BACKGROUND ON THE QIC-DVCW

REPORT ORGANIZATION

This final report of the Quality Improvement Center on Domestic Violence in Child Welfare (QIC-DVCW) is organized to provide a comprehensive understanding of our research on an Adult & Child Survivor-Centered Approach to improving how child welfare agencies and collaborating partners serve and improve outcomes for families experiencing domestic violence (DV) and co-occurring child maltreatment.

- Section 1 offers an introduction and background on the QIC-DVCW, including a description of the importance of this work, the Adult & Child Survivor-Centered Approach (the Approach), and our use of implementation science.
- Section 2 describes our work with three QIC-DVCW Projects (Projects) in Massachusetts, Illinois and Pennsylvania.
- Section 3 describes evaluation design and methods, including a description of the QIC-DVCW's implementation, cost, and outcomes studies; our research questions and logic model; and methods used, by data source.
- In Section 4 presents the results of our cross-site implementation study.
- Section 5 presents detailed cross-site results of the outcomes study.
- Section 6 presents the results of the cost study for the two Projects for which we had sufficient data.
- In Sections 7 through 9 we share Project-specific results.
- In Section 10 offers a discussion and thoughts about the application of our results.
- Section 11 sets forth the strengths and limitations of the QIC-DVCW evaluation.
- Implications for the future are described in Section 12.

BACKGROUND

In 2016, the Children's Bureau awarded grant #90CA1850 to Futures Without Violence (FUTURES) to lead the QIC-DVCW to build evidence for a collaborative, trauma-informed approach to domestic violence and co-occurring child maltreatment in child welfare caseloads. Building on current research, practice wisdom and a prior federal initiative fifteen years earlier that funded demonstration projects to implement and evaluate 60 recommendations for child welfare agencies, domestic violence programs and family courts, the QIC-DVCW described an Adult & Child Survivor-Centered Approach to implement with demonstration projects.

Importance of this work

Domestic violence is a serious public health issue. According to the National Intimate Partner and Sexual Violence Survey, one in 2 women and more than 40% of men experienced sexual violence, physical violence and/or stalking by an intimate partner during their lifetime (Loomis, et al., 2022). The CDC survey underscores the pervasiveness of this violence, the immediate impacts of victimization, and the lifelong health consequences for survivors. Women are disproportionately impacted, and experience high rates of severe intimate partner violence, rape, stalking, and long-term chronic disease and other negative health impacts, such as post-traumatic stress disorder symptoms. (Smith, et al., 2018) Many of them are mothers.

Research shows that one in five children is exposed to family violence in their lifetime and one in every three or four children will witness domestic violence. (Finkelhor, et al., 2015). Nationally, there is a 30 to 60 percent overlap of child maltreatment and domestic

violence (Catalano, 2019). The co-occurrence of domestic violence and child maltreatment can have significant effects on children, although exposure to domestic violence does not equate to child abuse or neglect under the law in many jurisdictions, nor should it. Impacts on children include behavioral, emotional, cognitive, and social difficulties. The impact of domestic violence may trigger a "toxic stress response," which can alter the architecture in the brain (National Scientific Council on the Developing Child, 2005/2014) possibly leading to stress-related diseases and poorer health outcomes in adulthood. Not all children exposed to violence will develop trauma or trauma symptoms; however, when assessing families for service delivery, children's experiences must also be taken into consideration.

The support of family and community are essential to strengthening children's capacity for resilience, their ability to recover from traumatic experiences, and thrive (Vogel & the Family Systems Collaborative Group, 2017). Building protective factors at multiple levels and across sectors, funding two-generation service models, avoiding removals of children from the care of a parent whenever possible, prioritizing kinship placements, and many other strategies can be effective in enhancing parent and child well-being and rebuilding the parent-child bond that can be disrupted by abuse in the home (Chamberlain, 2018).

In addition, research has demonstrated that collaborations between child welfare agencies and domestic violence programs can have immense impact on the lives of families and children struggling with co-occurring traumas, social disparities, and limited access to adequate resources in their communities. A more coordinated approach that promotes integrated knowledge about domestic violence, training on trauma-informed responses, and joint policy design enables child welfare agencies, court systems, and domestic violence programs to improve the safety, permanency, and well-being for child welfare involved pregnant and parenting families experiencing domestic violence (Center for Human Research, 2014).

INTERVENTION: AN ADULT & CHILD SURVIVOR–CENTERED APPROACH[4]

Six guiding principles and two practice frameworks are the foundation of an Adult & Child Survivor-Centered Approach (Approach) implemented by the QIC-DVCW Project sites. The principles articulate the fundamental priorities and values of the Approach. Together these principles create a common vision for collaborating partners– irrespective of their specific missions, goals, and strategies– about how to strengthen services for and improve outcomes of families who are experiencing domestic violence and are involved in the child welfare system. The Protective Factors for Survivors framework provides guidance about building protective factors that mitigate negative impacts of DV and increase the likelihood of positive outcomes for adult and child survivors. The Relational and Systemic Accountability framework provides guidance about working consistently, safely, and productively with persons who cause harm to their families by using violence and coercive control.

Guiding Principles

Collaboration

Multiple existing and new community partners are essential to more effectively promote the safety of child and adult survivors and accountability for the person using violence and coercive control, help families access needed resources, and support the healing and well-being of all family members.

Collaboration drives the Approach. Existing collaborative partnerships among child welfare

[4] The Adult & Child Survivor-Centered Approach has been rebranded as Bridges to Better: Groundwork for building survivor-centered systems. The Protective Factors for Survivors framework is now Pathways to Healing, and the Relational and Systemic Accountability framework is now Pathways to Accountability. For ease of the reader and clarity of project participants, throughout most of this document authors have used the original name of the intervention. In the Implications for the Future section, we refer to Bridges to Better.

agencies, courts, and programs for survivors and their abusive partners are critical for meeting the needs of families experiencing domestic violence who are involved with the child welfare system. Engaging new partners further strengthens community capacity – faith communities, childcare centers, schools, law enforcement, mental health and substance use treatment providers, homeless shelters, public housing agencies, and other child- and family-serving organizations can play important roles in helping families experiencing DV. Family-level (or case-level) collaboration involves staff working in partnership with DV survivors themselves, with people who use violence when possible, and with staff of other agencies. Institutional- and community-level collaboration focuses on partners aligning their policy, practice, organizational culture, and programming across sectors in order to help families, regardless of their individual mandates or missions.

Connectedness

The safety and well-being needs of child and adult survivors of domestic violence are inextricably linked.

While adult survivors and child survivors of domestic violence are heterogeneous groups with varied experiences, reactions and needs, DV can negatively impact both child and adult survivors in a family. Thus, improving outcomes for child and adult survivors who are involved in the child welfare system requires domestic violence to be treated as a family matter where the safety, healing, and well-being of adults and children are addressed interdependently.

Planning with survivors

Child and adult survivors are safer and better off overall when planning is conducted *with* them and integrates their perspectives.

Survivors of domestic violence know the most about their own circumstances, including how helpful prior interventions and responses of systems have been to their safety and well-being. In addition, adult survivors' self-assessments of risk are often more accurate than formal risk assessments. Thus, collaborative partners should work closely with survivors to craft safety and case plans that consider both research-based indicators of high risk *and* survivors' knowledge and perspectives. Plans should be revised and refined as survivors' circumstances change over time.

Unique Strengths and Challenges

Planning and interventions should integrate family members' strengths, support nurturing parent-child relationships and address the family's unique contexts and challenges.

Intervention strategies must be flexible and individualized for survivors in order to address their specific circumstances and characteristics. In addition, while managing risk is necessary, alone it is not sufficient to create optimal outcomes for adult and child survivors and families as a whole. Thus, planning and interventions should build upon families' strengths and successes, honor their cultural beliefs, remove barriers to help, leverage parents' love and desire for their children to thrive, and actively address challenges to their healthy functioning (e.g., social isolation, substance use disorders, housing and employment instability, trauma).

Equity

Collaborative partners should actively work toward racial, ethnic, and gender equity in families' access to resources and services and in their outcomes.

Studies have provided strong evidence that structural racism and other social inequities related to race, ethnicity, and gender contribute to poorer outcomes for children and adults. In addition, adult and child survivors of DV may experience institutional biases by the systems, organizations, or service providers they turn to for help when they are confronted with victim-blaming and gender-biased attitudes, practices, and expectations which result in additional trauma for survivors (e.g., blaming the mother for not protecting her children from witnessing violence; believing mothers should be primarily

responsible for parenting). When social inequities related to race, ethnicity, and gender intersect with DV, survivors are at increased risk of inequitable treatment and, consequently, poorer well-being outcomes. In order to help all families to thrive, collaborative partners should actively work at the individual, institutional, and community levels to maximize adult and child survivors' access to the resources and services they need, reduce the social inequities they face, and increase racial, ethnic, and gender equity.

Healing and Well-Being

Collaborative partners must actively build protective factors that contribute to adult and child survivors' healing and well-being in addition to addressing their risk factors.

Assessing and addressing risk should not singularly determine collaborative partners' planning and interventions. Strategies should also focus on building survivors' protective factors to ensure that families are on a trajectory of healthy and productive outcomes.

For more information on the principles of the Approach, see https://bridgestobetter.org/resources/overview-of-bridges-to-better-groundwork-for-building-survivor-centered-systems

Protective Factors for Survivors

Domestic violence protective factors are individual and relational attributes, as well as environmental and social conditions, that help to reduce the impact of DV, build individual strengths, promote healthy development, and establish environments that support safety, healing and well-being of family members. An environment of on-going DV can make it more difficult to reinforce or build protective factors because the person using violence often directly or indirectly undermines survivors' relationships, access to resources, parenting role, and sense of self-worth. Nonetheless, building survivors protective factors is essential for their healing and well-being. Protective factors can be strengthened even under adverse circumstances, and growth in any one of the protective factors can be the foundation for current or future growth in others. The five interrelated protective factors for DV survivors are relevant for children as well as adults:

Safer and more stable conditions

Experiencing safer and more stable conditions while in an abusive relationship, planning to leave, or after leaving are essential for buffering the negative effects of domestic violence and for healing from the impact of DV and co-occurring child maltreatment. In this context safety means being free from physical, sexual, or emotional fear and harm in one's physical and social environments and relationships, such as threats, intimidation, humiliation, stalking, economic abuse, coercion, and isolation.

But safety is not an absolute and the degree of safety that can be achieved is influenced by many factors. Safer options for one family may not be feasible for another family. Survivors' personal histories, cultural norms, and adverse experiences– including systemic oppression– influence how safety is perceived, understood, and experienced. The type, availability, and manner in which support, help, and resources are offered is another major determinant of safety and stability. The degree of safety that can be achieved is dependent, in part, upon the attitudes and actions of the abusive partner, and upon survivors' access to meaningful support, help and resources. Thus, it is essential for survivors and practitioners to jointly and continually discuss survivors' rights, safety options, community resources, ways to remove obstacles that may interfere with safer conditions, and strategies that reduce domestic violence risk factors. The goal is to ensure that adult and child survivors' safer conditions do not provide just a temporary respite, but longer-term stability.

Achieving more stable conditions enhances and sustains safety. Stable conditions include predictable and consistent positive experiences in one's physical and social environments and relationships including housing, employment, finances, transportation, childcare, education, and

interpersonal interactions. Unstable conditions can negatively affect adult and child survivors' choices, decision-making, problem-solving, sense of security, self-efficacy, social interactions, emotional responses, parenting skills, and access to help. Stable conditions can help to buffer the impact of stressful and traumatic experiences on adult and child survivors and increase adults' sense of control over their lives and what happens to their children.

Social, cultural, and spiritual connections

Research studies have documented that adult and child survivors' healthy and constructive relationships positively impact their healing and well-being. Social, cultural, and spiritual connections for survivors of DV refer to sustained relationships with people, institutions, the community, or a force greater than oneself that promote a sense of connectedness and positive identity which results in feelings of trust, belonging, faith, hope, and a belief that one matters. Social, cultural, and spiritual connections are valuable resources for survivors because they provide:

- *concrete support* (e.g., physical and mental health services, restraining orders, safe housing, financial assistance, links to jobs);
- *affiliative support* (e.g., friendship, connectedness with others who share similar circumstances);
- *emotional support* (e.g., non-judgmental advice; empathy);
- *informational support* (e.g., guidance and advice, recommendations for services or resources); (e) cultural support (e.g., shared identity, traditions, and a sense of community); and
- *spiritual support* (e.g., hope and encouragement; a sense of meaning and purpose to life).

When families are faced with traumatic experiences like domestic violence, these types of support are particularly important because abusive partners often rely on isolation and limiting survivors' options (Stark, 2007). Survivors may also lack social connections if they experience language or cultural barriers or have to give up their jobs, change schools, or leave family and friends behind when fleeing from domestic violence. Lack of social connections can cause parental stress, rather than reduce stress (Raikes & Thompson, 2005).

Research also indicates that an important resource protecting children from the negative effects of exposure to violence is a healthy relationship with a caring, supportive, trustful adult (Osofsky, 1999). Children's own social connections, both with peers and adults, also help to promote multiple aspects of their development, such as language skills, social skills, self-confidence, and self-esteem (Carpendale & Lewis, 2006).

Resilience and a growth mindset

The negative physical, emotional, economic, social and behavioral impacts of violence and coercive control adult and child survivors experience should never be minimized. But for many survivors, alongside the harm they are experiencing are personal strengths, social support, spiritual connectedness, and the potential to persevere and meet their challenges; that is, resilience. Resilience is the process of positive adaptation and personal growth– coping, problem solving, becoming more resourceful and functioning well– despite the experience of adversity like domestic violence and co-occurring child maltreatment. Positive adaptation can take many forms and is influenced by individuals' unique characteristics, life histories, social and cultural contexts, and level of violence and control in the present.

Displaying resilience requires a growth mindset– that is, the optimistic belief that one's abilities, circumstances, and challenges can be improved through a commitment to change and consistent effort. A growth mindset enables adult and child survivors to understand that, although domestic violence is a reality in their lives, they do not have to suffer forever. Displaying resilience and a growth mindset have a positive effect on the

parent, the child, and the parent-child relationship. When adult survivors have a sense of purpose, take positive action, see evidence of their ability to make good choices in addressing challenges and adversity, internalize a belief in their own power to change, and feel more in control, they are able to provide more nurturing attention to their children, which in turn fosters children's own resilience and growth mindset in the face of stressors.

Nurturing parent–child interactions

Research has shown that the single most important resource for promoting children's healthy development, well-being and healing is having at least one loving, nurturing, and protective adult in their life. Nurturing parent-child interactions occur when a parent or parent-figure consistently responds to and meets the needs of a child in an attuned,[5] affectionate, patient, and caring manner. As the well-being of adult and child survivors is inextricably linked, by strengthening nurturing parent-child interactions, both will benefit and thrive. Nurturing parent-child interactions lay the foundation for a sustained emotional bond of trust, love, and affection between a parent and child which can help to buffer children from the negative impact of stress and traumatic experiences. Nurturing parent-child interactions also lay the foundation for a sustained sense of self-efficacy in parents; self-efficacy refers to believing that one is competent and able to carry out the actions necessary to achieve a goal.

Promoting and understanding nurturing parent-child interactions in the context of domestic violence is a complex matter. Adult survivors' sense of self-efficacy, ability to meet their child's needs and quality of the parent-child bond may be compromised by the abusive partner's pattern of control, coercion, intimidation or isolation, or by systems, organizations or service providers that fail to provide needed help. This is not universally true, however. Many survivors take action to protect their children from harm, and many succeed. In addition, adult survivors often find ways to protect their children and themselves from continued harm that may seem counterintuitive to an understanding of nurturing parent-child interactions (e.g., harshly punishing a child to avoid more severe harm from the person using violence). Thus, it is important to support adult survivors in strengthening their relationships with their children in ways that are meaningful and helpful to the parent and child.

Social and emotional abilities

There is increasing evidence that building social and emotional abilities in both children and adults should be a priority when serving families who experience highly stressed conditions and circumstances like domestic violence. Overall, social and emotional skills are the knowledge, attitudes, and abilities necessary to understand and manage emotions, set and achieve positive goals, feel and show empathy for others, and make responsible decisions. Key social and emotional skills include: (a) self-efficacy; (b) expressing negative emotions in ways that don't harm others; (c) considering the consequences of one's thoughts, emotions, and behavior before acting; (d) planning and carrying out purposeful actions; (e) trying again when first attempts are not successful; (f) advocating for one's own needs; and (g) developing a sense of right and wrong. Social and emotional skills facilitate the development of adult and child survivors' healthy self-concept, self-esteem, and ability to effectively interact, communicate, and collaborate with others. Building a strong social and emotional foundation will help survivors be better equipped to handle stress and persevere through significant challenges and adversity in their lives.

For more on Protective Factors for Survivors, see https://bridgestobetter.org/resources/pathways-to-healing-protective-factors-for-adult-child-survivors-of-domestic-violence

Relational and Systemic Accountability

The domestic violence Relational and Systemic Accountability framework is an essential component of the Approach. It is grounded in the knowledge and observations of practitioners who have long worked with persons who use domestic violence, as well as on recent research. (Morrison, et al., 2017; McGinn, et al., 2017; Silvergleid, C. S., &

[5] Attuned refers to being aware of and responsive to another's feelings and/or needs.

Mankowski, 2006). For example, studies show that participants in battering intervention programs can significantly reduce or eliminate their use of coercive control with their intimate partner when awareness, accountability, support, and internal motivation are present (Edleson, 2012). Too frequently, however, people who use violence who are also parents or caregivers of children are not meaningfully engaged in child welfare system interventions with families experiencing domestic violence (Pence & Taylor, 2003) despite legal requirements that they be contacted and offered services through a case plan. As a result, the adult survivor is often held solely responsible for the children's exposure to domestic violence and for "failure to protect" them. The lack of engagement of fathers with a history of DV[6] can increase the risks to children (Pence & Taylor, 2003) while meaningful engagement of fathers by child welfare workers can result in fathers reporting improvements in their own parenting (Gladstone, et al., 2012).

Thus, this framework provides guidance about meaningfully engaging persons who use violence against their intimate partners and children within the household in ways that are safe for survivors and that promote accountability. The framework focuses on the abusive partner's accountability to adult and child survivors, to other key relationships, and to themselves. The framework describes two dimensions of accountability: relational and systemic.

Relational accountability

Relational accountability involves using the *power of relationships, connections, and human interactions* to reduce violence and support positive change. Relational accountability uses existing relationships (e.g., with family, friends, clergy) as well as acquired relationships resulting from the context of domestic violence (e.g., with judges, practitioners, community members). Relational accountability is bidirectional in that involves how persons who use violence interact with others, acknowledge responsibility for their coercive behaviors, and demonstrate efforts to make positive change, as well as how others respond to DV offenders, hold them responsible for their behaviors, and encourage positive change and growth. Examples of relational accountability strategies include having honest and caring conversations about the violence; offering connections to professional help; creating a system of ongoing "check ins"; and setting limits and establishing consequences (e.g., not being invited to family gatherings).

Systemic accountability

Systemic accountability involves using the *authority of systems* to reduce violence and guide and support people to make healthier choices for themselves and their families. Examples of systemic accountability strategies include employing legal sanctions; developing case plans with clear expectations; holding the person using harm equally responsible for assuring children's safety and well-being; and removing obstacles to making positive change (e.g., helping offenders find employment, secure housing, address mental health needs).

Generally, the approach conceives accountability on the part of the person who uses violence as:

- addressing, challenging, and ultimately reducing or ceasing their coercive control;
- establishing clear reasons and expectations for positive change (e.g., realizing the impact that their violent behaviors can have on their children);
- demonstrating via one's actions a commitment to healthier beliefs, attitudes, and behaviors that result in positive change and enhanced well-being; and
- accepting consequences for the use of coercive control.

This conception of accountability stands in contrast to the common practice of equating accountability with punishment and the criminal justice system. Research has shown that limiting responses to DV perpetration to punitive approaches is often ineffective

[6] Readers should note that there is no parallel research on lack of engagement of mothers with a history of DV.

(Trevena & Boynton, 2016; Meyer, 2018; Heckert & Gondolph, 2000). The QIC-DVCW rejects the notion that accountability must always involve legally punitive measures. However, the specific accountability strategies used should be informed by the level of risk or danger posed by the person who is using violence, their patterns and tactics of coercive control, and their level of investment in change. When risk is high and the person using violence cannot be engaged, it may be necessary to involve law enforcement and the court to limit their access to the survivors or to impose more serious consequences for continued use of violence.

Accountability measures beyond law enforcement and restraining orders can include the following activities:

- Document and talk to the person about their abusive behaviors and their impact on other family members.
- Promote equitable standards of parenting for both parents and ensure that case plans reflect those standards, within the family's cultural norms.
- Create case plans that articulate expectations for changing abusive behaviors.
- Ensure that referrals to battering intervention services include clear descriptions of abusive behaviors.
- Communicate regularly with service providers and family members to monitor behaviors.
- Enlist relatives and community leaders to talk to the person using violence about their behaviors or to take action to prevent abuse.
- Write court affidavits and case records that place responsibility for harm on the abusive partner.
- Use legal remedies to keep adult and child survivors safe from DV.
- Restrict access to children in foster or kinship care when warranted.
- Petition the court to require supervised visitation or to mandate that the person get treatment.
- Open child welfare cases in the name of the abusive parent rather than in the name of the survivor parent.

The accountability framework is grounded in the premise that holding people who use violence accountable for their behavior and the harm they cause, and supporting their positive change, is a more viable strategy than punitive-focused approaches. Effectively implementing the accountability framework requires collaboration among agencies, organizations and programs that serve people who use violence and their families; a shared understanding/vision of accountability; coordinating mechanisms for establishing it; and communicating continuously about changes in attitudes and behaviors.

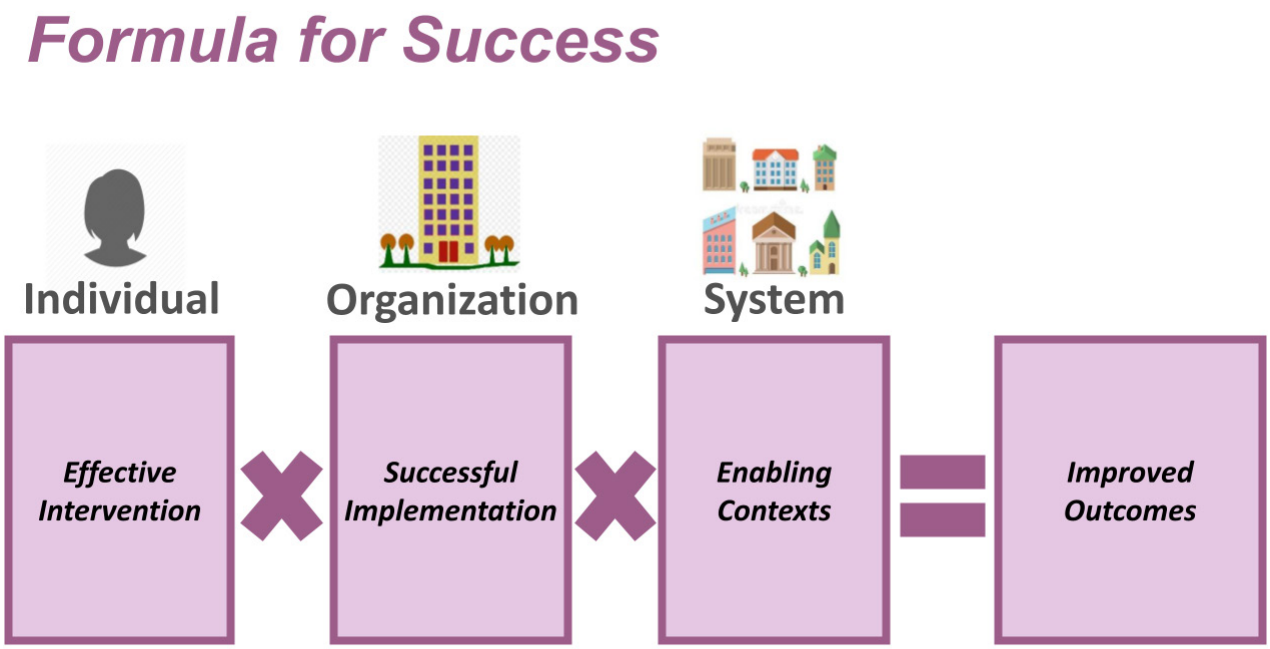
For more information on Relational & Systemic Accountability framework, see https://bridgestobetter.org/resources/pathways-to-accountability-for-people-who-use-violence

IMPLEMENTING THE APPROACH WITH IMPLEMENTATION SCIENCE

To maximize the potential for the intervention to achieve improved outcomes as indicated in the logic model, the QIC-DVCW used implementation science to guide its implementation of the intervention with projects. This growing field provides guidance for effective implementation based on extensive analysis of evaluation literature (Durlak & DuPre, 2008; Fixsen et al., 2005). In brief, the implementation science field is based on the primary assumption that implementation matters. That is, how we implement and the organizational and policy context in which we implement an intervention can affect whether that intervention achieves its intended positive outcomes. For example, if practitioners do not fully understand how to use an intervention or do not gain skills for putting it to use, then the intervention may not be implemented as intended and consequently fail to

achieve outcomes for children and families. Figure 1 visualizes this idea as a formula for success, purposefully showing the relationship between these broad factors as multiplicative, not additive. It shows that improving outcomes requires an effective intervention, successful implementation, and enabling contexts.

Figure 1. Implementation Science Formula for Success

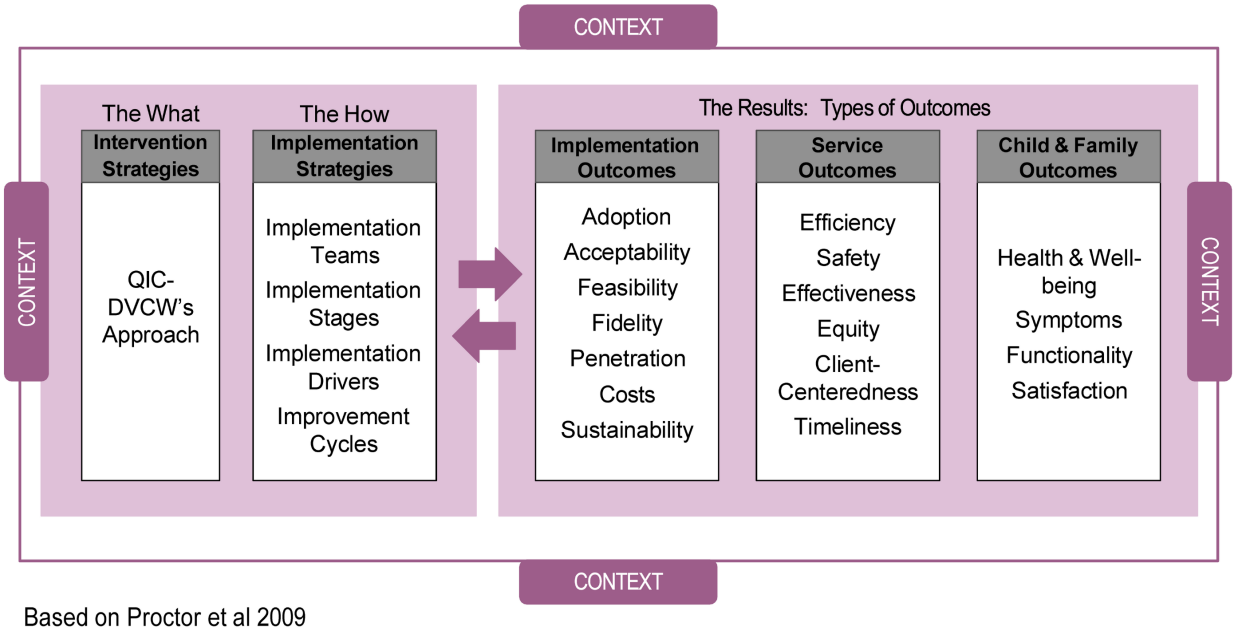


Note: Adapted from the National Implementation Research Network

Implementation Outcomes

The idea of successful implementation as shown in the *formula for success* is also connected to the evaluation's research questions. Specifically, the implementation study component of the evaluation investigated the extent to which the implementation of the QIC-DVCW's intervention was successfully implemented. This evaluation work was informed by the *Conceptual Model for Implementation Research* and its implementation outcomes taxonomy, which was developed by Dr. Enola Proctor and colleagues (2009). Proctor and colleagues describe implementation outcomes that may be assessed to understand the implementation success. They also lay out a logical sequence of relationships between the intervention, implementation strategies, and different types of implementation outcomes. In brief, Figure 2 shows that once an intervention strategy is selected, by applying implementation strategies, projects should achieve implementation outcomes which in turn should lead to improvements in service delivery (i.e., service outcomes) and ultimately improvements in the lives of children and families served by the program. Thus, this additional conceptual model complements the *formula for success* by specifying additional details of the steps that move from intervention to child and family outcomes. Although the *Conceptual Model for Implementation Research* does not add specificity on context, it acknowledges that context is relevant to the process of implementing interventions and achieving positive outcomes and, therefore, aligns with the *formula for success* on this matter. Importantly, child and family outcomes will not be realized if implementation outcomes fall short.

Figure 2. Conceptual Model for Implementation Research



Based on Proctor et al 2009

For the purposes of the QIC-DVCW evaluation, we defined implementation outcomes as follows.

- **Adoption**: *The extent to which providers/ practitioners decide to use or try a practice.*
- **Acceptability**: *The extent to which the practice is viewed as agreeable, palatable, satisfactory (includes content, complexity, comfort, delivery, and credibility)*
- **Feasibility**: *The extent to which the practice is viewed as suitable or practical for everyday use*
- **Fidelity**: *The extent to which the practice is delivered as intended*
- **Penetration/Reach**: *The extent to which the practice is spread across organization or target population*
- **Sustainability**: *The extent to which the practice is maintained, continued; also routinized and integrated*
- **Costs**: *The extent to which the practice is viewed as cost effective or high benefit-cost*

Implementation Strategies Using the Active Implementation Frameworks

The QIC-DVCW partners selected the Active Implementation Frameworks (AIF) provided by the National Implementation Research Network (NIRN) to organize and guide its use of implementation strategies. The AIFs were selected for two main reasons. The AIFs were determined to be a good fit with the goals of the QIC-DVCW, and some members of the QIC-DVCW partnership team were familiar with the AIFs.

Figure 3 briefly describes the AIFs selected by the QIC-DVCW, which included implementation teams, implementation stages, implementation drivers, and improvement cycles (Metz & Bartley, 2012). **Implementation teams** work to implement high-quality processes, and provide local expertise about the context, strengths, and barriers to change. Within the **implementation stages**, the team, in partnership with the QIC-DVCW, engaged in activities necessary for successful services and systems change. The **implementation**

drivers are the core components that provide the necessary infrastructure and support for competent and sustainable service delivery. The team engaged in **improvement cycles**, aiming to provide rapid feedback loops to address obstacles and maximize functionality. In all, these implementation strategies were well informed by implementation science and laid a foundation for implementing the Approach and working toward improved outcomes for children and families.

Figure 3. Active Implementation Frameworks Selected to Guide the QIC-DVCW

- **Implementation teams**: *Create teams that actively work to implement high-quality implementation.*
- **Implementation stages**: *Conduct stage-appropriate implementation activities.*
- **Implementation drivers**: *Focus on implementation drivers (competency, organizational, leadership) that provide the necessary infrastructure and support for competent and sustainable service delivery.*
- **Improvement cycles**: *Use feedback loops and improvement cycles to address implementation obstacles and maximize implementation functionality.*

Table 1 provides a brief description of how each AIF Implementation Framework was used by Implementation Teams and how it connected to the evaluation.

Table 1. Active Implementation Frameworks Used by Implementation Teams and Connection to Evaluation

Implementation Framework	How Implementation Teams Used It	How It Connected to Evaluation
Implementation Teams	Project sites were led and guided by implementation and project management teams The QIC-DVCW was led and guided by a management team	Measured collaboration with the Centering Racial Equity in Collaboration Survey
Implementation Stages	Teams focused on specific types of activities at specific stages	Measured early stages of implementation with early testing Measured implementation pace and completion of implementation with the Universal Stages of Implementation Completion
Implementation Drivers	Project teams assessed driver capacity to identify which drivers needed development or support	Measured fidelity to the Approach with the Fidelity Checklist Measured driver capacity with the Drivers Assessment

Implementation Framework	How Implementation Teams Used It	How It Connected to Evaluation
Improvement Cycles	Project teams used data feedback loops to develop and monitor implementation	Used continuous quality improvement approaches throughout the life of the project

Implementation Teams

Implementation teams comprise a core group of people who represent constituents of the project and its related systems. They are charged with guiding the implementation from beginning to end. Prior research has indicated that implementation teams are crucial to successful implementation because they provide a focused and accountable structure to increase the likelihood that an effort will not be abandoned or derailed (Metz & Bartley, 2012). The QIC-DVCW utilized several different kinds of teams to guide and oversee implementation as follows:

- QIC-DVCW Management Team
- QIC-DVCW Technical Assistance Teams
- Project Implementation Teams
- Project Management Teams

The use of implementation teams is important because they provide an active and engaged process for developing and monitoring implementation. In contrast to a passive implementation process where people "let implementation happen," implementation teams are critical to supporting the implementation process and "making implementation happen" (Blase et al., 2012). MA, IL, and AC Project Implementation and Management teams were responsible for making decisions about how to apply the Approach in the local context, monitoring the Approach locally, and assisting with problem-solving when Project-specific barriers were identified. Thus, each of the Projects' implementation teams developed their own implementation plans and oversaw these plans. Additionally, the QIC-DVCW Management Team provided cross-site oversight of the entire QIC-DVCW project.

Implementation Stages

As an implementation strategy, implementation stages are helpful for understanding and promoting the right implementation activities occur at the right time. Because implementation does not happen all at once, staging implementation is a realistic, thoughtful, and systematic approach to determining when to do specific activities. From the Active Implementation Frameworks, the QIC-DVCW was structured around four primary stages:

- Exploration: Assessing the local context for the Approach, determining supports needed, and establishing Approach leadership within local site
- Installation: Establishing the necessary infrastructure for using the approach, including procedures and supports for child welfare staff and community partners
- Initial Implementation: Initiating implementation of the Approach and continuing to use implementation strategies (especially implementation drivers) at all levels of organizations
- Full Implementation: Working to ensure the Approach is integrated into all levels and ecosystems of the child welfare system and used with fidelity

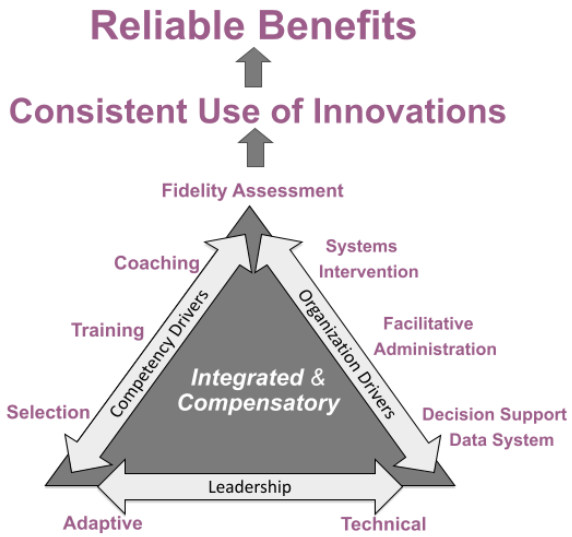
Implementation Drivers

Implementation drivers are a very important framework because they focus on the infrastructure that is required to implement and sustain the Approach. They promote the consistent and competent use of the Approach; thus, when implementation drivers are well-implemented, the Approach should be delivered

with high fidelity. As shown in Figure 4, this framework is conceptualized as having three main drivers, which represent different levels of the implementation process and include: (1) competency drivers, (2) organization drivers, and (3) leadership drivers.

Competency drivers are those most connected to practicing the Approach with families and they include staff selection, training, coaching, and fidelity assessment. Competency drivers help change and support new practice behaviors. Organization drivers are the activities or processes that make an organization and system welcoming and supportive of the Approach. They include systems intervention, facilitative administration, and decision support data system. Leadership drivers are concerned with the strategies and tactics used by leaders to address technical problems and adaptive problems. Technical problems are those that can be readily addressed due to high levels of agreement and certainty around the problem and solution. In contrast, adaptive problems are those where the problem is more difficult to define and understand and solutions are not readily known or agreed upon. The leadership driver acknowledges that effective leadership requires both technical and adaptive problem-solving.

Figure 4. Implementation Drivers



Improvement Cycles

Improvement cycles are the data-oriented activities that implementation teams use to monitor implementation and learn about its barriers and facilitators. Different types of activities may be used to activate improvement cycles, including plan-do-study-act processes, pilot/usability testing, evaluations of trainings, and other mechanisms that provide feedback from direct service staff to the implementation teams. By using improvement cycles, intervention and implementation methods may become more effective and efficient over time. Examples of activities that used improvement cycles for the implementation of the Approach include:

- Holding "cross-site" meetings with Projects, Evaluation Team, and Project partners
- Summarizing and sharing training evaluation results with the Training Team
- Summarizing and sharing preliminary results with Project Management Team
- Presenting a variety of evaluation information to Project managers, caseworkers, and supervisors

TERMINOLOGY/DEFINITIONS

Project

A demonstration **Project** consisted of two or more child welfare local or regional offices; one or more local domestic violence programs that serve survivors, people who use violence, or both; judges and legal professionals from the associated dependency court; and additional community partners identified and invited by project managers.

Project intervention and comparison sites

Intervention site: Community or geographical area in which staff of multiple agencies worked collaboratively to implement the Approach and participated in the research of the QIC-DVCW.

Representatives of multiple agencies formed implementation teams who were provided technical assistance to guide the project, and staff of those agencies were trained and coached on the Approach.

Comparison site: Community or geographical area in which staff of multiple agencies conducted business as usual and participated in the research of the QIC-DVCW.

Domestic violence

Domestic violence: Violence and control by one adult toward another in a current or former intimate relationship (e.g., spouses, dating partners, or people who have a child together). Acts of DV include physical, sexual, emotional, economic, and psychological abuse and coercive control. Coercive control refers to strategies used to gain or maintain power and dominance over a partner. (NOTE: In the Allegheny County, Pennsylvania Project and in many other jurisdictions, the term intimate partner violence is used to identify this dynamic.)

SECTION 2. QIC-DVCW AND THE DEMONSTRATION PROJECTS

STRUCTURE AND POPULATION

The QIC-DVCW was a cooperative agreement between Futures Without Violence (FUTURES) and the Children's Bureau (CB) at the Administration for Children and Families (ACF), Award #90CA1850. FUTURES is a health and social justice non-profit with a simple mission: to heal those among us who are traumatized by violence today, and to create healthy families and communities free of violence tomorrow.

Supported by a National Advisory Committee and guided by a Management Team with representation from five national partner organizations, the QIC-DVCW partnered with three demonstration projects to implement an Adult & Child Survivor-Centered Approach to creating a trauma informed and family-centered set of responses to DV. The QIC-DVCW centered around families who were experiencing DV and co-occurring child maltreatment and were involved with a child welfare agency.

QIC-DVCW Partnerships

Four organizations and a university partnered with FUTURES on the QIC-DVCW.

- The Center for the Study of Social Policy (CSSP) works to achieve a racially, economically, and socially just society in which all children, youth, and families thrive.
- Latinos United for Peace and Equity - Caminar Latino (LUPE) creates opportunities for Latino families to transform their lives and communities and works nationally to change the social conditions that give rise to violence.
- The National Council of Juvenile and Family Court Judges (NCJFCJ) provides judges, courts, and related agencies involved with juvenile, family, and domestic violence cases with the knowledge and skills to improve the lives of the families and children who seek justice.
- The Center for Health and Safety Culture at Montana State University (CHSC) is an interdisciplinary center serving communities and organizations through research, training, and support services to cultivate healthy and safe cultures.
- The University of Kansas School of Social Welfare (KUSSW) aims to transform lives and social contexts and promote social, economic, and environmental justice in Kansas, the nation and the world.

Site Selection

A competitive Request for Applications was released by the QIC-DVCW in August 2017, and more than 100 individuals from over 20 states participated in an informational webinar. Nine out of 10 jurisdictions who submitted letters of interest also submitted full applications, and one additional application was received for a total of ten. Six applications were from city, county or state child welfare agencies, one was from a provider contracted by public child welfare to provide case management and foster care services, and three applications were from tribal communities.

The review process included (1) standardized scoring of individual applications by multiple reviewers, (2) deliberations with the Children's Bureau, and (3) follow up phone calls to several applicants to discuss specific aspects of their proposals. In October 2017, the QIC-DVCW Management Team recommended approval of the Massachusetts (MA) and Illinois (IL) applications to the Children's Bureau. Because the original research design relied on having a large number of supervisory units involved in demonstration projects, after difficult deliberations the QIC-DVCW Management Team decided to focus on finding a

third site large enough to support the research as designed.

Over several months, the QIC-DVCW Project Director, Principal Investigator, and other members of the QIC-DVCW Management Team engaged in dialogue with child welfare and/or domestic violence agencies in eight states as well as making inquiries in several other jurisdictions. Lawsuits, privatization efforts, competing initiatives, federal Families First legislation, high caseloads, staff turnover, and the absence of any type of partnership with DV programs by child welfare were all cited as reasons for declining to become involved with the QIC-DVCW.

In May 2018, Allegheny County, Pennsylvania agreed to join us as our third and final demonstration project after multiple conversations about the importance of the research, the clear alignment with the practice values and goals of Allegheny County Office of Children, Youth and Families, and the strong and long-term partnership between child welfare and a large domestic violence program in Pittsburgh.

DEMONSTRATION PROJECTS AND PARTNERS

The three QIC-DVCW Projects were led by child welfare agencies with varying administrative structures and partners. Massachusetts and Illinois both have state-administered child welfare systems, with Illinois contracting some case management and foster care functions to private agencies. Pennsylvania has a state supervised and county administered child welfare system. Each Project involved associated dependency courts, domestic violence service providers and a range of community partners.

Projects identified intervention and comparison child welfare offices and partnering organizations and entities. Intervention and comparison groups included child welfare caseworkers, supervisors and managers, DV advocates, staff of other community-based organizations and dependency courts.

Although the study design was standard across the QIC-DVCW Projects, the designation of intervention and comparison offices was not identical across the three Projects. Namely, the Illinois and Allegheny County, PA Projects' intervention and comparison sites included *all* child welfare staff, while in the Massachusetts Project child welfare staff were voluntary, and therefore shaped inclusiveness of the intervention and comparison office designation.

In each Project, multi-agency implementation teams established specific goals and executed local plans to achieve those goals. Multi-agency management teams supported the work of the implementation team and addressed issues at the policy level.

Massachusetts Project

In Massachusetts (MA), Susan Hubert is the Director of the Domestic Violence Unit (DVU) at the Department of Children and Families (DCF). Ms. Hubert partnered with consultant Sam Wright Calero to lead the MA Project's Management and Implementation teams, with funding for the consultant position provided by the QIC-DVCW. The Director of the DVU is a senior level management position in the DCF Central Office, and Ms. Hubert has 30+ years of experience in the DVU.

Massachusetts Sites and Teams

The MA Project included two intervention child welfare area offices in medium to small cities (Lawrence and Haverhill) in the Northern Region, two comparison offices (Malden and Lowell) plus the Northern Regional Office of DCF. This region has a long history of innovative thinking, commitment to learning, collaboration with domestic violence programs, and stable leadership. Collaborating partners included two DV programs serving survivors (the YWCA of Northeastern Massachusetts and Supportive Care, Inc.) and one that serves both adult and child survivors and people who use violence (Jeanne Geiger Crisis Center). The YWCA and Supportive Care, Inc. provide bi-lingual and bi-cultural services that are responsive to the needs of their communities and have strong commitments to social and racial justice. QIC-DVCW funding supported their participation in the MA Project.

Jeanne Geiger Crisis Center provides Intimate Partner Abuse Education Programs (IPAEPs) and used QIC-DVCW funding to implement Strong Fathers, an evidence informed program designed for child welfare-involved fathers who have used violence. Additional partners at intervention sites included Essex County Juvenile Court, including their Probation Office, the DCF Office of Management, Planning and Analysis, DCF staff leading Father Engagement Teams, a DVU supervisor, DV and mental health specialists, and the Lawrence Police Department. At comparison sites, Respond, Inc. and Alternative House provide DV services, and Eliot Community Services offers IPAEP services to people who use violence.

MA DCF came to the QIC-DVCW with a long and impressive track record in designing and supporting strong DV child welfare case practice, much of it already consistent with the approach being implemented. For three decades, the MA DCF Domestic Violence Unit has played a significant role in the development of child welfare policy and has provided mandatory training for investigators, new supervisors and social workers. The unit has also been involved in the design of an array of service models to meet the needs of child and adult survivors of DV and to promote healthy accountability for fathers who use violence, aligned with local offices' Father Engagement Teams. DV Specialists are deeply integrated into field offices to provide case consultation, participate in Area and Regional Clinical Review Teams, and offer training and support to social workers, supervisors and managers. As a result, DV practice in MA DCF was, in some respects, at a higher starting baseline in both intervention and comparison offices than other projects. During the course of the project, statewide initiatives were also underway to promote placement stability, reduce caseloads and develop racial equity leadership teams in all offices. Community DV partners have actively collaborated with DCF for years, working together to identify areas of need for families experiencing violence, collaborating on increasing safety for families, and thinking creatively about services to meet those needs. For example, pre-QIC-DVCW, community partner organizations and DCF worked together to implement a continuum of programming for fathers whether or not they have used violence.

Taken as a whole, these various factors may have influenced project-level evaluation results.

Voluntary Participation of MA DCF Staff

To maximize staff commitment, MA conducted information sessions at area offices and recruited volunteers for the project to utilize the Approach and participate in the accompanying research. This recruitment strategy may have helped to sustain staff's strong and continued commitment through challenges like Covid-19. Across the four offices involved in the research, approximately 86% of staff volunteered to participate, and rates of attrition were low throughout the course of the Project.

Illinois Project

The Illinois Department of Children and Family Services (IL DCFS) also had two managers leading Project Management and Implementation teams. Norma Machay was the Immersion Site Director in Lake County leading a pilot of a community-connected approach to child welfare that DCFS and its partners saw as being aligned with its goals related to DV practice. Nisha Patel, Statewide Administrator of the Domestic Violence Intervention Program (DVIP) was co-manager. To support administrative and logistical work of the Project, the QIC-DVCW funded a part-time assistant over the course of the grant. Ms. Machay's role as Immersion Site Director is part of the Northern Region structure of DCFS, while Ms. Patel's statewide role is part of the Clinical Division of DCFS.

Illinois Sites and Teams

Lake County (Waukegan and surrounding areas) was identified by IL DCFS as the intervention site due to its status as an immersion site for innovative, family-centered and community-connected practices, while Winnebago County (Rockford and surrounding areas) was identified as the comparison site due to demographic similarities. In addition to staff members of these offices, DCFS representation on the Project included Regional and Area Administrators, Office of Legal Services, General Counsel's Office, Early

Childhood Project and Contracts Administration. Contracted agencies providing child welfare services who participated in the Project included One Hope United, Alden Shores, Nicasa and Community Youth Network, and CASA of Lake County.

The domestic violence advocacy community is strong and vocal in Illinois and had been encouraging DCFS to expand DV consultation capacity through the tenures of two previous DCFS Directors. Over the course of several years prior to the QIC-DVCW, DCFS DV policies and procedures were revised, programming was expanded and DV training was required of staff of both child welfare (investigation and permanency units) and contracted providers of services for families and children (foster care, specialized foster care and intact family units). During this time DCFS staff had access, albeit limited access, to consultations though the statewide DVIP. Staff of the DVIP, ranging from one to four people at any given time, were responsible for providing assistance on DV cases across 102 IL counties. Project leaders utilized QIC-DVCW funding to hire two DV Co-located Advocates to work in individual DCFS offices (both Lake and Winnebago Counties) to provide more accessible DV consultation, increase local training capacity, and provide support for staff and for all members of the family – for example, accompanying investigators in the field. A primary goal was to build evidence to obtain sustainable funding and create political support for additional advocate positions to supplement the work of the statewide DVIP.

Implementation and Management Team DV partners included A Safe Place, Remedies Renewing Lives, the Illinois Coalition Against DV, DCFS DVIP, the Network: Advocating Against Domestic Violence, and the Family Defense Center (now Ascend Justice). Other partners on teams included the 19th Circuit Juvenile Court, the State's Attorney's Office, Lake County Public Defender's Office, Court Appointed Special Advocate (CASA) Office, and a parent advocate with lived expertise as a survivor of both domestic violence and a child welfare intervention. QIC-DVCW funding supported participation by some of the DV partners listed above.

DV Co-Located Advocates and the Approach

While the DV Co-located Advocate in Lake County was trained on the Approach and worked to utilize the principles and frameworks in her consultations with staff and in her work with families, the advocate in Winnebago County did not have access to the same training and support from the QIC-DVCW due to their status as a comparison site. Both advocates were supervised through the respective DV programs who employed them and provided the same basic service to child welfare caseworkers and supervisors, as well as to families. At times, the lines in the Project between the introduction of the advocate positions and implementation of the Approach became blurred, but each time the Implementation and Management Teams identified relevant issues and found solutions that allowed them to move forward.

Allegheny County, Pennsylvania Project

In Allegheny County (AC), Pennsylvania, an experienced project manager (although with no direct experience in domestic violence) was originally assigned to lead the AC Project based at the Department of Human Services, Office of Children, Youth and Families (AC CYF). Project manager Elizabeth Heidenreich worked closely with Dara DeChellis, a former practice specialist who had recently been hired to coordinate all intimate partner violence (IPV) initiatives at CYF. When Ms. Heidenreich left for a new position, Ms. DeChellis became the sole Project manager. Both positions were partially funded through the QIC-DVCW, with decreasing levels of support over the five-year grant period.

The Project Implementation and Management Teams were combined until about halfway through implementation for a variety of reasons. The Management Team was co-facilitated by Women's Center & Shelter of Greater Pittsburgh (WC&S) Program Director Rhonda Fleming and CYF Manager of Integration Support Amy Sula.

Allegheny County, Pennsylvania Sites and Teams

The Allegheny County Office of Children, Youth and Families is a nationally known leader in child

welfare and has undertaken several practice improvement initiatives in recent years, such as participating in the Quality Improvement Center on LGBTQ Youth and developing a Conferencing and Teaming case practice model. Women's Center & Shelter of Greater Pittsburgh is the primary DV agency serving child welfare involved families in the Pittsburgh area and is a long-term partner with AC CYF. They offer a range of services for DV survivors and a MENS Group that serves people who use violence and coercion. In addition, the 5th Judicial District Children's Court has been a strong leader around issues of family violence. FUTURES and NCJFCJ have partnered with AC CYF and other organizations and agencies in Allegheny County over several years to support advancements in DV responses. FUTURES has consulted on enhancing battering intervention programming and helped advise AC CYF and WC&S on an expanded DV consultation model within child welfare. These partnerships provided a strong foundation for implementation of the Approach.

AC CYF named their East and Central Regional Offices as intervention sites, and Mon Valley and North Regional Offices as comparison sites. CYF and WC&S negotiated a re-assignment of intimate partner violence (IPV) specialists to child welfare offices to accommodate the research design, and specific judges assigned to intervention offices heard cases in which the Approach was used. Similar efforts were undertaken in other provider organizations to avoid contamination in the research. However, because all county offices exist within the city of Pittsburgh, some key organizations were excluded from the Project and the research.

Several partners participated on the AC Implementation Team, including workers, supervisors, managers and peer coaches from intervention offices; the County Solicitor; the 5th Judicial District Children's Court; WC&S; Allegheny Family Network (family support); KidsVoice; Parent Advocates from the Juvenile Court Project; Holy Family Institute; and specialists in IPV, father engagement, behavioral health and best practices. The Management Team included intervention site Regional Directors and Clinical Managers, senior CYF administrators, the Director of the Juvenile Court Project, a Children's Court Cross-System Specialist, CYF Policy and Best Practice Manager and Training Manager, and judicial officers when available.

Allegheny County CYF Intake Office

The AC CYF Intake Office that investigates Child Protective Services (CPS) reports chose not to participate in the project, which meant that investigators were not trained in, nor did they utilize, the Approach. About 30% of CYF cases come in the form of CPS reports and are assigned for a 60-day investigation, followed by case management by a Regional Office as needed. Regardless of the report type, DV may be a contributing factor or co-occur with reportable conditions for a CPS response. (In contrast, in both Massachusetts and Illinois child welfare investigators were trained and used the Approach.)

The other 70% of reports accepted by the AC CYF Intake Office are identified as General Protective Services (GPS) cases and may be either screened out or assigned to a Regional Office for an assessment. The types of reports that are identified as GPS cases include Intimate Partner Violence (1) when disclosed by a parent, (2) when coercive control or emotional/psychological abuse is present, or (3) when a child skips school because of fear for their parent's safety

Memoranda of Understanding

The QIC-DVCW negotiated a Memorandum of Understanding (MOU) with each Project that was signed by collaborating agencies and our own national partners. The MOUs created agreements about the roles and responsibilities of Projects and the QIC-DVCW, implementation and research activities, and financial issues related to the grant.

QIC–DVCW Teams

FUTURES established a number of teams to guide and support implementation of the Approach within Projects, the research, and communication and dissemination strategies.

QIC–DVCW Management Team

The QIC-DVCW Management Team developed the intervention, provided strategic direction for implementation and evaluation, and anticipated and responded to opportunities and challenges pertinent to the success of the QIC-DVCW. Each national partner agency (see Figure 5) was represented on the QIC-DVCW Management Team. In addition, a former Director of Orange County, CA child welfare provided critical child welfare leadership expertise as a consultant on the Management Team. National partners brought expertise in child welfare and dependency court systems change, project management, DV and fatherhood practice and policy, cross-system collaboration, institutional analysis, racial and gender equity, implementation science, evaluation, adult learning, and innovation in design.

QIC–DVCW Technical Assistance Team

Each Project's Implementation and Management teams worked with a QIC-DVCW technical assistance (TA) lead individual or 2-person team from FUTURES, CSSP, and LUPE, along with one consultant. In addition, a retired judge from NCJFCJ partnered with other TA providers to align efforts and convened a cross-site cohort of judicial officers for learning and application of the Approach in dependency court proceedings. QIC-DVCW TA Teams worked collaboratively across Projects to develop approaches and strategies for a common intervention being implemented in 3 unique sites, and to share expertise in specific topic areas. The role of the TA Team was to coordinate, broker and/or directly provide TA requested by the project, and to develop or facilitate access to resources to support completion of Project implementation plans.

The principles of QIC-DVCW TA helped create common expectations between providers and recipients:

1. Focus on results by helping Projects develop and carry out strategies that are informed by research, experience, and adult learning theory;
2. Provide "demand-driven" TA and co-design TA with the Project seeking help;
3. Build on local capacity to enable people to use what is learned, with new knowledge and skills;
4. Build on the experience and wisdom of people working in the field;
5. Use data to help TA recipients make decisions;
6. Respect, raise, and respond to issues of race, class, culture, language, age, and power; and
7. Reflect a commitment to diversity by appreciating and responding to different experiences, skills, backgrounds, and perspectives.

QIC–DVCW Training Team

The QIC-DVCW Training Team was led by a Program Director at FUTURES who guided the design and delivery of a training curriculum multiple times at each Project, first in-person and then remotely during COVID as new staff were hired. The trainers were from FUTURES, LUPE, NCJFCJ, and a pool of expert consultants. Project managers planned and executed significant logistical requirements for training approximately 500 people across the three projects.

QIC–DVCW Coaching Team

Experienced practitioners from FUTURES, LUPE and a pool of consultants provided monthly coaching for supervisors and managers of partnering agencies at each Project intervention site. Most cohorts provided a shared learning and support space across agencies, although a few groups remained sector-specific (either child welfare or domestic violence and other community partners).

QIC–DVCW Communications Team

The Communications Team from FUTURES and the Center for Health and Safety Culture developed a QIC-DVCW communications plan, designed and

launched a website (https://DVChildWelfare.org), and produced resources on the Approach. Some resources were tailored specifically for projects implementing the intervention, and some for a broader range of stakeholders interested in keeping abreast of the work of the QIC-DVCW. The website and resources are currently being re-designed and re-organized for three audiences – service providers, policymakers and researchers – to provide user-friendly, just-in-time resources for others interested in leveraging the work and actionable insights of the QIC-DVCW.

QIC–DVCW Evaluation Team

Evaluators at the University of Kansas (KU) designed the QIC-DVCW's implementation, outcome and cost studies, and facilitated the development and testing, human subject protection procedures/approval, administration, and analysis of the research related to all three studies. The Evaluation Team worked in partnership with the QIC-DVCW Management Team members, along with select members of the National Advisory Committee (NAC), to design 18 data collection strategies. The NAC was particularly involved in the adult survivor field survey development and testing. The KU evaluation team also were the main interviewers/facilitators of the focus groups and sole interviewers for the qualitative interviews of adult survivors. Additionally, the team managed the extensive data acquisition over the life of the QIC-DVCW from the three projects as required for multiple outcomes. As a part of the implementation study, monthly implementation summary reports and regular implementation tool analysis reports were provided to Project teams. Lastly, the evaluation team provided TA on evaluation via videos, FAQs, and in person team-based consultation to the Projects.

The team developed (using first person language) and applied research principles in all aspects their work on the QIC-DVCW:

- **Pursue Racial Equity:** We acknowledge that the long-standing history of colonization and White supremacy has shaped, and continues to shape, the systems involved in research (e.g., academic institutions that produce research, organizations that fund research, and policies that guide research). Thus, scientific knowledge largely privileges White ways of knowing while devaluing and dismissing others. This pattern marginalizes people of color and privileges Whiteness. To disrupt this reproduction of privileged and marginalized knowledge, we name and counter White supremacist culture. We center the knowledge and strengths of communities and individuals who survive and overcome White supremacy-sponsored marginalization. We practice critical reflexivity that includes the recognition of implicit biases and structural oppression.
- **Center the Voices of Families:** We raise up voices of families who have experienced domestic violence and are involved in child welfare systems. We engage people with lived experiences in evaluation and dissemination, such as getting survivors' feedback on survey design and measurement. We prioritize the safety of survivors in all aspects of our research. In a social context in which (1) survivors are often unduly blamed for child maltreatment and their own abuse and (2) people who use violence are rarely, if ever, engaged for positive change or held accountable for the violence, we check our assumptions about the framing of domestic violence in child welfare, taking care that our research does not contribute to negative biases or stereotypes about either survivors or people who use violence.
- **Practice a Collaborative Approach:** We value and practice collaboration with all stakeholders in all processes. Through our actions and words, we embody that "We are better when we work together." We prioritize the team over individual achievement. We seek to identify opportunities for leadership and ways to support team members' growth and professional development as a way to share power and promote shared leadership.

- **Conduct Research for Positive Social Change:** We further social justice and focus on system change in all aspects of the research process - conceptualization, development, implementation, analysis, interpretation, and dissemination. We design and plan for replicability with real-world application. We approach all dissemination activities as strategic and innovative in pursuit of our anti-oppression and positive social change research agenda.
- **Be Kind and Courageous:** We are kind and courageous as evidenced by our actions and words. We nurture appreciation and receive feedback as a gift. We raise hard issues and face them openly.

IMPLEMENTATION ACTIVITIES

To support implementation, the QIC-DVCW provided baseline analysis of practice and policy, training, leadership development at multiple levels, and TA to each Project. The five goals of TA were to (1) build new knowledge and skills, (2) support new and durable relationships among partners, (3) influence values and beliefs, (4) encourage deeper engagement with families and partners, and (5) move Projects to measurable outcomes. Each Project developed their own implementation plans and utilized TA to support and advance those plans. The QIC-DVCW provided funding for expanded services, Project infrastructure, and consultation. We also provided communications and evaluation support to Projects as needed.

Stakeholder and partner engagement

QIC-DVCW TA Teams worked with Project managers to identify and engage survivors, partners from DV and other community-based organizations, battering intervention programs, dependency courts, behavioral health, family and youth advocacy centers, CASA, GALs, law enforcement, and other entities. The IL Project hosted a public launch event to build interest and understanding among local leaders and community residents, featuring a survivor with lived experience of DV and child welfare involvement who remained involved with the Project over time. Some community-based organizations received QIC-DVCW funding for Project participation.

Over time, TA Teams or Project leaders themselves identified additional individuals (e.g., state leaders on racial disproportionality) or organizations (e.g., culturally specific organizations known to work with survivors or people who use violence) who might make important contributions to the work underway. Ultimately, Project leaders made final determinations about whether and how to expand participation.

Covid-19 understandably presented significant challenges to continued engagement of child welfare staff and partners. The pandemic disrupted and strained every aspect of people's lives, encompassing workplace adjustments; public health requirements; the creation of new routines; parents' involvement and monitoring of their children's education, and mental and emotional health and well-being during lockdowns; the suspension of social and recreational outlets; and more. No realm of participants' personal or professional lives remained untouched. For those participants who dealt with seriously ill family members or even lost family members to Covid-19, the effects, of course, were far deeper. Despite these extreme and long-lasting challenges, each Project managed to continue their participation in the QIC-DVCW, although participation in team meetings and other activities decreased during the pandemic.

Institutional Analysis and Community Mapping

QIC-DVCW teams led by the Center for the Study of Social Policy conducted Institutional Analyses (IAs) with two Projects. The IAs were conducted to better understand the experiences of families living with DV who are involved in the child welfare system. The IA was narrowly focused on opportunities and challenges within the child welfare system and among community partners to implement the Approach. The focus of inquiry was: *How do adult and child survivors of domestic violence experience child welfare and community interventions*

from the time an investigation is launched until the development of their first case plan? How do DV offenders experience child welfare and community interventions during this time?

The Institutional Analysis (IA) is a diagnostic process used to understand how systems contribute to poor outcomes for particular populations. The focus of the IA is on the policies and practices implemented by institutions, and their unintended consequences for families, and not on the behaviors of individual actors such as judges, police, or social workers. By examining how something comes about, rather than looking at individuals involved in the work, the process aims to reveal systemic problems and produce recommendations for systemic change.

Because of time constraints, the QIC-DVCW did not conduct an IA at one Project, opting instead to facilitate a multi-stage community mapping process in which partnering agencies and entities reflected on Approach principles and frameworks and identified touchpoints in the life of a family involved with child welfare for DV. The mapping process led to the Project identifying specific goals for implementation.

Approach Training

QIC-DVCW expert trainers conducted a 2-day Approach training for approximately 500 professionals, originally in-person and then virtually during the pandemic, with anywhere from 15 to 30 individuals in any given training. Staff of child welfare agencies, DV programs, dependency courts, judges, community partners, and others were trained together to establish a common understanding of the Approach and to deepen relationships through shared learning and practice. Curriculum content began with an experiential exercise (a version of In Her Shoes originally developed by the Washington State Coalition Against Domestic Violence) that required trainees to “step into a survivor’s shoes” and make difficult choices within limited options for safety and connections to community. Additional training content was designed to make biases visible as a step toward advancing racial, ethnic, and gender equity; facilitate a contextual assessment of DV; build protective factors that help adult and child survivors of DV; develop skills to engage and hold people who use violence accountable; and collaborate at the case level. Local project trainers were integrated as trainers where possible. The training received positive evaluations from trainees, although some felt that it lacked sufficient time for practicing new skills.

Coaching of supervisors and managers

Middle managers play critical roles in supporting and guiding their staff, whether in child welfare, court or a community partner agency, to execute high quality, innovative, effective work with individuals and families in day-to-day practice. For this reason, coaching to support implementation focused on these key leaders. Coaching was defined as "*The use of structured, focused interactions using appropriate strategies, tools, and techniques to promote desirable and sustainable practice change to benefit the organization and families.*" (Adapted from Mink, Owen, & Mink, 1993; Cox, Bachkirova, & Clutterbuck 2010)

Three coaching goals were defined:

- Develop and support a local learning community to establish buy-in and understanding of the Approach, and to promote innovation in utilizing it with and on behalf of families;
- Support integration of coaching on the Approach into supervision at multiple levels, and into office and organizational culture; and
- Develop specific coaching techniques on the Approach that can help other jurisdictions that are invested in developing skilled practice in working with families experiencing domestic violence.

Thirteen QIC-DVCW coaches with expertise in systems change, consultation, collaboration, child welfare, working with survivors of domestic and sexual violence, and engagement of people who use violence paired up to facilitate monthly group coaching sessions over two years with more than 100 supervisors, managers and directors of collaborating agencies. Cohorts ranged from 6 to

14 people depending on the Project. Supervisors and managers/directors were coached separately to encourage people to be vulnerable and honest about their learning needs and challenges.

The QIC-DVCW initially provided in-person coaching as often as possible. Covid-19 forced a shift to remote coaching for the remainder of the project, which had a detrimental effect on participation in some cohorts, and which coaches themselves found to be challenging in terms of engaging and holding the focus of participants who were often dealing with their own children and remote work demands.

Coaches used a variety of strategies along a continuum from pure coaching to a hybrid of coaching & teaching to build direct skills of participants and encourage supervisors and managers to use a parallel approach with their own staff. Across all three Projects, QIC-DVCW coaches met on a regular basis to share ideas, tools, and resources which teams were authorized to adapt and tailor to the needs of their cohort. Coaches designed agendas and tools to support understanding and utilization of Approach principles and frameworks in cases involving DV and co-occurring child maltreatment. Strategies used by coaches included but were not limited to powerful questions, reflective practice, hope questions, conversations and exercises to improve critical thinking about racial and gender equity and DV, dialogue and planning to advance adaptive leadership, goal setting, "homework" assignments, between-session check-ins, and role plays. Specific supervision tools, tips for applying frameworks and trauma-informed practice, case review tools and case scenarios, talking points, Approach exploration questions for supervision, and other resources were developed and utilized. In addition, while each cohort took up issues around institutional bias throughout the two years of coaching, during the racial reckoning that followed George Floyd's murder coaches held intentional space with cohorts for reflection, processing, and healing as well as facilitating difficult and necessary conversations about child welfare's role in maintaining white supremacy, framed in one cohort as the policies and practices that serve as metaphorical "chokeholds" on Black and brown families.

Judicial leadership

After attending training, judges from all 3 Projects gathered in person for a 2-day meeting with FUTURES and NCJFCJ to identify opportunities for (1) judicial leadership on the Approach and (2) accountability for child welfare systems' efforts within dependency court proceedings involving DV. Participants heard from a person with lived experience of the system and then grappled throughout the meeting with the differences between the Approach and "business as usual" on survivors of family violence. Thereafter, judges from the 3 Projects were periodically convened (virtually) for continued shared learning facilitated by a retired judicial officer on the TA Team. During the re-organization of courts during Covid-19, these meetings continued but were more sporadic due to other demands on judges.

Collaboration and Equity

Project Implementation Teams established goals and objectives to advance racial, ethnic, and gender equity, critical elements of improving systems responses to families experiencing DV. TA and funding from the QIC-DVCW supported these efforts, some of which are described here. One Project developed and distributed a repository of equity research and writing to inspire team members to engage in their own learning as well as through team discussions and review of data. Another Project used QIC-DVCW funds to engage a nationally known racial equity consultant to train participants of collaborating agencies on systemic racism in preparation for a planned series of community meetings about the impacts of the child welfare system. In that same Project, supervisors in an intervention office took a deep dive into data on service referrals for Black/African American fathers who used violence. They later used QIC-DVCW funds for extended leadership development to sustain and advance capacity and commitment for equity work. At our third Project, an anti-racism subcommittee leveraged an agency-wide commitment to address disparities and to create an action plan aimed at addressing the effects of racism on the workforce and in practice. DV partners in this same Project undertook a review of all policies and procedures through an equity lens and made substantive

revisions in operations.

Because existing collaboration surveys in wide use at the time our work began did not address issues of racial inequities and differential power, QIC-DVCW partners LUPE, FUTURES, and KU developed a Centering Racial Equity in Collaboration Survey to both evaluate and generate action to deepen and strengthen partnerships in Projects. In addition to typical collaboration indicators such as shared vision and goals, the survey was used by Implementation and Management teams over time to assess issues such as representation, power and resource sharing, decision making, communication, and other equity practices.

Collaboration and action to reduce or eliminate biases at the case level was primarily supported through coaching of supervisors and managers across participating agencies, Approach training, and the production of practice tips and resources appropriate and intended for use in all partnering organizations and agencies.

The QIC-DVCW also hosted a well-attended and highly rated virtual conference with policy and practice tracks focused on advancing leadership, collaboration, racial and gender equity, and local project engagement. The conference was held during the pandemic in March of 2021, and provided project participants a much-needed boost of interest and energy at a difficult time in implementation when interest was waning to some degree.

Services

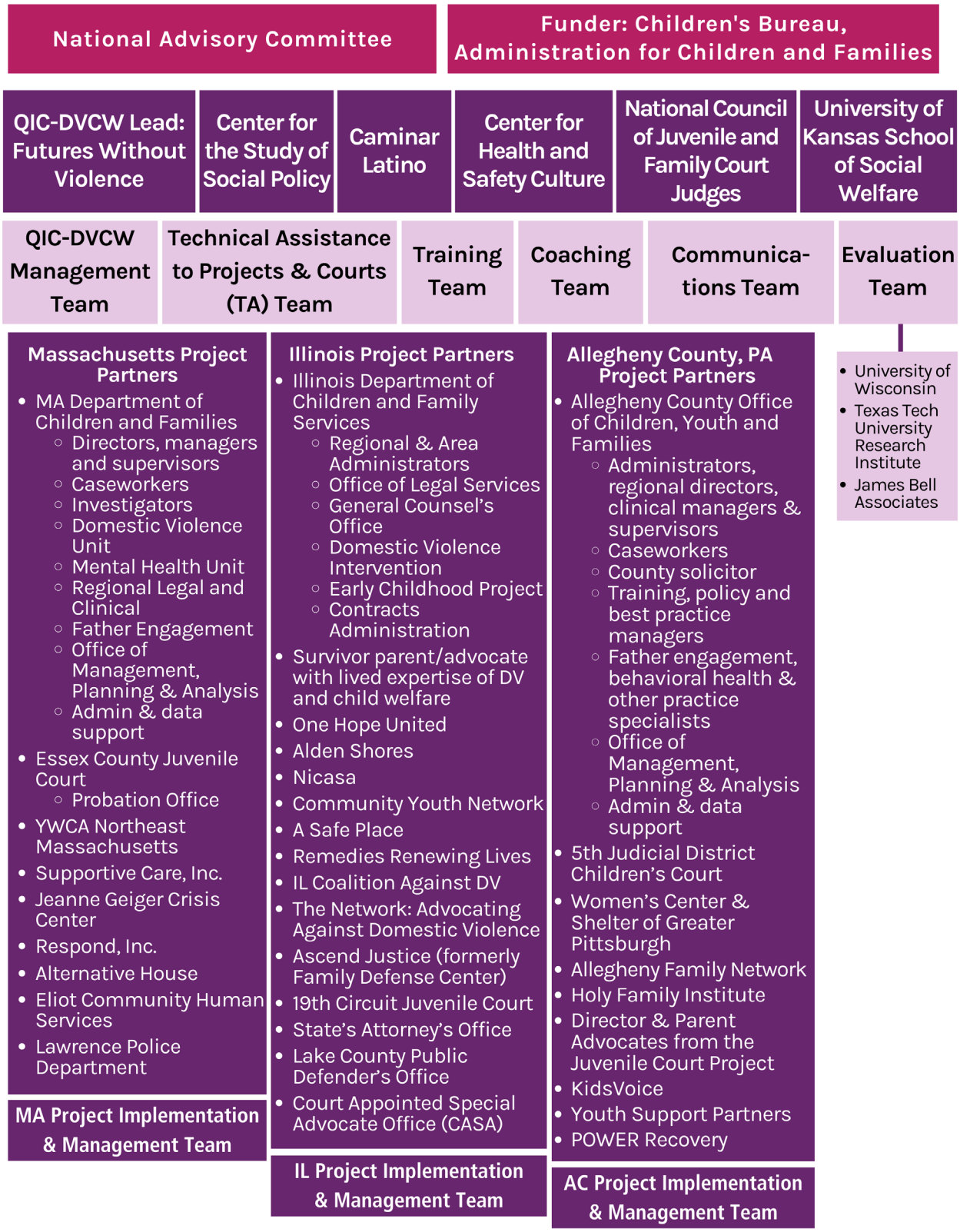
In addition to providing funding for infrastructure needs (e.g., consultants, project participation, and management), the QIC-DVCW also funded the expansion of services and programming for survivors and people who use violence, including DV/IPV specialists in two of the three Projects. Two of the 3 projects implemented Strong Fathers, an evidence-supported group model for fathers who have used violence and are involved in child welfare. One site secured alternate funding to ensure programming would be sustained. Similarly, the third site, which implemented Kid's Club and Moms' Empowerment for adult and child survivors, absorbed this service into their budget after QIC-DVCW funding ended.

Communications and evaluation support

Project managers developed creative communication strategies for keeping focus on the Approach and the research being conducted, such as developing bi-weekly local practice tips and creating posters for offices. Projects were provided TA on communications planning internally and with external stakeholders (e.g., public launch events and briefings). TA Teams also worked with Project managers to identify venues to build integration of the Approach into other agency priorities, such as community partnership meetings at Illinois' immersion site.

Throughout the QIC-DVCW, the KU team worked continuously to provide Projects evaluation-related TA on various aspects of the research. They developed short videos, offered webinars, produced written resources, and facilitated Project-specific meetings for child welfare staff and partners on a variety of topics: implementation science, completing surveys and measures, understanding and utilizing implementation data, and developing benevolent incentives (meaning families, and not workers, benefitted) for survey completion. In addition, KU modified procedures for the Adult Survivor Field Survey multiple times to ensure that interviews would be safe and trauma-informed, and that data gathering could continue during Covid-19.

Figure 5. QIC-DVCW Organization Chart



SECTION 3. EVALUATION DESIGN & METHODS

EVALUATION DESIGN

The QIC-DVCW evaluation design consisted of a cross-project evaluation of the Adult & Child Survivor-Centered Approach (Approach), involving the use of a common research design, measurement constructs, and data collection procedures across the three participating Projects. Nevertheless, differences in objectives and operating environments required Project-specific modifications in the data collection procedures. Thus, the Principal Investigator (PI) and the Evaluation Team worked closely with each of the three projects to identify these differences and develop appropriate accommodations. However, these Project-level modifications did not impact the overall evaluation design.

Three Studies: Implementation, Outcomes, and Cost

The QIC-DVCW evaluation included three interrelated studies: outcome, implementation, and cost. The outcome study examined the impact of the Approach on short-term and intermediate outcomes of children and families. The implementation study examined which factors are associated with successful implementation and sustainability. The cost study examined the relative costs of the Approach. QIC-DVCW evaluation design and consequential research questions were based on the logic model (see Figure 8) developed in 2017.

Research Questions

The research questions for each of the studies are presented below in Figure 6.

Figure 6. Research Questions

OUTCOME STUDY:	IMPLEMENTATION STUDY:	COST STUDY:
What is the impact of the survivor-centered approach on adult and child survivor safety, child permanency, and child and family well-being? • For which families, and in which social contexts, does the survivor-centered approach improve these outcomes?	What factors are associated with successful implementation and sustainability of an adult and child survivor-centered approach?	What are the costs associated with the implementation and maintenance of an adult and child survivor-centered approach, and how to these costs compare to the costs of "practice as usual"?

To support the analysis of the research questions, an analytic outcome-based adaptation of the original logic model was created to facilitate clear reporting of results, using an enumeration system and applying Proctor et al.'s (2020) implementation outcome framework. See Figure 7.

Figure 7. Analytic Outcome-Based QIC-DVCW Logic Model with Proctor's Implementation Framework Applied

Intervention	Implementation Strategies	1.A. Implementation Outcomes	1.B. Service Delivery Outcomes(Practice Behaviors)	2. Child & Family Outcomes
The Approach	**Teams** (Site Implementation Teams, QIC-DVCW Management Team, TA Team, Communication Team, Eval Team) **Staging** **Driver Assessment, Development, and Support (TA)** (hiring protocols, training, coaching, fidelity monitoring, facilitative admin, systems interv., data for decision making, leadership) **Improvement Cycles** (training results, early testing, preliminary results)	Adoption (decision to use/ try practice) Acceptability (practice viewed as agreeable, palatable, satisfactory) Feasibility (practice viewed as suitable or practical for everyday use) Fidelity (practice is delivered as intended) Penetration (practice is spread across organization or target pop) Sustainability (practice is maintained or continued; also routinized and integrated) Costs (practice is viewed as cost effective or high benefit-cost)	**1.B.1. Child Welfare Practice** 1.B.1.1. Planning, decision-making, & practice address Protective Factors for Survivors framework 1.B.1.2. Planning, decision-making, & practice address RSA Framework 1.B.1.2.a. Early and ongoing identification and assessment of domestic violence 1.B.1.2.b. Survivor-informed engagement, accountability, and support for person using violence (PUV) 1.B.1.2.c. AS engaged by CW relative to PUV 1.B.1.3. Practice is DV-informed, individualized, and dynamic 1.B.1.4. Racial, ethnic, and gender equity in their practices and services 1.B.1.5. CW-Partner Communication and Collaboration in Case Activities **1.B.2. Community Partner Practice** 1.B.2.1. Community partner planning, decision-making, & practice address Protective Factors for Survivors framework 1.B.2.2. Community partner planning, decision-making, & practice address RSA Framework 1.B.2.3. Community partner practice is DV-informed, individualized, and dynamic 1.B.2.4. Racial, ethnic, and gender equity in their practices and services 1.B.2.5. CW-Partner Communication and Collaboration in Case Activities **1.B.3. Cross-Organization Communication & Collaboration** 1.B.3.1. CW-Partner Communication at Mgmt Level 1.B.3.2. CW-Partner Collaboration at Mgmt Level 1.B.3.3. Shared Approach Principles 1.B.3.4. Shared Frameworks (PF, RSA) 1.B.3.5. Data-Driven/ Community Stakeholder Inclusion & Feedback 1.B.3.6. Racial, ethnic, and gender equity in their collaborative work together	**2.A. Child Survivor Outcomes** 2.A.1. Increase Safety 2.A.1.1. Decrease maltreatment by person using violence and/or adult survivor 2.A.1.2. Decrease exposure to DV 2.A.2. Increase Permanency 2.A.2.1: Decreased Rate of Foster Care Removals 2.A.2.2: Increased Reunification Rate 2.A.2.3: Increased Stability 2.A.3. Increase Well-Being 2.A.3.1. Increase in emotional and social development and physical health 2.A.3.2. Increase supportive relationships with specific individuals (grandparents, parents/parent figure, siblings) **2.B. Adult Survivor Outcomes** 2.B.1.Increase safer and more stable conditions 2.B.1.1. Decrease experiences of physical, sexual, psychological, economic abuse, including use of children and systems as instrument in DV 2.B.1.2. Decrease in DV-related risk level 2.B.1.3. Increase stability (I.e., employment, housing) 2.B.1.4. Increase empowerment related to safety 2.B.2. Increase well-being 2.B.2.1. Increase social, cultural, and spiritual connections 2.B.2.2. Increase resilience and growth mindset 2.B.2.3. Increase nurturing parent and child interactions 2.B.2.4. Increase social and emotional abilities 2.B.2.5. Decrease trauma symptoms and depression **2.C. Person Using Violence Outcomes** 2.C.1. Decrease blaming adult survivor and justification for violence 2.C.1.1 Increase understanding of the impact of DV on adult and child survivors* 2.C.2. Promote positive beliefs, attitudinal, & behavioral change 2.C.2.1. Demonstrating motivation to change 2.C.2.2. Increase understanding of healthy relationships 2.C.2.3. Increase nurturing parent and child* interactions* 2.C.3. Increase well-being & supports 2.C.3.1. Decrease trauma symptoms, depression, anxiety, and stress* *from Person Using Violence survey only

Given the quasi-experimental design to test the Approach, when feasible, the research question types included three kinds of comparisons: sites (intervention and comparison), project (three projects), and time. Feasibility was determined by research questions and subsequent data collection activity. For example, all the Implementation Study questions were focused on understanding the process of implementation of the Approach, so comparisons were feasible at the project and time levels, but not at the site level (i.e., comparison offices did not implement the Approach). Lastly, there were some evaluation activities that were descriptive only, by design or because of challenges due to sample size.

Under the **Implementation Study** research question *(What factors are associated with successful implementation and sustainability of this approach?)* three implementation outcome sub-questions were asked:

- How did the implementation drivers change at different time points during the intervention across and between Projects?
- What contributed/inhibited successful implementation of the Approach? (implementation strategies – e.g., training, TA, teams)
- How did assessed fidelity change at different time points during the intervention?

These questions were examined, when possible, in two ways: (1) project site comparisons and (2) time comparisons.

For the **Outcomes Study** research question *(What is the impact of the survivor-centered approach on adult and child survivor safety, child permanency, and child and family well-being?)*, multiple outcome sub-research questions were asked:

- How did service delivery outcomes change?
- For which families, and in which social contexts, does an Adult & Child Survivor-Centered Approach improve outcomes?

These questions were examined in two ways (1) study group level (e.g., intervention and comparison groups) comparisons and (2) time comparisons.

For the **Cost Study** *(What are the costs associated with the approach, and how do these compare to the costs of "practice as usual?)* there was only one main research question. This question was examined by (1) study group level (e.g., intervention and comparison groups) comparisons and (2) project comparisons.

Figure 8. Logic Model of the Quality Improvement Center on Domestic Violence in Child Welfare (QIC-DVCW)

Inputs	Activities	Intervention	Consequent Practice Behaviors	Child & Adult Outcomes
QIC-DVCW • Leadership, planning, and development • Technical Assistance (TA) to participating sites for implementation and evaluation • Funding to support implementation and evaluation ***Project Sites*** • Leadership and support • Implementation teams • Domestic violence, battering-intervention and other social service programming within selected sites • Child welfare agency and dependency court practice guidance, structures, and expertise for domestic violence cases • Case-level service and outcome data	***Site Readiness*** • Assess and strengthen site implementation drivers, and collaborative processes and structures • Develop structures & processes for collaboration between QIC-DVCW and sites ***Intervention Implementation*** • Train and coach in child welfare and partner agencies • Enhance community services • Provide TA to support communication and collaboration of project partners	***Adult & Child Survivor-Centered Approach*** • Six principles • Risk and Protective Factors (RPF) Framework for Survivors of DV • Relational and Systemic Accountability (RSA) Framework	***Enhanced Child Welfare Practice*** • Domestic-violence informed planning, decision-making, and practice • Early and ongoing identification and assessment of domestic violence • Engagement and partnering with survivor parents and family • Individualized safety and case planning, referrals, support, and interventions • Survivor-informed engagement, accountability, and support for person using violence (PUV) • Actively work toward racial, ethnic, and gender equity in their practice, as well as in families' access to resources and services. ***Enhanced Community Partner Practice*** • CP planning, decision-making, and practice address Risk & Protective Factors Framework • CP Planning, decision-making & practice address RSA Framework • CP practice is DV-informed, individualized, and dynamic • Actively work toward racial, ethnic, and gender equity in their practice, as well as in families' access to resources and services. ***Increased Cross-Organization Communication & Collaboration*** • CW-Partner Communication in Case Activities • CW-Partner Collaboration in Case Activities • CW-Partner Communication at Mgmt Level • CW-Partner Collaboration at Mgmt Level • Shared Principles (Approach) • Shared Frameworks (RPF, RSA) • Data-Driven/Community Stakeholder Inclusion & Feedback • Actively work toward racial, ethnic, and gender equity in their collaborative work together.	***Child Survivor*** • Increase safety • Increase permanency • Increase well-being ***Person Using Violence*** • Decrease blaming adult survivor and justification for violence • Promote positive beliefs, attitudinal, & behavioral change • Increase well-being & supports ***Adult Survivor*** • Increase safer and more stable conditions • Increase social, cultural, and spiritual connections • Increase resilience and growth mindset • Increase nurturing parent and child interactions • Increase social and emotional abilities

Figure 9. Logic Model Expansion on Child & Adult Outcomes

Child & Adult Outcomes - Expanded	
Child Survivor • Increase safety • Increase permanency • Increase well-being	• Decrease exposure to DV • Decrease maltreatment by person using violence and/or adult survivor • Decrease time in care • Increase stability (residence, education/school) • Increase in emotional and social development and physical health • Increase supportive relationships with specific individuals (grandparents, parents/parent figure, siblings)
Person Using Violence • Decrease blaming adult survivor and justification for violence • Promote positive beliefs, attitudinal, & behavioral change • Increase well-being & supports	• Increase understanding of the impact of DV on adult and child survivors* • Demonstrating motivation to change • Decrease blaming adult survivor and justification for violence* • Increase understanding of healthy relationships* • Decrease trauma symptoms, depression, anxiety, and stress* • Increase nurturing parent and child interactions* *from PUV Survey only
Adult Survivor • Increase safer and more stable conditions • Increase social, cultural, and spiritual connections • Increase resilience and growth mindset • Increase nurturing parent and child interactions • Increase social and emotional abilities	• Decrease experiences of physical, sexual, psychological, economic abuse, including use of children and systems as instrument in DV • Decrease in DV-related risk level • Increase stability (i.e., employment, housing) • Increase social, cultural, spiritual connections • Increase resilience and growth mindset • Increase empowerment related to safety • Increase nurturing parent-child interactions • Increase social and emotional abilities • Decrease trauma symptoms and depression

Human Subject Institutional Review Board (IRB)

All research related work was reviewed by the University of Kansas Institutional Review Board. Some work specific to Illinois was also reviewed by the State of Illinois, Department of Family and Children's Service Institutional Review Board.

Certificate of Confidentiality

KU evaluators received a National Institute of Health's Certificate of Confidentiality. With the Certificate of Confidentiality, KU researchers can legally refuse to disclose information that may identify respondents, even by a court subpoena, in any federal, state, or local civil, criminal, administrative, legislative, or other proceedings. The certificate may not be used to withhold information from the Federal government needed for auditing or evaluating federally funded projects. A Certificate of Confidentiality does not prevent respondents or members of their family from voluntarily releasing information about their involvement in this research.

Registered as Clinical Trial

The QIC-DVCW evaluation was registered in 2019 as a Clinical Trial (NCT04200703) with the National Institute of Health, Clinical Trial registration system.

METHODS: BY DATA SOURCE

Overall, the QIC-DVCW evaluation used a mixed-method approach and multiple data collection methods including surveys, interviews, focus groups, case record reviews, administrative data, and implementation tracking. In addition, it was multi-informant by design, including caseworkers, supervisors, DV advocates, adult survivors, persons who use violence, community partners, and implementation and management teams. The following describes each of the data sources used in the QIC-DVCW evaluation.

Project Sampling Frame: Managing Project Roster for Fidelity Checklist, Self–Survey, & Family Survey

For the creation of the sampling frame for the Fidelity Checklist, Self-Survey, and Family Survey, the Evaluation Team worked with project managers to obtain sampling frame documentation for each person identified as being part of the project, this included comparison and intervention sites and child welfare and community partner staff. The sampling frame fields included were: first and last name, email address, agency/or unit (which identified if they were in the intervention or comparison group), and role. The categorization of role was set by the Evaluation Team to determine which Self Survey version to send staff member. The role categories were child welfare supervisors (including administrators and managers), child welfare caseworkers (and related direct service frontline staff), or community partners (including supervisors, direct line staff and other community roles such as judges.) For the purposes of the Fidelity Checklist administration, the field of the name of the caseworker's supervisor was also collected. The Evaluation Team worked with Project managers to update and maintain the sampling frame documentation files.

Drivers Assessment

The Drivers Assessment survey was developed in alignment with the Implementation Study's use of Implementation Science and the Implementation Drivers framework. Implementation Drivers are the key components of capacity and the functional infrastructural supports that enable a program's success. The three domains of Implementation Drivers are Competency, Organization, and Leadership (see Figure 4). Thus, the Drivers Assessment was designed to provide scores for each Driver domain, measuring the extent to which a site was implementing the infrastructure necessary to adopt and sustain the Approach. The use of Drivers also intersects with the Implementation

Stages framework, which would suggest that the degree to which Drivers are installed is likely to be lower in early implementation and greater in later stages of implementation. Likewise, the use of Drivers relates to Implementation Outcomes in that higher scores would indicate the outcomes of adoption in early-to-mid stages of implementation and sustainability in later stages of implementation.

Research Questions

The research question answered using the Drivers Assessment was: How did the implementation drivers change at different time points during the intervention across and between sites? This research question connects to the Implementation Study outcomes of adoption and sustainability.

Samples and Recruitment

Study participants included all members of each local project's Management Team and Implementation Team. The QIC-DVCW Evaluation Team worked with the project leads (i.e., Project managers and Project TA Teams) of each site to recruit study participants. Project leads shared information with Management Team and Implementation Team members at their regular in-person monthly meetings, inviting them to participate in the Drivers Assessment survey. Participants provided passive consent via information statements. For individuals absent from the meeting, an electronic version of the survey was forwarded to them by email by the Project manager and a survey link provided. No demographic data was collected as part of the Drivers Assessment.

Data Collection Procedures

Participants were asked to complete the Drivers Assessment up to twice per year. The Drivers Assessment survey was completed by sites between 2019 to 2021 with site level variation in the number of times it was completed.

- Allegheny County completed the survey in 2020 and 2021
- Illinois completed the survey in 2019 and 2020
- Massachusetts completed the survey in 2019, 2020, and 2021

Data were collected to identify the participants' responses according to site; however, no individuals' identifying information was collected. The Drivers Assessment data were collected and managed using REDCap electronic data capture tools hosted at The University of Kansas. REDCap (Research Electronic Data Capture) is a secure, HIPAA compliant, web-based software platform designed to support data capture for research studies, providing 1) an intuitive interface for validated data capture; 2) audit trails for tracking data manipulation and export procedures; 3) automated export procedures for seamless data downloads to common statistical packages; and 4) procedures for data integration and interoperability with external sources.

Measures

The Drivers Assessment survey was developed in alignment with the Implementation Study's use of implementation science and the Implementation Drivers framework. Implementation Drivers are the key components of capacity and the functional infrastructural supports that enable a program's success. The three domains of Implementation Drivers are Competency, Organization, and Leadership (see Figure 4). Thus, the Drivers Assessment was designed to provide scores for each Driver domain, measuring the extent to which a site was implementing the infrastructure necessary to adopt and sustain the Approach.

The Drivers Assessment comprised 15 items, six of which were organized under the Competency domain, six under the Organization domain, and three under the Leadership domain. Participants rated each item on a Likert scale from 0 to 2 where:

- 0 = not in place/the component does not exist or has not yet been initiated
- 1 = partially in place/part of the component has been established, the component has

been conceptualized but not fully used, or the component exists but is not being utilized on a regular basis

- 2 = in place/the component is part of this system and "evidence" of this component is observable
- NA = Don't know (data were not included in the analysis)

Scores were observed at items and domain levels. Domain scores were obtained by averaging the items in that domain (i.e., summing each item in the domain and dividing by the number of items). Thus, each domain score could range from 0 to 2. For each domain, we estimated Cronbach's alpha, which measures the reliability of the items within the identified conceptual domain (i.e., leadership driver, competency driver, and organization driver). Our observed Cronbach's alphas were: Leadership domain = 0.692; Competency domain = 0.771; and Organization domain = 0.865. According to scientific standards, Cronbach's alpha should be between 0.70 and 0.95. Thus, the leadership domain's internal consistency was slightly low and the other two domains' internal consistency was adequate.

Analytic Approaches

Basic descriptive statistics were prepared to describe how the Drivers within intervention sites changed, comparing and contrasting average scores across the three project sites and over three data collection times (i.e., 2019, 2020, and 2021). These analyses also described scores by the Driver domains to understand whether patterns of change were distinct to any of the Driver domains.

Analysis of Variance (ANOVAs) were run to compare average scores over the three time points at the Cross-project and Project level. These statistics are used as indicators of whether each time period's average score was significantly different from the overall average score. The p-value reports the probability of observing a false positive (null hypothesis) to be true. In other words, it measures how likely it is that any observed difference between groups is due to chance (Dahiru, 2008).

For example, $p < 0.05$ means that we have a 95% or greater confidence that the observed difference between average scores over time is true for the population with less than 5% chance that the differences over time are not truly observed in the population.

Covid-19

As the Drivers Assessment was designed to be administered online via REDCap, Covid-19 did not directly impact the evaluation activity.

Fidelity Checklists

Fidelity Checklists were developed for the purpose of understanding the implementation outcome of fidelity. Fidelity refers to the full and effective use of the Approach as intended. Regarding the evaluation's use of Implementation Outcomes, this data source was focused on **fidelity as an implementation outcome**.

Research Questions

The research question answered using the Fidelity Checklists was:

- How did the fidelity to the Approach change at different time points during the intervention across and between sites? This research question connects to the Implementation Study outcome of fidelity.

Samples and Recruitment

Using the sampling frame documentation files ([See Sampling Frame description] i.e., list of participants from the Project managers), the Evaluation Team emailed caseworker/staff participants and asked them to review the Fidelity Checklist information statement and choose one of three options: (1) agree to participate, (2) decline to participate, and (3) need more information. The Evaluation Team also emailed supervisor participants, inviting them to complete the checklist for each caseworker once per month. For the sample description see Table 35.

Data Collection Procedures

Participants were asked to complete the Fidelity Checklist once per month. For Massachusetts, instead of supervisors providing the name of the staff person, the Evaluation Team provided the supervisor with a list of staff member names and corresponding study generated IDs and asked that they enter the study ID on the Fidelity Checklist.

Measures

Fidelity Checklists were completed by supervisors of child welfare caseworkers and community partners who were trained and coached in the Intervention sites. Supervisors rated their supervisees' practice behaviors along five dimensions, including (1) Approach knowledge, (2) work with adult and child survivors, (3) work with person using violence and coercion, (4) Principles practice, and (5) overall fidelity. Each of these dimensions was rated on a 9-point Likert scale where 1-3 indicated "needs work," 4-6 indicated "acceptable" and 7-9 indicated "good work."

Analytic Approaches

Average Fidelity Checklist scores and standard deviations were calculated for each site at each of the three data collection times for which the site had Fidelity Checklist data. These descriptive data were used to describe how the fidelity scores changed, comparing and contrasting average scores across the three Projects and over three data collection times (i.e., 2019, 2020, and 2021). These analyses also described average scores by each of the five domains of the Fidelity Checklist to understand whether patterns of change were distinct to any of the five domains (e.g., did one domain change over time while others did not?).

ANOVAs were run to compare average scores over the three time points. These statistics are used as indicators of whether each time period's average score was significantly different from the overall average score. The p-value reports the probability of observing a false positive (null hypothesis) to be true. In other words, it measures how likely it is that any observed difference between groups is due to chance (Dahiru, 2008). For example, $p < 0.05$ means that we have a 95% or greater confidence that the observed difference between average scores over time is true for the population with less than 5% chance that the differences over time are not truly observed in the population.

Covid-19

Due to the disruptions caused by Covid-19 to child welfare partner agencies, the PI worked with Project managers, along with the QIC-DVCW Project Director, to delay or stop administering Fidelity Checklist during March 2020-June 2020 in the Allegheny County and Massachusetts Projects.

Final Coaching Assessment

The Final Coaching Assessment was developed to assess the Approach coaching experience at the conclusion of coaching from the perspective of the managers and supervisors who had participated in Approach coaching. The Final Coaching Assessment consisted of two parts: (1) a brief online survey, to assess coaching participation and satisfaction, and Approach levels of knowledge and (2) focus groups conducted by coaching cohort. See the Measures section below for information about the assessment.

Research Questions

- The research questions answered using the final coaching assessment were:
- What contributed/inhibited successful implementation of the Approach? (implementation strategies – e.g., training, TA, teams)
- 1.B.1.2. Were there significant differences between the intervention and comparison sample in child welfare practice planning, decision-making, & practice addressing the Relational and Systemic Accountability (RSA) framework?

- 1.B.1.5. Were there significant differences between the intervention and comparison sample in child welfare - partner communication in case activities?
- 1.B.3.3. How did sites' use of shared Approach principles change at different time points during the intervention?
- 1.B.3.4. How did sites' use of shared frameworks (Protective Factors [PF] and RSA) change at different time points during the intervention?
- 1.B.3.5. How did sites data-driven/community stakeholder inclusion & feedback change at different time points during the intervention?
- 1.B.3.6. How did sites actively work toward racial, ethnic, and gender equity in their collaborative work together change at different time points during the intervention?

Samples and Recruitment

Final Coaching Assessment participants included individual professionals who attended coaching. The Evaluation Team worked with the coaches of each site to recruit study participants. These coaches shared information with coaches at their regular monthly meetings, inviting them to participate in the survey and an online focus group session. Participants were asked for passive consent via information statements. For individuals absent from the meeting, an electronic version of the survey was forwarded to them by email by the coaches and a survey link provided. The survey was preceded by the information statement. A total of 48 participants consented to participate via the survey. A total of 44 participants completed the demographics part of the survey. Of the 44 participants, all but one had been in their position for over a year. See Table 2 for demographic information. A total of 10 coaching focus groups were conducted online in July 2021 and included in the analysis.

Table 2. Final Coaching Assessment Sample Demographic Characteristics (N=44)

Sample Characteristics	n	(%)
Type of Organization - Employed/Representing		
Public child welfare agency	32	(73)
Domestic violence program for survivors	8	(18)
Private child welfare agency	2	(5)
Battering intervention program	2	(5)
Prefer not to say	2	(5)
Other (Parent Peer Support)	1	(2)
Responsible fatherhood program	0	(0)
Highest Education Degree		
Master's (or higher) of social work (MSW)	28	(64)
Other master's (or higher) degree	7	(16)
Other bachelor's degree	5	(11)
Bachelor of social work (BSW)	3	(7)
High School degree or GED	1	(2)
Associate's degree	0	(0)

Sample Characteristics	n	(%)
Race/Ethnicity Identity		
White/Caucasian/European origin	31	(70)
Black or African American	6	(14)
Latino/a	5	(11)
Prefer not to say	2	(5)
Asian or Asian American	1	(2)
Indigenous, Native American, or Alaska Native	0	(0)
Middle Eastern or North African	0	(0)
Native Hawaiian or Other Pacific Islander	0	(0)
Biracial/Multiracial	0	(0)
Gender Identity		
Woman	36	(82)
Man	6	(14)
Non-binary/Agender/Genderqueer	0	(0)
Two-spirit	0	(0)
Prefer to self-describe	0	(0)
Prefer not to say	0	(0)
Missing	2	(5)
Trans Gender Identity		
No	42	(95)
Yes	0	(0)
Not sure	0	(0)
Prefer not to say	1	(5)
Missing	2	(5)
Other Languages Spoken		
No	34	(77)
Yes (Spanish=6, Japanese=1, German=1)	8	(18)
Missing	2	(5)

Data Collection Procedures

For each group, as participants joined, they were given a link to view the study Information Statement that covered their consent to both the focus group and the survey. After consenting, they were invited to complete the survey before the focus group began. The coaching focus groups were conducted by two members of the Evaluation Team. The focus groups were audio recorded and professionally transcribed.

Measures

The final coaching assessment survey measured the following: coaching participation and coaching satisfaction, using a 5-point Likert scale from Strongly Disagree to Strongly Agree, and including a Prefer not to say. In addition, 18 survey items measured level of knowledge of nine Approach knowledge areas before and after completing Approach coaching, with the before assessment using a retrospective pre-test approach. For example, for the knowledge area of "identification of DV," the retrospective pre-test item was "Before the Approach coaching: To identify DV" and the after item was "After the Approaching coaching: To identify DV." In addition, there was an open-ended comment box for participants to share any additional information regarding their experience with Approach coaching.

Analytic Approaches

Simple percentages were used to analyze the survey results. After the audio recordings were transcribed, the transcripts were loaded into Dedoose a collaborative web-based qualitative software. Two Evaluation Team members coded the transcripts using a codebook developed a priori based on the purpose of the interviews and the constructs embedded into the interview guide. The codebook was expanded and refined as coding of the first three transcripts were completed. Following coding, a matrix (Miles, Huberman, & Saldana, 2019) was used to examine code-based excerpts by participants. Using thematic analysis techniques, themes and dimensions were identified.

Covid-19

As the survey part of the Final Coaching Assessment survey was designed to be administered online via REDCap, Covid-19 did not directly impact it. The focus groups of the Final Coaching Assessment were conducted online, which likely would have been the platform needed given that all 10 focus groups were held July 2021, meaning traveling to conduct them in person would have been prohibitive.

Centering Racial Equity in Collaboration Survey

The Centering Racial Equity in Collaboration survey was developed to be used by the QIC-DVCW to assess perceptions of strengths of the QIC-DVCW projects' collaboration within different working groups (e.g., implementation team, management team). The instrument was developed because at the time of implementation in 2019, partners of the QIC-DVCW knew of no instrument that infused racial equity into the assessment of collaboration among organizational partners. For the purpose of the survey, collaboration was defined as *exchanging information, altering activities, sharing resources, and enhancing the capacity of other organizations for mutual benefit and to achieve a common purpose.* The aim of the survey was to help implementation and/or management teams in one or more of the following ways:

- Assess how well the collaborative group was working to implement the Approach
- Identify specific areas to focus on to improve collaboration effectiveness
- Compare the ideas individuals have about collaboration with the realities of collaboration in practice
- Monitor the peaks and valleys of collaboration over time

RESEARCH QUESTIONS

The research questions answered using the Centering Racial Equity in Collaboration survey were all under Cross-Organization Collaboration & Communication:

- 1.B.3.1. How did child welfare - partner communication at management level change at different time points during the intervention?
- 1.B.3.2. How did child welfare - partner collaboration at management level change at different time points during the intervention?

- 1.B.3.3. How did sites' use of shared Approach principles change at different time points during the intervention?
- 1.B.3.4. How did sites use of shared frameworks (PF and RSA) change at different time points during the intervention?
- 1.B.3.5. How did sites' data-driven/community stakeholder inclusion & feedback change at different time points during the intervention?
- 1.B.3.6. How did sites actively work toward racial, ethnic, and gender equity in their collaborative work together change at different time points during the intervention?

Samples and Recruitment

Study participants included all members of each local Project's Management Team and Implementation Team. The study team worked with the project leads (i.e., Project managers and Project TA providers) of each site to recruit study participants. Project leads shared information with Management Team and Implementation Team members at their regular in-person monthly meetings, inviting them to participate in the two surveys. Participants were asked for passive consent via information statements. For individuals absent from the meeting, an electronic version of the survey was forwarded to them by email by the project manager and a survey link provided.

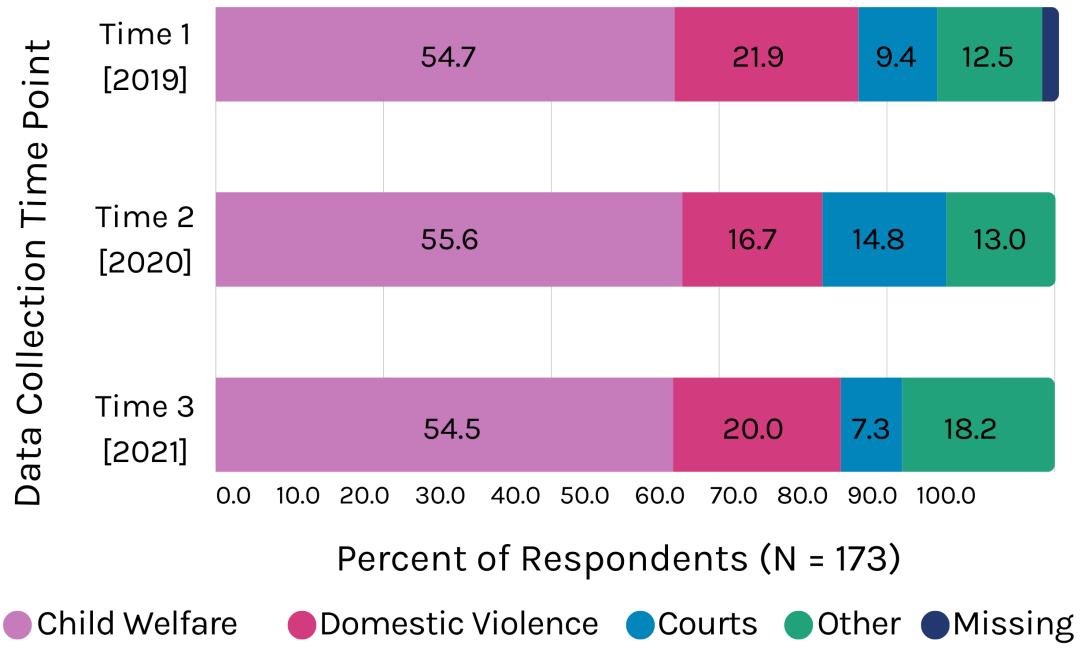
Table 3. (Collaboration Survey) Respondent Characteristics by Data Collection Time Point

Respondent Characteristic	Time 1 [2019] n (%)	Time 2 [2020] n (%)	Time 3 [2021] n (%)
Total Sample Size			
Complete Survey	64 (92.8)	54 (79.4)	55 (69.7)
Incomplete Survey	5 (7.2)	14 (20.6)	24 (30.3)
Race			
Black	13 (20.3)	15 (27.8)	13 (23.6)
White	43 (67.2)	35 (64.8)	36 (65.5)
Asian or Pacific Islander	0 (0.0)	0 (0.0)	1 (1.8)
American Indian/Alaskan Native	0 (0.0)	0 (0.0)	0 (0.0)
2+ Races	3 (4.7)	2 (3.7)	0 (0.0)
Other	0 (0.0)	0 (0.0)	1 (1.8)
Prefer Not to Answer/Missing	5 (7.8)	2 (3.7)	4 (7.3)
Ethnicity			
Latino/a Origin/Descent	7 (10.9)	4 (7.4)	6 (10.9)
Other	56 (87.5)	47 (87.0)	46 (83.6)
Prefer Not to Answer/Missing	1 (1.6)	3 (5.6)	3 (5.5)
Type of Organization (Not Mutually Exclusive Categories)			
Public Child Welfare	36 (56.3)	29 (53.7)	30 (54.5)
Private Child Welfare	1 (1.6)	2 (3.7)	0 (0.0)

Respondent Characteristic	Time 1 [2019] n (%)	Time 2 [2020] n (%)	Time 3 [2021] n (%)
DV Program for Survivors	12 (18.8)	8 (14.8)	9 (16.4)
Battering Intervention Program	5 (7.8)	2 (3.7)	3 (5.5)
Responsible Fatherhood Program	0 (0.0)	0 (0.0)	0 (0.0)
Court/Legal System	6 (9.4)	4 (7.4)	3 (5.5)
Legal Advocates	6 (9.4)	5 (9.3)	2 (3.6)
Resettlement/Immigration Support	0 (0.0)	0 (0.0)	0 (0.0)
School/Education System	3 (4.7)	0 (0.0)	0 (0.0)
Early Childhood/Daycare	1 (1.6)	1 (1.9)	0 (0.0)
Faith Community	0 (0.0)	0 (0.0)	0 (0.0)
Health Care Provider	0 (0.0)	0 (0.0)	0 (0.0)
Mental or Behavioral Health	3 (4.7)	3 (5.6)	4 (7.3)
Substance Use Disorder	2 (3.1)	0 (0.0)	2 (3.6)
Housing Support	2 (3.1)	1 (1.9)	1 (1.8)
Municipal Government	0 (0.0)	2 (3.7)	1 (1.8)
Policy Maker	0 (0.0)	0 (0.0)	1 (1.8)
Other	5 (7.8)	3 (5.6)	7 (12.7)
CW or DV Experience			
Less than 1 Year	0 (0.0)	0 (0.0)	4 (7.3)
1 to 5 Years	12 (18.8)	12 (22.2)	8 (14.5)
6 to 10 Years	8 (12.5)	13 (24.1)	5 (9.1)
More than 10 years	42 (65.6)	28 (51.9)	38 (69.1)
Missing	2 (3.1)	1 (1.9)	0 (0.0)

Notes. *N* = 173

Figure 10. (Collaboration Survey) Respondents Type of Organization by Data Collection Time Point



Data Collection Procedures

With the support of the Evaluation team and TA leads, all Project site implementation and management teams administered the Centering Racial Equity in Collaboration survey once per year, in 2019, 2020, and 2021. In 2019, the survey was administered during implementation and management team meetings via paper copies, distributed by TA/Project managers, and by REDCap (i.e., web-based platform) for those participants who were unable to attend. After 2020, because team meetings moved to a remote platform, the survey was exclusively distributed via REDCap.

Measures

The Centering Racial Equity Collaboration survey includes three parts: Part I: Demographic Questions, Part II: Collaboration Domains, and Part III: Collaboration Spectrum.

- Part I included demographic questions including Type of Organization, years of child welfare and/or DV service/professional work.
- Part II of the instrument contains 44 items. In the implementation/pilot instrument version administered during the duration of the QIC-DVCW implementation, Part II's 44 items were organized into 22 domains: shared vision, mission, and goals; clarity and structure, sustainability, decision-making, resource sharing, diverse representation, dismantling structural oppression, leadership development, mutual respect, community engagement, cultural humility, participatory data, data informed, data feedback loop from diverse stakeholders, learning approach, principles, and frameworks. Participants rated each Part II item on a Likert scale from 1 to 5 where:
  - 1 = Strongly Disagree
  - 2 = Disagree
  - 3 = Neutral or No Opinion
  - 4 = Agree
  - 5 = Strongly Agree
  - NA = Don't know (data were not included in the analysis)

- Part III was a collaboration continuum scaling measure to assess participant's perception of their "collaborative group" (i.e., implementation and/or management team) current placement the continuum.

At the conclusion of the QIC-DVCW implementation, a Confirmatory Factor Analysis ([CFA]; see description in Analytic Approaches section directly below) was conducted. Based on this CFA, the 44 survey items clustered into 15 domains.

Analytic Approaches

Multiple linear regressions with clustered standard errors were run to compare means over the three time points, accounting for clustering across project sites. The p-value < 0.05 is an indicator of whether time-specific means significantly diverged from the overall mean score in a positive or negative direction.

Cronbach's alpha measures the reliability of the items within the identified conceptual domain. A score between 0.70 and 0.95 is considered to be within an acceptable range of reliability. We used exploratory factor analyses (EFA) to identify convergent and discriminant validity of several newly created scales. We conducted reliability analysis to identify scales with acceptable internal consistency ($a > 0.70$). Mean scores were calculated for all identified scales that gave equal weight to all items; this approach aligns with the early stages of item-validation for the newly created used within the self-survey. All individual items, associated mean scores, and reliability scores are reported.

Covid-19

As the Centering Racial Equity in Collaboration survey was designed to be administered online via REDCap, no Covid-19 based modifications were required.

Key Informant Interviews

The Key Informant Interviews were designed to understand what supported and got in the way of the Approach implementation from the perspective of individuals who were members of the Projects' Implementation and/or Management Teams. Gaining the insight of these individuals contributed to the triangulation of the data to answer the Implementation Study research question "what contributed/inhibited the successful implementation of the approach," which measured **acceptability, feasibility**, and **sustainability** implementation outcomes, as well as the Cross-Organizational Communication & Collaboration area of the Service Delivery Outcomes. The analysis is cross-site to maintain the confidentiality of the participants.

Research Questions

The research questions answered using the Key Informant Interviews were:

- What contributed/inhibited successful implementation of the Approach? (Implementation strategies – e.g., training, TA, teams)
- 1.B.3.2. How did CW-Partner collaboration at management level change at different time points during the intervention?
- 1.B.3.4. How did sites use of shared frameworks (PF and RSA) change at different time points during the intervention?
- 1.B.3.5. How did sites data-driven/ community stakeholder inclusion & feedback change at different time points during the intervention?

Samples and Recruitment

Key Informant Interviews participants were 26 key informants in the QIC-DVCW project sites, including members of each local Project's Management Team and Implementation Team, Project managers, court staff, and community

partners. The selection for these interviews was purposeful because of the limited time of the project. The Evaluation Team worked with the project leads (i.e., Project managers and Project TA Teams) of each site to recruit study subjects. Based on the Project managers' preference, either the Project manager or the Evaluation Team invited subjects to participate in the interviews via email and requested the subjects to communicate directly with the Evaluation Team to schedule appointments. Participants were asked for passive consent via information statements.

Table 4. Key Informant Interviews Demographic Characteristics (N=26)

Sample characteristics	n	(%)
Type of Organization -Employed/Representing		
Public child welfare agency	11	(42)
Domestic violence program for survivors	5	(19)
Private child welfare agency	0	(0)
Battering intervention program	3	(12)
Responsible fatherhood program	0	(0)
Parent advocate/representative	2	(8)
Judge	2	(8)
Attorney	3	(12)
Other	6	(23)

Sample characteristics	n	(%)
Highest Education Degree		
Master's (or higher) of social work (MSW)	7	(27)
Other master's (or higher) degree	8	(31)
Other bachelor's degree	2	(8)
Bachelor of social work (BSW)	2	(8)
High School degree or GED	2	(8)
Associate's degree	0	(0)
PhD	2	(8)
Other	3	(12)
Length of Current Position		
0 to 5 years	15	(58)
6 to 10 years	5	(19)
11 to 15 years	4	(15)
16 to 20 years	1	(4)
Missing	1	(4)
Overall Length in CW and/or DV		

Sample characteristics	n	(%)
0 to 5 years	3	(12)
6 to 10 years	2	(8)
11 to 15 years	6	(23)
16 to 20 years	7	(27)
21 to 25 years	3	(12)
26 to 30 years	3	(12)
31 to 35 years	1	(4)
35 to 40 years	1	(4)
Race/Ethnicity Identity		
White/Caucasian/European origin	14	(54)
Black or African American	4	(15)
Latino/a, or Spanish origin	7	(27)
Prefer not to say	0	(0)
Asian or Asian American	1	(4)
Indigenous, Native American, or Alaska Native	0	(0)
Middle Eastern or North African	0	(0)
Native Hawaiian or Other Pacific Islander	0	(0)
Biracial/Multiracial	1	(4)
Prefer to self-describe	0	(0)
Gender Identity		
Woman	21	(81)
Man	4	(15)
Non-binary/Agender/Genderqueer	1	(4)
Two-spirit	0	(0)
Prefer to self-describe	2	(4)
Prefer not to say	1	(2)
Trans Gender Identity		
No	25	(96)
Yes	1	(4)
Not sure	0	(0)
Prefer not to say	0	(0)
Other Languages Spoken		
Hindi	1	(4)
Spanish	7	(27)
N/A	18	(69)

Data Collection Procedures

Participants completed one demographic survey and an interview. The interviews took place in September and October 2021 via Zoom and were audio recorded. One of two Evaluation Team members conducted 26 interviews. Twenty-one interviews were conducted by the PI; the five Project manager interviews were conducted by one of the co-PIs, who was less familiar to the Project managers. The decision to not have the PI interview the Project managers was made to increase the Project managers' comfort to share openly and decrease the possible influence of the PI-Project manager relationship dynamic during the interview. Interviews lasted between 30 and 90 minutes.

Measures

The Key Informant Interviews used a semi-structured interview guide to understand what supported and got in the way of the Approach implementation. The key topics were perceptions of (1) Approach-informed practices and policy put in place at the site, (2) the ways the Approach benefited families experiencing DV and child welfare system involved, (3) what and who promoted changes at site, and (4) what got in the way of implementation.

Analytic Approaches

After the audio recordings were transcribed, the transcripts were loaded into Dedoose a collaborative web-based qualitative software. Two Evaluation Team members coded the transcripts using a codebook developed a priori based on the purpose of the interviews and the constructs embedded into the interview guide. The codebook was expanded and refined as coding of the first three transcripts were completed. Following coding, a matrix (Miles, Huberman, & Saldana, 2018) was used to examine code-based excerpts by participants. In addition to thematic analysis, the Implementation Drivers framework, used as one of the AIF of the QIC-DVCW implementation study, were applied to the findings, to assist in answering the implementation study question:

What contributed/inhibited successful implementation of the Approach?

Covid-19

The Key Informant Interviews protocols were developed in 2021 after Covid-19 restrictions were in play. Therefore, the plan was for the interviews to be conducted remotely. Also, given all 26 interviews were conducted in September and October 2021, travel to conduct them in person would have been prohibitive.

Universal Stages of Implementation Completion

The Universal Stages of Implementation Completion (Uni-SIC) is a web-based tool developed by the Oregon Social Learning Center to help communities achieve higher levels of implementation success when integrating an evidence-based or evidence-informed model into community settings (Saldana & Chamberlain, 2012). It was used as part of the Implementation Study due to its direct connection to the Implementation Stages framework (see Figure 3 on page 14) and the implementation outcomes of **adoption** *and* **sustainability** (see Figure 2 on page 13).

A key premise is that by monitoring stages of implementation via key activities, Projects can be more successful in their implementation. The Uni-SIC was originally developed as part of a randomized implementation trial focused on comparing two different implementation strategies for the same evidence-based intervention. It has been adapted for more than 20 evidence-based/informed interventions to identify common implementation activities. Research on the Uni-SIC has demonstrated its strong psychometric properties and stable predictive ability of duration (time required to implement) and proportion (thoroughness of implementation) across interventions. The Uni-SIC can serve as a benchmark for ideal implementation.

Within the QIC-DVCW, the Uni-SIC addressed two key aspects of implementation:

- Duration: How long does implementation take implement each stage of implementation? and,
- Completeness of implementation: To what degree is the implementation completed?

Research Questions

In the QIC-DVCW, we applied the Uni-SIC to answer the following research questions:

- How long did it take sites to complete each stage of implementation, including pre-implementation and implementation?
- To what degree did sites complete implementation?

Samples and Recruitment

All three sites were included in data collected through the Uni-SIC. As these data were strictly dates and did not involve the collection of any human subject data, no recruitment activities were necessary.

Data Collection Procedures

The Evaluation Team provided an Excel spreadsheet to each site for the purposes of collecting Uni-SIC data. This tool provided a list of implementation activities that were organized into three phases and 8 stages (see below). Project managers were asked to provide the date that each activity was completed. An Evaluation Team member periodically emailed the spreadsheet to project managers to request the input of dates and to answer any questions that arose as the spreadsheet was completed. Upon receiving the dates, the Evaluation Team member entered dates for each site's activities into a web-based reporting system that was provided by the Uni-SIC developer.

Measures

The full Uni-SIC instrument is provided in the Appendices. Table 5 presents a summary of the Uni-SIC instrument. The duration metrics were estimated for each of the three phases by calculating the difference between dates. The proportion of completed metrics were estimated by calculating the number of completed activities out of the number of required activities. The specific activities required were identified from prior research. All calculations were provided to the Evaluation Team by the Uni-SIC developers' reporting website.

Table 5. Summary of the Universal Stages of Implementation Completion Tool

3 Phases	8 Stages	Number of Activities
Pre-Implementation	Engagement	4
	Consideration of Feasibility	4
	Readiness Planning	10
Implementation	Staff Hired and Trained	5
	Fidelity and Adherence Monitoring Established	4
	Services and Consultation	4
	Ongoing Services, Consultation, Fidelity, Feedback	11
Sustainment	Competency	4

Analytic Approaches

The Uni-SIC provided four metrics for each site:

- Duration for pre-implementation (in days)
- Duration for implementation (in days)
- Duration for sustainment (in days)
- Proportion of implementation activities completed (percentage).

These metrics are descriptive and not used in any other quantitative analysis.

Covid-19

Covid-19 impacted the Evaluation Team's data collection efforts around the Uni-SIC. During the shutdown in spring 2020 and in the subsequent months of increased stressors on the child welfare system, the Project Managers identified the Uni-SIC as one area where they could de-emphasize the data collection task as a priority. To accommodate this, the Evaluation Team negotiated by project when to send the email request for updated Uni-SIC information.

Self-Survey

The Self Survey was a four time point online survey aimed at measuring service delivery outcomes (i.e., Consequent Practice Behaviors in the Logic Model) over time from the perspective of providers (e.g., professional staff members identified by the project sites as being included in QIC-DVCW identified intervention and comparison offices). To account for differences in provider role, three Self-Surveys versions were developed and administered to all three project sites: **1. Caseworker Self-Survey, 2. Supervisor Self-Survey (for child welfare supervisors), and 3. Community Partner Self-Survey**. These versions were piloted by individuals who served in those provider roles but were not in the QIC-DVCW Project site offices. In addition, in Allegheny County, the Project that utilizes "specialist" roles, a separate Allegheny County-specific specialist self-survey was created for time 2 and beyond to address the challenges in survey completion reported by the specialists. See Analytic Approach section below for how the Specialist Self-Surveys were handled. See Table 6 for eligible sample tables by provider role and site.

Table 6. (Self-Survey) Eligible Sample by Provider Role across all Partner Sites

Sample	All Cohorts N (%)	T1 Cohort n (%)	T2 Cohort n (%)	T3 Cohort n (%)
Eligible Providers	1,270 (100%)	595 (100%)	437 (100%)	238 (100%)
Child Welfare Workers	797 (63%)	322 (54%)	310 (71%)	165 (69%)
Child Welfare Supervisors	184 (14%)	113 (19%)	55 (13%)	16 (7%)
Community Partners	289 (23%)	160 (27%)	72 (16%)	54 (24%)

Caseworker Self-Survey

Research Questions

The research questions answered using the Caseworker Self-Survey were:

- 1.B.1.1. Were there significant differences between the intervention and comparison sample in CW practice planning, decision-making, & practice addressing Protective Factors for Survivors framework?
- 1.B.1.2 Were there significant differences between the intervention and comparison sample in CW practice planning, decision-making, & practice addressing Relational and Systemic Accountability framework?
- 1.B.1.4. Were there significant differences between the intervention and comparison sample in CW practice actively working toward racial, ethnic, and gender equity in their practice as well as in families' access to resources and services?
- 1.B.1.5. Were there significant differences between the intervention and comparison sample in measures of CW-Partner communication and collaboration in case activities?

Samples and Recruitment

The subjects of the Caseworker Self Survey were employees of participating child welfare agencies who served in the capacity of front-line child welfare case workers or managers and child welfare front-line supervisors. All three participating child welfare agencies agreed to direct their eligible workers and supervisors to participate in the study (see Sampling Frame Section in Methods for more information).

The child welfare self-survey sample is predominantly caseworkers. For caseworkers, we observed baseline differences between intervention and comparison sites by race/ethnicity and languages spoken. The intervention sites tended to have child welfare respondents who were more diverse, representing a larger proportion of *Black and not Latino/a* and *Latino/a and any race* self-identification. In addition, more respondents *speak English and Spanish* at the intervention sites relative to the comparison sites.

Table 7. (Self-Survey) Child Welfare Sample Baseline Differences in Demographic Characteristics between Intervention & Comparison

Variable	Intervention		Comparison		Test Statistic	df	*p*
	n	M(SD)	n	M(SD)	t		
Age (in years)	370	40.2 (11.5)	214	39.8 (11.3)	0.414	582	0.679
	n	%	n	%	X^2	df	*p*
Gender					**0.010**	**1**	**0.922**
Female	221	81.2	129	81.1			
Other Identification	44	16.2	25	15.7			
Missing	7	2.6	5	3.2			
Race/Ethnicity					**10.148**	**3**	**0.017***
Black and not Latino/a	43	15.8	17	10.7			
Latino/a and any race	51	18.7	16	10.1			
White and not Latino/a	157	57.7	111	69.8			
Other race and not Latino/a	7	2.6	7	4.4			
Missing	13	4.8	8	5.0			
Languages Spoken					**6.571**	**2**	**0.037***
English Only	217	79.8	133	83.6			
English and Spanish	45	16.5	13	8.2			
English and Other Language	8	2.9	8	5.0			
Missing	2	0.7	5	3.1			

Notes. Intent-to-Treat Sample *N* = 431; intervention *n* = 272, comparison *n* = 159. Chi-square tests for independence do not include missing values. The *p*-value reports the probability of observing a false positive (null hypothesis) to be true; statistically significant p-values are denoted by an asterisk (*).

Intervention and comparison sites represent similar composition of caseworkers and supervisors, education level, child welfare experience, and job safety. We observed a higher proportion of social workers at the comparison sites had received at least some domestic violence training within the last 2 years.

Table 8. (Self-Survey) Child Welfare Sample Baseline Differences in Training/Employment Experiences between Intervention & Comparison

Variable	Intervention		Comparison		Test Statistic	df	*p*
	n	%	n	%	X^2		
Role in Child Welfare					**2.755**	**1**	**0.097**
Caseworker	208	76.5	110	69.2			
Supervisor	64	23.5	49	30.8			
Education Level					**0.414**	**1**	**0.520**
Bachelor's Degree or less	138	50.7	74	46.5			
Graduate degree	131	48.2	80	50.3			
Missing	3	1.1	5	3.1			
Child Welfare Experience					**3.776**	**4**	**0.437**
Less than 1 year	26	9.6	14	8.8			
1 to 2 years	57	20.9	23	14.5			
3 to 5 years	34	12.5	27	17.0			
6 to 10 years	30	11.0	17	10.7			
More than 10 years	122	44.9	73	45.9			
Missing	3	1.1	5	3.1			
DV Training Exposure					**4.685**	**1**	**0.030***
None within last 2 years	66	24.3	24	15.1			
Some within last 2 years	203	74.6	130	81.8			
Missing	3	1.1	5	3.1			
Job Safety (prior 6 months)					**0.888**	**2**	**0.642**
Always safe	96	35.3	53	33.3			
Sometimes unsafe	139	51.1	76	47.8			
Frequently/always unsafe	21	7.7	16	10.1			
Missing	16	10.1	14	8.8			

Notes. Intent-to-Treat Sample *N* = 431; intervention *n* = 272, comparison *n* = 159. Chi-square tests for independence do not include missing values. The *p*-value reports the probability of observing a false positive (null hypothesis) to be true; statistically significant p-values are denoted by an asterisk (*).

Data Collection Procedures

Electronic rosters of eligible workers and supervisors were provided to the Evaluation Team by the participating child welfare agencies. In two of the Projects, Illinois and Allegheny County, these rosters included all agency caseworkers who are serving child welfare involved families experiencing domestic violence. In the Massachusetts Project, this roster included all caseworkers serving child welfare involved families experiencing domestic violence who did not choose to opt out of the study. Each subject was asked to complete four 20-minute web-based surveys over a period of three years. A baseline survey was administered in the winter/spring of 2019 (MA in January 2019, IL in March 2019, and AC in April 2019). Follow-up surveys were repeated

every 9-12 months through the end of the study data collection period (September 2021). Surveys were administered using REDCap, which is a web-based, HIPPA-compliant survey platform. Subjects were sent email notifications and reminders about their surveys to their employment-based email addresses. Subjects gained access to the surveys via a survey portal, containing the survey, as well as links to frequently asked questions, help page, and the evaluation email help line.

One project site, Allegheny County, PA utilized a benevolent incentive approach for the Self-Survey, which was approved by the KU IRB.

Measures

The Child Welfare Caseworker Self-Survey contained multiple sections. In Section A covered questions about subjects' demographic characteristics, education and work experience and was only asked of first-time respondents. Section B covered perceptions of accessibility of community services and supports in 29 items (1=almost always accessible to 5=not at all accessible) and was only included at baseline. Section C covered:

- Job satisfaction (1 item, 1=very dissatisfied to 5=very satisfied),
- Secondary trauma (6 items, 1=almost all the time to 5=never),
- Quality of supervision received from their immediate supervisors (29 items, 1= all the time to 5=never),
- Unit-level work climate (5 items, 1= all the time to 5=never) and safety (1 items, 1=none of time to 5=always),
- Job safety (2 items, item 1, 1=none of the time to 5=always, if 3-5, then item 2 was shown to assess how unsafe, 1=a little unsafe to 4=my life was in danger),
- Approach-related attitudes and beliefs about,
  - Adult victim/survivors ([note: "victim/survivor" term used for user recognition] 3 items, 1=always true to 5=never true)
  - People who use violence (4 items, 1=always true to 5=never true)
  - Effectiveness of CW practices to achieve good outcomes (8 items, 1=very effective to 5=not at all effective)
  - Case plans (4 items, 1=always true to 5=never true)
  - Family safety assessments (2 items, 1=completely agree to 5=completely disagree)
  - Working with families of difference racial, ethnic, and cultural backgrounds (4 items, 1=completely agree to 5=completely disagree); and,
- Approach-related practice behaviors
  - Frequency (14 items, 1= all the time to 5=never)
  - Perception of job responsibilities (5 items, 1=strongly agree to 5=strongly disagree)
  - Preparation by agency to do (10 times, 1=well prepared to 5 not at all prepared).

Analytic Approaches

Sample descriptive statistics are provided for the full intent-to-treat sample by data collection time period; proportion of missing data for each item is identified. We used exploratory factor analyses (EFA) to identify convergent and discriminant validity of several newly created scales. We conducted reliability analysis to identify scales with acceptable internal consistency ($a > 0.70$). Mean scores were calculated for all identified scales that gave equal weight to all items; this approach aligns with the early stages of item-validation for the newly created used within the self-survey.

Baseline equivalency. We report baseline analyses to identify any significant baseline differences across sites for the Time 1 Cohort. In addition, high missingness on items during data collection Time 3 and Time 4 may bias results towards individuals who were highly motivated to engage in the intervention activities. We used 100 imputed

data sets to mitigate bias associated with missingness, but these strategies may not fully resolve these concerns.

Multivariate analyses. To align with the logic model and associated research questions, we ran separate analyses for (a) child welfare caseworker self-ratings/supervisor ratings of caseworkers and (b) community partner self-ratings of practice behaviors. Given the large proportion of missing data due to attrition in both samples, we focused longitudinal analyses on the T1 Cohort (which had the most complete data). We explored the extent of missing data and reported relationships for the complete cases sample, models using full information maximum likelihood, and models for the full intent-to-treat sample using multiple imputation. We used multiple imputation using chained equations (MICE) using Stata 17 (StataCorp, 2021) to address missingness reported within the independent variables using 100 iterations. Fraction of missing information (FMI); all model variables had relative efficiency greater than 0.995. We used linear mixed models to estimate repeated measures from the same individuals reporting over time, allowing for us to measure between and within group variance over time.

Covid-19

As the Caseworker Self-Survey was designed to be administered online via REDCap, no Covid-19 based modifications were required.

CW Supervisor Self-Survey

Research Questions

The research questions answered using the CW Supervisor Self-Survey were:

- 1.B.1.1. Were there significant differences between the intervention and comparison sample in CW practice planning, decision-making, & practice addressing Protective Factors for Survivors framework?
- 1.B.1.2 Were there significant differences between the intervention and comparison sample in CW practice planning, decision-making, & practice addressing the Relational and Systemic Accountability framework?
- 1.B.1.4. Were there significant differences between the intervention and comparison sample in CW practice actively working toward racial, ethnic, and gender equity in their practice as well as in families' access to resources and services?
- 1.B.1.5. Were there significant differences between the intervention and comparison sample in measures of CW-Partner communication and collaboration in case activities?

Samples and Recruitment

The subjects of the CW Supervisor Self-Survey were employees of participating child welfare agencies who served in the capacity of child welfare front-line managers and supervisors. All three participating child welfare agencies agreed to direct their eligible workers and supervisors to participate in the study. See Table 7 and Table 8 for sample description.

Data Collection Procedures

Electronic rosters of CW supervisors were provided to the Evaluation Team by the participating child welfare agencies. In two of the sites, Illinois and Allegheny County, these rosters included all agency supervisors who are serving child welfare involved families experiencing domestic violence. In the Massachusetts site, this roster included all supervisors who are serving child welfare involved families experiencing domestic violence who have not chosen to opt out of the study. Each subject was asked to complete four 20-minute web-based surveys over a period of three years. A baseline survey was administered in the winter/spring of 2019 (MA in January 2019, IL in March 2019, and AC in April 2019). Follow-up surveys were repeated every 9-12 months through the end of the study data collection period (September 2021). Surveys were administered using REDCap, which is a web-based, HIPPA-compliant survey platform. Subjects were sent email notifications and reminders about

their surveys to their employment-based email addresses. Subjects gained access to the surveys via a survey portal, containing the survey, as well as links to frequently asked questions, help page, and the evaluation email help line.

Measures

The CW Supervisor Self-Survey contained multiple sections. In Section A covered questions about subjects' demographic characteristics, education and work experience and was only asked of first-time respondents. Section C (mirrors Section C of Caseworker Self-Survey) covered:

- Job satisfaction (1 item, 1=very dissatisfied to 5=very satisfied),
- Secondary trauma (6 items, 1=almost all the time to 5=never),
- Quality of supervision received from their immediate supervisors (29 items, 1= all the time to 5=never),
- Unit-level work climate (5 items, 1= all the time to 5=never) and safety (1 items, 1=none of time to 5=always),
- Approach-related attitudes and beliefs about,
  - Adult victim/survivors ([note: "victim/survivor" term used for user recognition] 3 items, 1=always true to 5=never true)
  - People who use violence (4 items, 1=always true to 5=never true)
  - Effectiveness of CW practices to achieve good outcomes (8 items, 1=very effective to 5=not at all effective)
  - Case plans (4 items, 1=always true to 5=never true)
  - Family safety assessments (2 items, 1=completely agree to 5=completely disagree)
  - Working with families of difference racial, ethnic, and cultural backgrounds (4 items, 1=completely agree to 5=completely disagree); and,
- Approach-related practice behaviors
  - Frequency (14 items, 1= all the time to 5=never)
  - Perception of job responsibilities (5 items, 1=strongly agree to 5=strongly disagree)
  - Preparation by agency to do (10 times, 1=well prepared to 5 not at all prepared).

Analytic Approaches

See above in Caseworker Self-Survey Analytic Approaches section.

Covid-19

As the CW Supervisor Self-Survey was designed to be administered online via REDCap, no Covid-19 based modifications were required.

Community Partner Self-Survey

Research Questions

The research questions answered using the Community Partner Self-Survey were:

- 1.B.2.1. Were there significant differences between the intervention and comparison sample in community partner planning, decision-making, & practice addressing Protective Factors for Survivors framework?
- 1.B.2.2. Were there significant differences between the intervention and comparison sample in community partner planning, decision-making, & practice addressing the Relational and Systemic Accountability framework?
- 1.B.2.4. Were there significant differences between the intervention and comparison sample in measures of actively working toward racial, ethnic, and gender equity in community partner practice, as well as in families' access to resources and services?
- 1.B.2.5. Were there significant differences between the intervention and comparison sample in CW-Partner communication and collaboration in case activities?

Samples and Recruitment

The subjects of the Community Partner Self-Survey were staff and non-client representatives of community partner agencies that work in close collaboration with the child welfare agencies in the three participating sites. Electronic rosters of eligible community partners were provided to the Evaluation Team by the participating child welfare agencies after the community partner agencies identified staff and other representatives to complete the surveys.

The Community Partner Self-Survey sample is predominantly female. For partners, we observed baseline differences between intervention and comparison sites by race/ethnicity. The intervention sites tended to have child welfare respondents who were more diverse, representing a larger proportion of *Black and not Latino/a* and *Latino/a and any race* self-identification.

Table 9. Community Partner Sample Baseline Differences in Demographic Characteristics between Intervention & Comparison

Variable	Intervention		Comparison		Test Statis-tic	df	*p*
	n	M(SD)	n	M(SD)	t		
Age (in years)	**370**	**40.2 (11.5)**	**214**	**39.8 (11.3)**	**0.414**	**582**	**0.679**
	n	**%**	**n**	**%**	**X^2**	**df**	**p**
Gender					**0.000**	**1**	**0.996**
Female	81	81.0	47	79.7			
Other Identification	19	19.0	11	18.6			
Missing	0	0.0	1	1.7			
Race/Ethnicity					**8.636**	**3**	**0.035***
Black and not Latino/a	17	17.0	7	11.9			
Latino/a and any race	15	15.0	2	3.4			
White and not Latino/a	61	61.0	48	81.4			
Other race and not Latino/a	5	5.0	1	1.7			
Missing	2	2.0	1	1.7			
Languages Spoken					**5.267**	**2**	**0.072**
English Only	83	83.0	55	93.2			
English and Spanish	12	12.0	1	1.7			
English and Other Language	5	5.0	3	5.1			

Notes. Intent-to-Treat Sample *N* = 159; intervention *n* = 100, comparison *n* = 59. Chi-square tests for independence do not include missing values. The *p*-value reports the probability of observing a false positive (null hypothesis) to be true; statistically significant p-values are denoted by an asterisk (*).

Intervention and comparison sites represent similar composition of education level, child welfare experience, and job safety.

Table 10. (Self-Survey) Community Partner Sample Baseline Differences in Training/ Employment Experiences between Intervention & Comparison

Variable	Intervention		Comparison		Test Statistic	df	*p*
	n	%	n	%	X^2		
Education Level					**0.637**	**1**	**0.425**
Bachelor's Degree or less	36	36.0	25	42.4			
Graduate degree	64	64.0	34	57.6			
Child Welfare Experience					**2.631**	**2**	**0.268**
Less than 1 year	72	72.0	36	61.0			
1 to 2 years	10	10.0	6	10.2			
More than 2 years	16	16.0	16	27.1			
Missing	2	2.0	1	1.7			
Job Safety (prior 6 months)					**1.069**	**2**	**0.586**
Always safe	51	51.0	31	52.5			
Sometimes unsafe	44	44.0	26	44.1			
Frequently/always unsafe	1	1.0	2	3.4			
Missing	4	4.0	0	0.0			
Organization Type					**4.488**	**3**	**0.213**
Domestic Violence	36	36.0	12	20.3			
Court/Legal	37	37.0	28	47.5			
Other Behavioral Health	7	7.0	6	10.2			
Other Services	18	18.0	10	16.9			
Missing	3	3.0	4	6.8			

Notes. Intent-to-Treat Sample *N* = 159; intervention *n* = 100, comparison *n* = 59. Chi-square tests for independence do not include missing values. The *p*-value reports the probability of observing a false positive (null hypothesis) to be true; statistically significant p-values are denoted by an asterisk (*).

Data Collection Procedures

Each subject was asked to complete four 20-minute web-based surveys over a period of three years. A baseline survey was administered in the winter/spring of 2019 (MA in January 2019, IL in March 2019, and AC in April 2019). Follow-up surveys were repeated every 9-12 months through the end of the study data collection period (September 2021). Surveys were administered using REDCap, which is a web-based, HIPPA-compliant survey platform. Subjects were sent

email notifications and reminders about their surveys to their employment-based email addresses. Subjects gained access to the surveys via a survey portal, containing the survey, as well as links to frequently asked questions, help page, and the evaluation email help line.

Measures

The Community Partner Self-Survey contained multiple sections. In Section A covered questions about subjects' demographic characteristics, education and work experience and was only asked of first-time respondents.

Section B covered:

- Job satisfaction (1 item, 1=very dissatisfied to 5=very satisfied),
- Secondary trauma (6 items, 1=almost all the time to 5=never), and,
- Job safety (2 items, Item 1, 1=none of the time to 5=always, if 3-5, then Item 2 was shown to assess how unsafe, 1=a little unsafe to 4=my life was in danger).
- Section C covered:
- Approach-related attitudes and beliefs about
  - Adult victim/survivors ([note: "victim/survivor" term used for user recognition] 3 items, 1=always true to 5=never true)
  - People who use violence (4 items, 1=always true to 5=never true)
  - Effectiveness of practices to achieve good outcomes (8 items, 1=very effective to 5=not at all effective)
  - Accountability based individualized approach to PUVs and importance of formal vs informal support for adult survivors (2 items, 1=always true to 5=never true)
  - Family safety assessments (2 items, 1=completely agree to 5=completely disagree)
  - Working with families of difference racial, ethnic, and cultural backgrounds (4 items, 1=completely agree to 5=completely disagree)
  - CW workers and agencies (4 items, 1=strongly agree to 5=strongly disagree), and,
- Approach-related practice behaviors
  - Perception of job responsibilities (15 items, 1=strongly agree to 5=strongly disagree)
  - Preparation by agency to do (10 times, 1=well prepared to 5 not at all prepared)
  - Frequency (13 items, 1= all the time to 5=never)

Section D covered perceptions of accessibility of community services and supports, in 29 items (1=almost always accessible to 5=not at all accessible) and was only included at baseline.

Analytic Approaches

See above in Caseworker Self-Survey Analytic Approaches section.

Covid-19

As the CW Supervisor Self-Survey was designed to be administered online via REDCap, no Covid-19 based modifications were required.

Family Survey – DV Case Specific

The Family Survey was designed to capture service delivery outcomes and family outcomes (child, adult survivor, and people who use violence) in DV identified cases. Developed by QIC-DVCW partners, including the Evaluation team, the survey instrument sought to gain information from the perspective of the caseworker on their Approach-informed practice with and knowledge of the families experiencing DV with open cases. The Family Survey was administered at two time points in both intervention and comparison offices to provide comparative data by study group and time point.

Research Questions

The service delivery outcome research questions answered using the Family Survey were:

- 1.B.1.1. Were there significant differences between the intervention and comparison sample in CW practice planning, decision-making, & practice addressing Protective Factors for Survivors framework?
- 1.B.1.2.a. Were there significant differences between the intervention and comparison sample in CW practice early and ongoing identification and assessment of domestic violence?
- 1.B.1.2.b. Were there significant differences between the intervention and comparison sample in CW practice survivor-informed engagement, accountability, and support for person using violence (PUV)?
- 1.B.1.2.c. Were there significant differences between the intervention and comparison sample in the extent the adult survivor was engaged by CW relative to people who use violence?

The family outcome research questions answered using the Family Survey were:

- 2.A.3. Were there significant differences between the intervention and comparison sample in child well-being?
  - 2.A.3.1: Improved Emotional, Social, & Physical Health
  - 2.A.3.2: Increased Social Support/ Meaningful Adult Relationships
- 2.B.1. Were there significant differences between the intervention and comparison sample in adult survivor safety and stability?
  - 2.B.1.1: Decreased DV-related Risk Level between adult survivor and person using violence
  - 2.B.1.2: Decreased Abuse of adult survivor, including use of children & systems
  - 2.B.1.3: Increased Stability
- 2.B.2. Were there significant differences between the intervention and comparison sample in adult survivor well-being?
  - 2.B.2.1: Increased Social, Cultural, & Spiritual Connections
  - 2.B.2.2: Increased Resilience & Growth Mindset
  - 2.B.2.3: Increase Social & Emotional Abilities
- 2.C.2. Were there significant differences between the intervention and comparison sample in positive beliefs, attitudinal, & behavior change among persons who use violence?
  - 2.C.2.1: Demonstrating Motivation to Change

Samples and Recruitment

The Family Survey (DV case specific) was completed by front-line child welfare case workers of the three QIC-DVCW child welfare agencies. All three participating child welfare agencies agreed to direct their eligible workers to participate in the study. One of the Projects, Massachusetts, gave their staff the option to opt out of the study. The child welfare agencies in the other two sites (Illinois and Allegheny County), required staff participation.

For Time 1, the sampling frame for this study was all cases open between December 2019 and September 2020, assigned to an eligible worker, and flagged in the child welfare system as having DV present. For our purposes, "flagged" meant DV was coded in any of the case documentation that was available in projects' electronic systems, such as reason for referral and risk assessments. We received data downloads of eligible cases on a monthly basis from sites. Every month, the Evaluation Team randomly selected up to 2 unique cases per worker for Massachusetts and up to 3 unique cases per worker for Allegheny County and Illinois as a part of the study sample. Cases were randomized using a Fisher-Yates shuffling algorithm. For Time 2, the Evaluation Team sent surveys to workers for all cases that

were identified in the original sampling frame (regardless of Time 1 survey completion).

A total of 2,101 cases at risk for co-occurring child maltreatment and domestic violence were identified across the three project sites and selected as the sampling frame for the CORES Survey (Allegheny = 786 cases, Illinois = 630 cases, Massachusetts = 685 cases). Of these, caseworkers initiated surveys for 951 (45%) of identified cases.

Among the 951 cases where caseworkers initiated surveys, 638 (67%) of the cases did not meet the inclusion criteria for the study; project sites non-eligible cases varied between 53% to 77% of cases being identified as non-eligible (see Table 11 for details). The primary reason for cases not meeting inclusion criteria were due to no active DV concerns being identified within 12 months prior to the Time 1 data collection date, followed by the caseworker having no contact with the family due to the case being closed or transferred prior to T1 survey engagement (see Table 12 for details).

Table 11. (Family Survey) Eligible Cases by Eligibility & Complete Status

Survey Response	All Sites N = 2,101	Allegheny n = 786	Illinois n = 630	Massachusetts n = 685
Non-Response / Insufficient Data	1,150 (55%)	390 (50%)	386 (61%)	374 (55%)
Survey Response	951 (45%)	396 (50%)	244 (29%)	311 (45%)
Non-eligible case	638	304	170	164
Eligible case	313	92	74	147

Table 12. (Family Survey) Non-Eligible Cases by Reason Provided by Caseworker

Reason provided by caseworker	All Sites N = 638	Allegheny n = 304	Illinois n = 170	Massachusetts n = 164
No Reason Given	46 (7%)	6 (2%)	13 (8%)	27 (16%)
Case Closed w/ No Family Contact	124 (19%)	67 (22%)	29 (17%)	28 (17%)
Case Transferred	29 (5%)	13 (4%)	14 (8%)	2 (1%)
Incorrect Case	26 (4%)	15 (5%)	7 (4%)	4 (2%)
No DV Identified within 12 mo prior to Time 1 Data Collection	405 (63%)	199 (65%)	105 (62%)	101 (62%)
Survivor Not Identified	8 (1%)	4 (1%)	2 (1%)	2 (1%)

Notes. When caseworkers were confirming domestic violence was present in the case now or within the past 12 months, they were provided with the following definition of domestic violence: "Domestic violence (DV) is violence or control between two adults in a current or former relationship (e.g., spouses, dating partners, or people who have a child together). Acts of DV include physical, sexual, emotional, economic, and psychological abuse and coercive control. Coercive control refers to strategies used to gain or maintain power and dominance over a partner."

Response rate for eligible cases across sites over the two time points was low with caseworkers only identifying and completing surveys for 313 eligible cases. Table 13 provides a breakdown of completed surveys by time point for cross-sites and by specific project sites and intervention exposure.

Please note that there were 12 cases where caseworkers completed Time 1 and initiated the survey during Time 2; however, the caseworkers indicated that they had not had any contact with the family since the T1 survey date. These cases were flagged as "T1 Only."

Table 13. (Family Survey) Survey Completion by Project Site, Intervention Group, and Data Collection Time

Variable	Intervention n (%)	Comparison n (%)
Cross-site	**174**	**139**
T1 Only	103 (59%)	90 (64%)
T2 Only	29 (17%)	16 (12%)
Both T1 & T2	42 (24%)	33 (24%)
Allegheny County	**53**	**39**
T1 Only	35 (66%)	19 (49%)
T2 Only	9 (17%)	7 (18%)
Both T1 & T2	9 (17%)	13 (33%)
Illinois	**40**	**34**
T1 Only	20 (50%)	26 (76%)
T2 Only	3 (8%)	6 (18%)
Both T1 & T2	17 (43%)	2 (6%)
Massachusetts	**81**	**66**
T1 Only	48 (59%)	45 (68%)
T2 Only	17 (21%)	3 (5%)
Both T1 & T2	16 (20%)	18 (27%)

Notes. Eligible *N* = 313. No significant cross-site differences were observed between intervention and comparison sites related to response rates by data collection time point.

All eligible cases were required to have identified the child and adult survivor to participate in the survey at Time 1. Cross-projects, caseworkers reported that over 90% of these eligible cases identified the person who uses violence (at some point in the case process) with no significant difference observed between intervention and comparison groups. Refer to Table 14 for details.

Table 14. (Family Survey) Proportion of Cases Identifying Child, Adult Survivor, and Person who Uses Violence (PUV)

Variable	Intervention n (%)	Comparison n (%)
Cross-project	174	139
Child Identification	174 (100%)	139 (100%)
Adult Survivor Identification	174 (100%)	139 (100%)
PUV Identification	160 (92%)	129 (93%)
Allegheny County	53	39
Child Identification	53 (100%)	39 (100%)
Adult Survivor Identification	53 (100%)	39 (100%)
PUV Identification	49 (93%)	36 (92%)
Illinois	40	34
Child Identification	40 (100%)	34 (100%)
Adult Survivor Identification	40 (100%)	34 (100%)
PUV Identification	37 (93%)	27 (79%)
Massachusetts	81	66
Child Identification	81 (100%)	66 (100%)
Adult Survivor Identification	81 (100%)	66 (100%)
PUV Identification	74 (91%)	66 (100%)

Table 15. (Family Survey) Demographics for Focal Child & Adult Survivor

Variable	Intervention M (SD) or n (%)	Comparison M (SD) or n (%)	Test Statistic F or X^2	df	p
Focal Child Characteristics					
Child Age at Time 1			1.506	1	0.220
Younger than 4 years old	56 (32%)	54 (39%)			
4 to 10 years old	118 (68%)	85 (61%)			
Child Gender			0.399	1	0.528
Male	85 (55%)	67 (51%)			
Female	71 (45%)	65 (49%)			
Missing	18	7			
Child Ethnicity			4.018	1	0.045*
Non-Latino/a Origin	59 (57%)	58 (72%)			

Variable	Intervention M (SD) or n (%)	Comparison M (SD) or n (%)	Test Statistic F or X^2	df	p
Latino/a Origin	44 (43%)	23 (28%)			
Missing	71	58			
Child Race			2.155	2	0.340
Black or African American	39 (30%)	41 (38%)			
White or Caucasian	78 (59%)	54 (51%)			
Other or Multiracial	15 (11%)	12 (11%)			
Missing	42	32			
Adult Survivor Characteristics					
AS Age at Time 1	31.60 (6.78)	30.89 (6.10)	-0.937	295	0.349
AS Gender			8.767	1	0.003*
Male	19 (11%)	3 (2%)			
Female	148 (89%)	127 (98%)			
Missing	7	9			
AS Ethnicity			3.003	1	0.083
Non- Latino/a Origin	59 (62%)	51 (75)%			
Latino/a Origin	36 (38%)	17 (25%)			
Missing	79	71			
AS Race			6.723	1	0.035*
Black or African American	30 (26%)	27 (31%)			
White or Caucasian	82 (70%)	48 (56%)			
Other or Multiracial	5 (4%)	11 (13%)			
Missing	57	53			
AS Language Spoke at Home			0.479	1	0.489
English	131 (89%)	108 (86%)			
Language Other than English	17 (11%)	18 (14%)			
Don't Know / Missing	26	13			
AS relationship to Focal Child			0.732	1	0.392
Biological parent	140 (94%)	115 (91%)			
Other relationship	9 (6%)	11 (9%)			
Don't Know / Missing	25	13			

Notes. *N* = 313; intervention *n* = 174, comparison *n* = 139. Only complete cases are used to compute proportions and inferential statistics for each variable; count is provided for missing information due to item non-response or missing administrative data. The *p*-value reports the probability of observing a false positive (null hypothesis) to be true; statistically significant p-values are denoted by an asterisk (*).

Table 16. (Family Survey) Demographics & Characteristics for Person who uses Violence

Variable	Intervention M (SD) or n (%)	Comparison M (SD) or n (%)	Test Statistic F or X^2	df	p
PUV Age at Time 1	33.64 (8.52)	33.26 (7.56)	0.364	234	0.716
PUV Gender			2.046	1	0.153
Male	127 (84%)	11 (89%)			
Female	25 (16%)	13 (11%)			
Don't Know / Missing	22	15			
PUV Ethnicity			3.555	1	0.059
Non-Latino/a Origin	83 (65%)	82 (77%)			
Latino/a Origin	44 (35%)	25 (23%)			
Don't Know / Missing	47	32			
PUV Race			1.353	3	0.717
Black or African American	40 (33%)	39 (37%)			
White or Caucasian	59 (49%)	50 (48%)			
Asian/Pacific Islander	3 (3%)	4 (4%)			
Other or Multiracial	19 (16%)	12 (11%)			
Don't Know / Missing	53	34			
PUV Relationship to Child			0.430	1	0.512
Biological parent	103 (71%)	89 (74%)			
Other relationship	43 (29%)	31 (26%)			
Don't Know / Missing	28	19			
AS ever filed DVPO against PUV?			2.201	1	0.138
No	86 (65%)	62 (55%)			
Yes	47 (35%)	50 (45%)			
Don't Know / Missing	41	27			
PUV ever arrested for assaulting AS or Child?			5.007	1	0.025*
No	44 (33%)	23 (20%)			
Yes	90 (67%)	91 (80%)			
Don't Know / Missing	40	25			

Variable	Intervention M (SD) or n (%)	Comparison M (SD) or n (%)	Test Statistic F or X^2	df	p
PUV ever been incarcerated for any reason?			2.557	1	0.110
No	55 (45%)	36 (35%)			
Yes	67 (55%)	68 (65%)			
Don't Know / Missing	52	35			

Notes. *N* = 313; intervention *n* = 174, comparison *n* = 139. Only complete cases are used to compute proportions and inferential statistics for each variable; count is provided for missing information due to item non-response. The *p*-value reports the probability of observing a false positive (null hypothesis) to be true; statistically significant p-values are denoted by an asterisk (*).

In the Family Survey, for cases where both T1 and T2 surveys were completed (paired complete case analysis), we reported inferential statistics at Time 1 to establish baseline equivalency for case characteristics across intervention and comparison groups (See Table 17).

Table 17. (Family Survey - Caseworker Report) Case Characteristics for Cases with Both T1 and T2 reported

Variable	Intervention		Comparison		Test Statistic F or X^2	df	p
	Time 1 n (%)	Time 2 n (%)	Time 1 n (%)	Time 2 n (%)			
DV reason for case referral?					0.473	2	0.789
Yes, primary concern	22 (52%)	N/A	15 (46%)	N/A			
Yes, DV is one of many	10 (24%)	N/A	10 (30%)	N/A			
No, DV identified later	10 (24%)	N/A	8 (24%)	N/A			
CW involvement					4.626	3	0.201
Referral, investigation, or assessment	18 (43%)	5 (12%)	16 (49%)	6 (18%)			
In-home non-voluntary/ court involved	16 (38%)	10 (24%)	7 (21%)	6 (18%)			
Out of home placement	8 (19%)	7 (18%)	8 (24%)	7 (21%)			
Other	0 (0%)	3 (7%)	2 (6%)	3 (9%)			
Case Closed	N/A	17 (41%)	N/A	11(33%)			
Out-of-Home Placement					0.291	1	0.590
Relative/Kinship Care	6 (75%)	4 (67%)	5 (63%)	5 (71%)			
Home-based Foster Care	2 (25%)	2 (33%)	3 (37%)	1 (14%)			
Other	0 (0%)	0 (0%)	0 (0%)	1 (14%)			

Variable	Intervention		Comparison		Test Statistic F or X^2	df	p
	Time 1 n (%)	Time 2 n (%)	Time 1 n (%)	Time 2 n (%)			
Placed with Sibling					1.133	1	0.567
No	4 (67%)	3 (75%)	2 (33%)	2 (33%)			
Yes	2 (33%)	1 (25%)	4 (67%)	4 (67%)			

Notes. *N* = 75; intervention *n* = 42, comparison *n* = 33. Only complete cases are used to compute proportions and inferential statistics for each variable. To assess for baseline equivalency between intervention and comparisons sites, inferential statistics (chi-square tests for independence) are specific to Time 1 comparisons. At Time 2, significant changes were observed in case characteristics from Time 1 as would be expected; however, significant differences between intervention and comparison sites were not observed.

Data Collection Procedures

Over a period of two years, each caseworker-participant was asked to complete two, 20-minute web-based surveys for 10 cases, for a total of 20 surveys for each subject. Time 1 survey administration began in December 2019. Subjects were sent surveys in waves; for example, caseworker-participants could be sent 2 surveys a month for 5 months. The number of surveys sent per wave and the numbers of waves will depend on the accrual rates of new cases identified with domestic violence at each site. Although the research design was to administer Time 2 six months after completion of the Time 1 survey, due to Covid-19 disruptions, Time 2 surveys administration was delayed. Family Survey data collection period ended in July 2021. Surveys were administered using Qualtrics, which is a web-based, HIPPA-compliant survey platform. Subjects were sent email notifications and reminders about their surveys to their employment-based email addresses, which will be provided to KU by the participating child welfare agencies. Subjects gained access to the surveys via a unique link in the emails, which also included links to frequently asked questions, help page, and the evaluation email help line.

One project site, Allegheny County, utilized a benevolent incentive approach for the Family Survey, which was approved by the KU IRB. For every completed Family Survey, $50 was placed in a family-resource account that caseworkers could access to support families.

Measures

The Family Survey included measures in three outcome areas: (1) adult survivor outcomes, (2) child survivor outcomes, and (3) child welfare practice. Along with these outcome measures and for the purposes of documentation of the case information, the following were included in the Family Survey.

Documentation of Family Case:

- Focal child identification (i.e., one child identified to reduce participant burden and to focus on a child based on the selection criteria described in sample above),
- Confirmation of dv in case,
- Case history,
- Adult survivor background information (4 items, e.g., relationship between adult survivor and focal child, language spoken at home),
- Background information on person using violence (6 items, all demographic information),
- Relationship between adult survivor and person using violence,
- Legal system involvement
  - Orders of protection (8 items, e.g., “was seeking the order required for their case plan compliance?” – yes/no/don’t know,

"has the person using violence violated the order?")

- Arrest (1 item)
- Incarceration (2 items, e.g., "were charges that led to the most recent incarceration related to any of the following?"), and

- Living situation and family composition.

Adult Survivor Outcomes

Well-being

- Empowerment related to safety (Adapted from Goodman et al. MOVERS see Adult Survivor Field Survey "Measures" section for fuller description, 16 items, Strongly Disagree to Strongly Agree)

Child Survivor Outcomes

Child Permanency

- Child Educational and School Stability (6 items, e.g., school attendance, absences, changing schools)

- Child Social Connections ([only if focal child is four years old or older] 1 item, number of connections)

Child Well-being

- Child emotional and social development and physical health (4 items, learning abilities, emotional development, physical health, social development; slider scale, none to significant delays/problems)

- Focal Child Social Emotional Development ([only if focal child is four years old or older] 10 items, e.g., "recognizes and manages their own emotions")

Child Welfare Practice

- Practice Behaviors with Adult Survivor, Child, Family (Case worker self-report, 39 items "In the last 6 months, how often have you done the following in this specific case," Always to Never)

- Practice Behaviors & Accountability with PUV (Case worker self-report, 18 items "In the last 6 months, how often have you done the following in this specific case," Always to Never)

Analytic Approaches

To address the high proportion of missingness at both baseline and follow-up, we followed recommendations from the Title IV-E Prevention Services Clearinghouse (Kerns, Wilson, Brown, Weiss, & Gubits, 2021). To provide full transparency for readers, we report results associated with complete cases for baseline, compete cases for follow-up, complete cases for T1 to T2, and the full sample using multiple imputation to address missingness. We ran analyses that assessed baseline equivalency between intervention and comparison samples. To assess for change over time, we used multiple imputation for chained equations (MICE) procedures followed by conducting ANCOVAs that assessed for differences between intervention and comparison samples at Time 2, controlling for project location and Time 1 baseline measure.

Covid-19

As mentioned above, the disruptions caused by Covid-19 on the child welfare partner agencies, the PI worked with Project managers, along with the QIC-DVCW Project Director, to delay or stop administering Family Surveys to caseworkers during March 2020-June 2020 in the AC and MA Projects. Each project site determined when the Family Surveys could re-start based on their communication with front-line caseworkers who would receive the Family Surveys.

In addition, during the second data collection period (during Covid-19), survey items were added to account for the Covid-19 impact on caseworker practice. Results from these Covid-19 impact questions are included in the results.

Adult Survivor Field Survey

Developed by QIC-DVCW partners, including the Evaluation team, the Adult Survivor Field Survey (ASFS) was designed to use the perspective of adult survivors in the QIC-DVCW intervention and comparison offices for testing whether there were differences between the intervention and comparison groups in (1) Child welfare practice service delivery outcomes; (2) Community partner practice service delivery outcomes; and (3) Adult survivor outcomes. Several aspects of the Adult Survivor Field Survey are important to note. First, the development of the survey, which will be explained in detail in the Measures section below, was a robust collaborative process completed over multiple years of work. The measurement approach ultimately moved away almost completely from standardized scales to project-generated items that were clustered around project specific constructs (e.g., increased stability, experience of harm). Second, in 2017, at the onset of planning for the administration of the ASFS, Futures Without Violence, as requested by the Evaluation Team, signed a contract with the University of Wisconsin Survey Center (UWSC) to provide the technical and logistical expertise to execute the ASFS and utilize their Computer Assisted Personalized Interview (CAPI) system, with the aim of conducting 400 interviews. UWSC and the Evaluation Team worked in partnership to construct the instrument for administration and prepare and launch it. The QIC-DVCW also provided training to the UWSC staff who would be supporting the interviews; this included supervisors and the interviewers themselves. More details are provided below.

Research Questions

- 1.B.1.1. Were there significant differences between the intervention and comparison sample in CW practice planning, decision-making, & practice addressing Protective Factors for Survivors framework?
- 1.B.1.2. Were there significant differences between the intervention and comparison sample in CW practice planning, decision-making, & practice addressing the Relational and Systemic Accountability framework?
- 1.B.1.3 Were there significant differences between the intervention and comparison sample in DV-informed, individualized, and dynamic CW practice?
- 1.B.1.4. Were there significant differences between the intervention and comparison sample in CW practice actively working toward racial, ethnic, and gender equity in their practice as well as in families' access to resources and services?
- 1.B.1.5. Were there significant differences between the intervention and comparison sample in measures of CW-Partner communication and collaboration in case activities?
- 1.B.2.1. Were there significant differences between the intervention and comparison sample in community partner planning, decision-making, & practice addressing Protective Factors for Survivors framework?
- 1.B.2.2. Were there significant differences between the intervention and comparison sample in community partner planning, decision-making, & practice addressing the Relational and Systemic Accountability framework?
- 1.B.2.3. Were there significant differences between the intervention and comparison sample in DV-informed, individualized, and dynamic community partner practice?
- 1.B.2.4 Were there significant differences between the intervention and comparison sample in how CW practitioners actively worked toward racial, ethnic, and gender equity in their practice, as well as in families' access to resources and services?
- 2.A.1. Were there significant differences between the intervention and comparison sample in measures of child survivor safety?
  - 2.A.1.2. Decreased exposure to DV

- 2.A.2. Were there significant differences between the intervention and comparison sample in child survivor permanency?
  - 2.A.2.3. Increased Stability
- 2.A.3. Were there significant differences between the intervention and comparison sample in child survivor well-being?
  - 2.A.3.1: Improved Emotional, Social, & Physical Health
- 2.B.1. Were there significant differences between the intervention and comparison sample in adult survivor safety and stability?
  - 2.B.1.2: Decreased Abuse of AS, including use of children & systems
  - 2.B.1.3: Increased Stability
  - 2.B.1.4: Increase in empowerment related to safety
- 2.B.2. Were there significant differences between the intervention and comparison sample in adult survivor well-being?
  - 2.B.2.1: Increased social, cultural, & spiritual connections
  - 2.B.2.2: Increased resilience & growth mindset
  - 2.B.2.4: Increased social & emotional abilities
  - 2.B.2.5: Decrease trauma symptoms and depression
- 2.C.2. Were there significant differences between the intervention and comparison sample in positive beliefs, attitudinal, & behavior change among persons using violence?
  - 2.C.2.3: Increase nurturing parent and child interactions

Samples and Recruitment

The Adult Survivor Field Survey sampling frame (i.e., population targeted for the sample) was the three geographic locations of the larger QIC-DVCW study in Illinois, Massachusetts, and Pennsylvania. The participant inclusion criteria were the following: experience of being harmed by DV, child welfare involved December 2019 and after, at least one child that is or under 10 years old. Survey participants were informed about the study in one of two ways.

- Child welfare caseworkers with individuals who meet the inclusion criteria on their caseload; or
- Domestic violence advocates informed individuals, who meet the inclusion criteria that they are working with.

In both paths, the professionals reviewed the study-prepared "Caseworker Script" or "Advocate Script" to present an overview of the study.

Individuals who expressed interest in participating completed a Release of Information (ROI) document stating that contact information could be shared with the Evaluation team who would then share with the UWSC (See Appendix Adult Survivor Field Survey for more information about ROI process, including examples). The UWSC interviewer team included a culturally fluent and Spanish speaking member, so recruitment efforts could be conducted in English and Spanish. Sample members were first contacted by phone. If interviewers were unable to schedule an interview appointment by phone, they also attempted to reach sample members by text message or email. In-person doorstep visits, if an address was provided on the ROI form, were approved on September 8, 2021. The interviewer did not contact the sample member more frequently than every other day. The average number of contact attempts per case was 12.3 attempts.

One hundred and fifteen individuals completed an ROI. Of those 115 individuals, 96 completed surveys (70 in intervention sites, 26 in comparison sites). It was not by design to have a disproportionate intervention sample. The ROI process meant a narrowed pathway to recruit participants, and with low numbers of respondents all were included. Table 18 shows overall sample disposition and response rate. See Table 19 and Table 20 for more information about the Adult Survivor Field Survey

sample. Table 21 provides the person using violence sample and Table 22 provides the focal child sample, as provided by the Adult Survivor Field Survey participants.

Table 18. (ASFS) Overall Sample Disposition and Response Rate

Final Disposition	All Sample
Completed Interview	96
Eligible, non-interview	16
Unknown eligibility, non-interview	0
Not Eligible	3
Totals	115
Final response rate (RR1)	85.7%

Notes. Eligible, non-interview types include: Known respondent refusals (1); refusals; partial, break-off (1); non-contact (4); and respondent away/unavailable (9).

Table 19. Distribution of Eligible & Complete Adult Survivor Field Surveys by Sites

Variable	N	Intervention n (%)	Comparison n (%)	X^2	df	*p*
Cross-sites	96	70 (100%)	26 (100%)	7.529	2	0.023*
Allegheny County	54	40 (57%)	14 (54%)			
Illinois	25	14 (20%)	11 (42%)			
Massachusetts	17	16 (23%)	1 (4%)			

Notes. A total of 100 surveys were initiated; however, 4 surveys were not included in the final analysis for the following reasons: ineligible (*n* = 3) and partial completion (*n* = 1). The *p*-value reports the probability of observing a false positive (null hypothesis) to be true; statistically significant p-values are denoted by an asterisk (*).

Table 20. (ASFS) Adult Survivor Demographics by Intervention & Comparison Groups

Variable	N	Intervention M(SD) or n(%)	Comparison M(SD) or n(%)	X^2 / Mann-Whitney U	df	*p*
Age (in years)	96	31.5 (7.3)	31.9 (7.7)	874.000		0.766
Gender				0.759	1	1.000
Male	2	2 (3%)	0 (0%)			
Female	94	68 (97%)	26 (100%)			
Latino/a				0.928	1	0.503
Yes	13	11 (16%)	2 (8%)			
No	82	59 (84%)	23 (86%)			
Missing	1	0 (0%)	1(4%)			
Race/Ethnicity				9.009	4	0.061

Variable	N	Intervention M(SD) or n(%)	Comparison M(SD) or n(%)	X^2 / Mann-Whitney U	df	*p*
Black or African American	19	10 (14%)	9 (35%)			
White or Caucasian	49	35 (50%)	14 (54%)			
Latino/a	13	11 (16%)	2 (8%)			
Other Race	4	3 (4%)	1 (4%)			
2+ Races Identified	11	11 (16%)	0(0%)			
Missing	0	0 (0%)	0 (0%)			
Language Spoken at Home				0.759	1	1.000
English	94	68 (97%)	26 (100%)			
Spanish	2	2 (3%)	0 (0%)			

Notes. *N* = 96: Intervention n=70, Comparison n=26. For gender, no respondents self-identified as transgender or non-binary. Fisher's Exact Test was used to correct for expected cell count less than 5; missing values were not included in the calculation of inferential statistics. To assess age difference between groups, we used the Mann-Whitney. The *p*-value reports the probability of observing a false positive (null hypothesis) to be true; statistically significant p-values are denoted by an asterisk (*).

Table 21. (ASFS) Person who Uses Violence Demographics by Intervention & Comparison Groups

Variable	N	Intervention M(SD) or n(%)	Comparison M(SD) or n(%)	X^2 / Mann-Whitney U	df	*p*
Age (in years)	89	34.7 (8.9)	33.4 (8.0)	786.500	1	0.637
Gender				0.733	1	1.000
Male	89	65 (93%)	24 (92%)			
Female	2	2 (3%)	0 (0%)			
Missing	5	3 (4%)	2 (8%)			
Latino/a				2.784	1	0.137
Yes	18	16 (23%)	2 (8%)			
No	72	50 (71%)	22 (85%)			
Missing	6	4 (6%)	2 (8%)			
Race/Ethnicity				6.582	4	0.160
Black or African American	28	17 (24%)	11 (42%)			
White or Caucasian	39	29 (41%)	10 (39%)			
Latino/a	18	16 (23%)	2 (8%)			
Other Race	2	1 (1%)	1 (4%)			
2+ Races Identified	4	4 (6%)	0 (0%)			
Missing	5	3 (4%)	2 (8%)			

Notes. *N* = 96: Intervention n=70, Comparison n=26. For gender, no respondents identified the PUV as transgender or non-binary. Fisher's Exact Test was used to correct for expected cell count less than 5; missing values were not included in the calculation of inferential statistics. To assess age difference between groups, we used the Mann-Whitney. The *p*-value reports the probability of observing a false positive (null hypothesis) to be true; statistically significant p-values are denoted by an asterisk (*).

Table 22. (ASFS) Focal Child Demographics by Intervention & Comparison Groups

Variable	N	Intervention M(SD) or n(%)	Comparison M(SD) or n(%)	X^2 / Mann-Whitney U	df	*p*
Child age (in years)	94	4.69 (3.5)	5.00 (4.1)	823.500		0.886
Gender				3.060	2	0.216
Male	51	39 (56%)	12 (48%)			
Female	43	31 (44%)	12 (48%)			
Missing	1	0 (0%)	1 (4%)			
Adopted or in Foster Care				.659	1	0.508
Yes	12	10 (14%)	2 (8%)			
No	83	60 (86%)	23 (92%)			
Missing	1	0 (0%)	0 (0%)			
Latino/a				3.645	1	0.086
Yes	21	19 (27%)	2 (8%)			
No	73	51 (73%)	22 (85%)			
Missing	2	0 (0%)	2 (8%)			
Race/Ethnicity				7.407	4	0.116
Black or African American	15	8 (11%)	7 (27%)			
White or Caucasian	31	22 (31%)	9 (35%)			
Latino/a	21	19 (27%)	2 (8%)			
Other Race	2	1 (1%)	1 (4%)			
2+ Races Identified	24	19 (27%)	5 (19%)			
Missing	3	1 (1%)	2 (8%)			

Notes. For gender, no respondents identified the focal child as transgender or non-binary. Fisher's Exact Test was used to correct for expected cell count less than 5; missing values were not included in the calculation of inferential statistics. To assess age difference between groups, we used the Mann-Whitney. The *p*-value reports the probability of observing a false positive (null hypothesis) to be true; statistically significant p-values are denoted by an asterisk (*).

Data Collection Procedures

Data collection began on November 6, 2020 and ended on January 31, 2022. The field survey was available in English and Spanish. The interviews were conducted using three modes: (1) Computer-Assisted Telephone Interview ([CATI], remote/telephone); (2) Zoom video interview (CATI, remote/Zoom); and (3) Computer-Assisted Personal Interview ([CAPI], in person. The software employed by the UWSC is CASES 5.6 provided by the Computer-Assisted Survey Methods Program at the University of California-Berkeley. The CASES program provides a comprehensive range of computer assisted interviewing tools. As a fully-featured CATI package, CASES has all the technologic programs necessary to install a sample (including importing pre-existing data into the sample records), prepare a data collection instrument, monitor survey progress, automatically send to the field those cases that require calling as a specific time or date (i.e., automatic call scheduling), code and clean data, produce reports, and output data into rectangular files for analysis. In the CASES program, the text of the survey appears question by question on a computer screen for the interviewer to read to the respondent. Routing through the interview is based on skip logic pre-programmed into the computer. Question wording may be adapted according to answers given previously in the interview. The system allows for pre-coded questions, open-ended questions, and combinations of the two. In addition, the computer allows only valid responses to be entered; when an invalid response is entered, the computer asks the interviewer to re-enter the response.

The average length of the interview was 51 minutes. (Note: This average was calculated from timers in the survey. It is the amount of time interviewers spent in the interview survey itself, but not total time spent with the Respondent from start to finish. This average includes situations where the interviewer was in the survey during the consent process. Also, this average includes situations where the interviewer might have encountered a technical problem while in the survey. As a result, this average could be slightly inflated.)

Measures

In order for the QIC-DVCW evaluation to center lived expertise of adult survivors, and their knowledge and experience of being parents involved with the child welfare system, the Adult Survivor Field Survey included measures in three areas: (1) adult survivor outcomes, (2) child welfare practice, and (3) community partner practice. Along with these outcome measures, demographic characteristics on the adult survivor, one focal child, and one identified person that uses violence were collected.

Adult Survivor Outcomes

Safety and Stability

DV/Harm was measured with QIC-DVCW generated times focused on experiences of harm across several domains listed below. Harm was defined to participants as “emotional, physical or sexual harm toward you” in current or past relationships with partners. The range of experience of harm was accessed by yes/no responses to the following: any form, past two years, and ever. Types of harm in the past six months (yes/no/not in the past six months, but has happened) measured included:

- *Economic or financial harm* (e.g., “anything that hurts you financially, like not giving you money that they should or not paying bills that you share, stealing money from you, running up bills in your name, ruining your credit, or anything else that has hurt you financially”),
- *Emotional or psychological harm* (e.g., “things like humiliating you; calling you names; trying to make you feel crazy or bad about yourself; trying to turn your children, family, or friends against you; or anything else that feels emotionally harmful to you”),
- *Being stalked* (e.g., “includes behaviors like spying on you, following you, calling or texting you repeatedly, constantly showing up uninvited at your workplace or friend’s houses, or other things like this”),
- *Threats of violence, physical harm* (e.g., “includes slapping, punching, kicking,

choking, pinching, or anything else that feels physically harmful to you") with a specific follow up question to assess injury (e.g., "cause any injury to your body such as bruises, marks, sprains, broken bones, or internal injuries") and if that injury resulted in medical attention (e.g., "any medical attention for physical injuries caused by the harm"),

- *Sexual violence* (e.g., "includes things that made you feel violated like unwanted touch, hurting you in your private parts, controlling your birth control choices, sharing pictures of you with others without your consent, having sex with you without your consent or anything else like this").

Coercive Control was measured with QIC-DVCW generated times focused on use of control by the person using violence across several domains listed below. All were rated on a scale from *1=every day or almost every day to 7=never.*

- *Use of Systems* assessed the participants' identified person who used violence making contact or threatening to make contact in the last six months, with one item for each of the following (1) police, immigration, protection orders, or courts; (2) child welfare. Use of systems included two items to measure use of order of protection as a coercion strategy ("ever attempted" and "ever successful") with a yes/no response options.
- *Use of Children* one item assessed use of children as a form of coercion ("used your [child/children] to get what [fill he/she/they] want").
- *Mental health and substance abuse coercion* assessed the participants identified person who used violence with one item for each of the following (1) "made you use any kind of drugs, including prescription medication, or alcohol" (2) "interfered with your attempts to get clean or sober," and (3) "kept you from taking care of yourself."
- *Use of Religious or Family Norms* one item assessed use of religious or family norms as a form of coercion ("used your religious beliefs or family loyalty to get you to do what [fill he/she/they] want").

Stability (Employment and Housing) was measured with QIC-DVCW generated items focused on employment, economic hardship, and housing. This included, number of jobs, length of employment, impact of Covid-19 on employment (yes/no). Economic hardship included items such as "how often has your household been able to meet all of your essential expenses?" rated on a scale from 1= *all of the time* to 5=*none of the time.* Housing measurement included number of moves, current living situation, and length of time in current living situation.

Empowerment Related to Safety included 13-items minorly adapted with permission from the Measure of Victim Empowerment Related to Safety (MOVERS) scale (Goodman et al., 2014), rated on a scale from *1 = definitely true to 7 = definitely false.*

Well-being

Social, Cultural, & Spiritual Connections were measured by three items (someone in life who helps with material needs, advice/encouragement, and supports parenting), rated on a scale from *1 = definitely true to 7 = definitely false.*

Resilience & Growth Mindset was measured by one item (confidence in achieving positive goals for self and child/ren), rated on a scale from *1 = definitely true to 7 = definitely false.*

Nurturing Parent-Child Relationship was measured by one item (frequency of ability to comfort your child) rated on a scale from *1 = never able to comfort child to 5 = always able to comfort child.*

Social and Emotional Abilities were measured by one item rated on a scale from *1 = definitely true to 7 = definitely false.*

Trauma symptoms included six items adapted from the PTSD Checklist scale (Wilkins, Lang, & Norman, 2011), which has been well tested and

demonstrated strong psychometric properties. For example, one item reads "In the past month, how much have you had repeated, disturbing memories, thoughts, or images of any type of stressful experience from the past?" Participants rated their experience on a scale from *1 = not at all to 5 = extremely.*

Depression was measured with one item. How often in the past two weeks have you felt down, depressed, hopeless, or like you had little energy? Participants rated their experience on a scale from *1 = all of the time to 5 = none of the time.* This was reverse coded.

Child Welfare Practice (Service Delivery Outcomes)

Caseworker

- *Overall Helpfulness* included 12 items. Eight items measured degree of helpfulness, rated on a scale from 1 = not at all to 5 = extremely. Four items measured frequency of helpfulness behaviors, rated on a scale from *1 = never to 5 = extremely often*, and included "I have not worked on a safety plan with my caseworker."
- *Actively Pursue Equity* included a total of four items: two items (respectful, understanding), participants rated their experience on a scale from 1 = not at all to 5 = extremely, and two items on assessment of safety, participants (yes/no) identified if they were asked by caseworker if they felt safe and then, frequency of action taken by caseworker for adult survivor and child/ren to be safer (*1 = none of the time to 5 = all of the time*).
- *Encourage Adoption of Healthier Behaviors with PUV* included one item assessing PUV being held accountable in case plan goals, rated on a scale from *1 = not at all to 5 = extremely.*

Community Partner Practice (Service Delivery Outcomes)

Advocate

- *Identification of DV advocate experiences* included one item to identify if experience (yes/no/don't know), and one item to identify name of agency or organization advocate worked for if known.
- *Overall Helpfulness* included 12 items. Eight items measured degree of helpfulness, rated on a scale from *1 = not at all to 5 = extremely*. Four items measured frequency of helpfulness behaviors, rated on a scale from *1 = never to 5 = extremely often*, and included "I have not worked on a safety plan with my advocate."
- *Actively Pursue Equity* included a total of four items: two items (respectful, understanding), where participants rated their experience on a scale from *1 = not at all to 5 = extremely*, and two items on assessment of safety, participants (yes/no) identified if they were asked by advocate if they felt safe and then, frequency of action taken by advocate for adult survivor and child/ren to be safer (*1 = none of the time to 5 = all of the time*).

Analytic Approaches

Analyses of the Adult Survivor Field Survey data began with comparing distributions between intervention and comparison groups related to family member demographics, consequent practice behaviors, and key outcomes as listed above. Next, chi-square tests for independence were used to compare intervention and comparison samples for categorical variables. Additionally, Fisher's exact test was applied when the expected cell size was less than 5 for all contingency tables. For comparison of quantitative scores across intervention and comparison groups, median scores and minimum and maximum values were reported; nonparametric tests, such as the Mann-Whitney U test, were used due to the small sample size and non-normal distribution of most measures.

Covid-19

Out of all the QIC-DVCW evaluation work, the impact of Covid-19 on the Adult Survivor Field Survey was the greatest. First, by design, the

Adult Survivor Field Survey was to be conducted in person, using the UWSC CAPI system. In March 2020, when Covid-19 restrictions on in person research were put in place, survey development and administration planning shifted to conducting the survey remotely (e.g., video or phone call). While this remote approach may have been experienced as normative at the time when across so many parts of life (e.g., businesses, schools) were transitioning to technical solutions to meetings, hearings, and other in person settings. UWSC interviewers who had experience conducting both in person and remote interviews were selected with the need for flexibility, as restrictions were hoped to decrease over time. By early 2021, the PI applied for and received permission from KU's IRB to have the option for in person field surveys.

Adult Survivor Interviews

The Adult Survivor Interviews aimed to gain an in-depth understanding of adult survivors' experiences with the child welfare system, and particularly their caseworkers in the intervention and comparison sites. Adult Survivors Interviews were designed as a sequential transformative design (Creswell, 2009). Based on the centering of adult survivor's lived experience, the Adult Survivor Field Survey, launched first, collected quantitative data on multiple outcomes (See Adult Survivor Field Survey methods), and Adult Survivor Interviews collected follow up qualitative interview data focused on one particular part of the adult survivors' experience (See Samples and Recruitment below for more detail).

Research Questions

The Adult Survivor Interviews provides descriptive information, however since the sampling frame drew from the Adult Survivor Field Survey, which was skewed toward adult survivors in the intervention offices, the sample (N=31, intervention n=27 and comparison n=4) does not support answering research questions examining the differences between the intervention and comparison groups. Therefore, the Adult Survivor Interviews data was included to contribute to reaching the evaluation goals, and particularly the QIC-DVCW and Evaluation Team principle of centering the lived experience of survivors. The Adult Survivor Interview data provides rich insight into the constructs embedded in the following research questions within the service delivery outcomes:

- 1.B.1.2.c. To what extent were adult survivors engaged by CW relative to people who use violence when comparing Intervention vs Comparison sites?
- 1.B.1.3. Were there significant differences between the intervention and comparison sample in DV-informed, individualized, and dynamic CW practice?

Samples and Recruitment

The Adult Survivor Interviews sample was a sub-sample of the Adult Survivor Field Study. In summary, the Adult Survivor Field Study inclusion criteria were the following: a parent or primary caregiver of at least one child under the age of ten who is involved in the child welfare system and who is identified as a DV survivor. Therefore, the sample for this study reflects these same inclusion criteria. However, months into data collection, in order to diversify the racial and ethnic representation of the sample, proposed subjects who identify as Black or African American, American Indian/Alaskan Native, Hispanic/Latino, API, multi-racial, and bi-racial always were included in the sampling frame to select for the interview, while white non-Latino/a proposed subjects were included in sampling frame and selected for interview using a randomized selection. The rationale for this targeted approach is because Black, Native American and some other people of color are disproportionately involved in the child welfare system, so prioritizing their perspective in this study through recruitment was critical to reach the study aims.

At the end of completing the Adult Survivor Field Survey (See above), the field survey interviewer asked participants if they were interested in participating in an interview for this qualitative

study. If the field survey participant agreed, then their contact information was shared with the lead researcher conducting this study. White, non-Latino/a field survey participants who agreed were informed that they may be contacted by a researcher. All Black or African American, American Indian/Alaskan Native, Hispanic/Latino, API, multi-racial, and bi-racial field survey participants were informed that they would be contacted by a researcher. The lead researcher and staff contacted the subject via phone, text, or email to coordinate scheduling an interview time.

Overview of Sample

We obtained a total of 31 qualitative interviews from survivors across the three project sites (27 from intervention sites, 4 from comparison sites). Table 23 shows the distribution of sample by site by intervention and comparison groups. Table 24 shows the sample demographics by intervention and comparison groups. Table 25 shows the participant's report of the person who uses violence demographics by intervention and comparison groups. Table 26 shows the participant's focal child demographics by intervention and comparison groups.

Table 23. (Adult Survivor Interviews) Distribution of Adult Survivor Interviews by Sites

Variable	N	Intervention *n* (%)	Comparison *n* (%)
Cross-sites	31	27 (87%)	4 (13%)
Allegheny County	11	10 (37%)	1 (25%)
Illinois	9	6 (22%)	3 (75%)
Massachusetts	11	11 (48%)	0 (0%)

Notes. *N* = 31.

Table 24. (Adult Survivor Interviews) Adult Survivor Interview Demographics by Intervention & Comparison Groups

Variable	Total M(SD) or n (%)	Intervention M(SD) or n (%)	Comparison M(SD) or n (%)
Age (in years)	31.3 (7.3)	31.6 (7.4)	29.0 (7.2)
Gender			
Male	0 (0%)	0 (0%)	0 (0%)
Female	31 (100%)	27 (100%)	4 (100%)
Ethnic Identification			
Latino/a	8 (26%)	7 (26%)	1 (25%)
Not Latino/a	23 (74%)	20 (74%)	3 (75%)
Missing	0 (0%)	0 (0%)	0(0%)
Race Identification			
Black	5 (16%)	4 (15%)	1 (25%)
White	18 (58%)	15 (56%)	3 (75%)

Variable	Total M(SD) or n (%)	Intervention M(SD) or n (%)	Comparison M(SD) or n (%)
Asian/Pacific Islander	1 (3%)	1 (4%)	0 (0%)
American Indian/Alaskan Native	0 (0%)	0 (0%)	0 (0%)
Other Race	5 (16%)	5 (19%)	0 (0%)
2+ Races Identified	2 (7%)	2 (16%)	0(0%)
Missing	0 (0%)	0 (0%)	0 (0%)
Language Spoken at Home			
English	31 (100%)	27 (100%)	4 (100%)
Spanish	0 (0%)	0 (0%)	0 (0%)

Notes. *N* = 31. For gender, no respondents self-identified as transgender or non-binary.

Table 25. (Adult Survivor Interviews) Person who Uses Violence Demographics by Intervention & Comparison Groups

Variable	Total M(SD) or n (%)	Intervention M(SD) or n (%)	Comparison M(SD) or n (%)
Age (in years)	34.5 (7.8)	35.0 (7.6)	31.0 (11.1)
Gender			
Male	30 (97%)	27 (100%)	3 (75%)
Female	0 (0%)	0 (0%)	0 (0%)
Missing	1 (3%)	0 (0%)	1 (25%)
Ethnic Identification			
Latino/a	9 (29%)	8 (30%)	1 (25%)
Not Latino/a	20 (65%)	18 (67%)	2 (50%)
Missing	2 (6%)	1 (4%)	1 (25%)
Race Identification			
Black	6 (19%)	6 (22%)	0 (0%)
White	17 (55%)	14 (52%)	3 (75%)
Asian/Pacific Islander	1 (3%)	1 (4%)	0 (0%)
American Indian/Alaskan Native	1 (3%)	1 (4%)	0 (0%)
Other Race	3 (10%)	3 (11%)	0 (0%)
2+ Races Identified	1 (3%)	1 (4%)	0 (0%)
Missing	2 (6%)	1 (4%)	1 (25%)

Notes: *N* = 31. For gender, no respondents identified the PUV as transgender or non-binary.

Table 26. (Adult Survivor Interviews) Focal Child Demographics by Intervention & Comparison Groups

Variable	Total M(SD) or n (%)	Intervention M(SD) or n (%)	Comparison M(SD) or n (%)
Child age (in years)	4.29 (4.0)	4.67 (4.1)	1.75 (0.5)
Gender			
Male	20 (65%)	18 (67%)	2 (50%)
Female	11 (35%)	8 (33%)	2 (50%)
Missing	0 (0%)	0 (0%)	0 (0%)
Adopted or in Foster Care			
Yes	3 (10%)	3 (11%)	0 (0%)
No	28 (90%)	24 (89%)	4 (100%)
Missing	0 (0%)	0 (0%)	0 (0%)
Ethnic Identification			
Latino/a	10 (32%)	9 (33%)	1 (25%)
Not Latino/a	21 (68%)	18 (67%)	3 (75%)
Missing	0 (0%)	0 (0%)	0 (0%)
Race Identification			
Black	3 (10%)	3 (11%)	0 (0%)
White	16 (52%)	13 (48%)	3 (75%)
Asian/Pacific Islander	0 (0%)	0(0%)	0 (0%)
American Indian/Alaskan Native	1 (3%)	1 (4%)	0 (0%)
Other Race	4 (13%)	4 (15%)	0 (0%)
2+ Races Identified	7 (23%)	6 (22%)	1 (25%)
Missing	0(0%)	0(0%)	0 (0%)

Notes: *N* = 31. For gender, no respondents self-identified as transgender or non-binary.

Data Collection Procedures

Due to Covid-19 restrictions, the Adult Survivor Interviews were conducted via video conference or phone. Verbal informed consent was obtained before the start of each interview. As part of the informed consent, subjects will be informed that their Adult Survivor Field Study data will be linked to the Adult Survivor Interview data, in this mixed-method study design. Survivors participated in a one-time 30-to-90-minute interview, with most interviews lasting 60 minutes. They were compensated with a $75 gift or Visa card for their participation. All interviews were audio-recorded.

Measures

The Adult Survivor Interviews used a semi-structured interview guide to understand what supported and got in the way of the Approach implementation. Open ended guiding questions allowed for flexibility in the narratives that participants shared. The key topics were the adult survivors' (1) first and strongest memory from experience with child welfare, (2) perception of what was most helpful to them about their child welfare experience, (3) perception of needs being met by child welfare, and (4) description of relationship with caseworker.

Analytic Approaches

After the audio recordings were transcribed, the transcripts were coded by two research team members, using a codebook developed by the two research team members that conducted all the interviews. The codebook was expanded and refined as coding of the first three transcripts were completed. Following coding, a matrix (Miles, Huberman, & Saldana, 2018) was used to examine code-based excerpts by participants. Initial thematic analysis was conducted by PI and revisions to themes were made following conversations with the Evaluation Team and Ruby White Starr.

Covid-19

Because of the timing of the interviews in the QIC-DVCW timeframe (designed after March 2020), the interviews were designed to be conducted remotely. However, Covid-19 impacted the adult survivor survey recruitment and sample, therefore Covid-19 in turn impacted the adult survivor interviews. In addition, it may be that Covid-19 related restrictions or health circumstances had impacts on the sample.

Strong Fathers Focus Groups

The Strong Fathers Focus Groups aimed to gain an in-depth understanding of fathers who had participated in the Strong Fathers program and whose children's cases were being managed by the QIC-DVCW intervention offices. As Strong Fathers was a program implemented as part of the increased focus on engaging the people who use violence, the program participants' perspectives and experiences were gathered in the focus group sessions.

Research Questions

Due to the fact that the Strong Fathers program was not implemented in comparison offices, the data from the Strong Fathers focus groups does not answer the research questions examining the differences between the intervention and comparison sample. However, given the limited self-report data from persons who use violence, the Strong Fathers Focus Group data provides lived experience answers from a sub-intervention sample in response to the following research questions:

- 1.B.1.2. Were there significant differences between the intervention and comparison sample in child welfare practice planning, decision-making, & practice addressing the relational and systemic accountability framework?
- 2.C.1. Were there significant differences between the intervention and comparison sample in person using violence blame of the adult survivor and justification for violence?
- 2.C.1.1: Increase understanding of the impact of DV on adult and child survivors
- 2.C.2.2. Increase understanding of healthy relationships
- 2.C.2.3. Increase nurturing parent child interactions
- 2.C.3. Were there significant differences between the intervention and comparison sample in increased well-being & support for people using violence?

Samples and Recruitment

Other than people who have or are currently members of programs/groups for people who use domestic violence, there were no other target demographics of proposed subjects. All populations meeting the inclusion criteria had access to study through the recruitment process. Initial contact of the subjects was made through contacting local domestic violence organizations with group-based programming for people who use violence. Subjects were sent an email from the research team, via the agency that hosts the program/group they attend/attended. Participants were asked for passive consent and completed demographic questionnaires.

All the participants identified as men (none

identified as transgender). The average age of participants was 40, ranging from 28 to 62 years of age. The average number of children of participants was 3.42, ranging from seven to one. Five of the participants resided with two children while the other two participants resided with one child each. Four were partnered/married, one was living with a partner, and two were not in a relationship at the time of the focus group. Four were employed full-time (with their time in a current job ranging from 8 months to 20 months) and three were not employed. Five had not moved in the past six months, and two had moved once. Four owned their home or apartment, and three rented their apartment. Four identified as White/Caucasian/European origin and two identified as Latino. Six participants identified as heterosexual and one preferred not to say. Table 27 shows participants rating their level of activity in seven group involvement.

Table 27. (Strong Fathers) Involvement in Types of Groups

Type of Involvement	Yes, Active n (%)	No, Not Active n (%)
A Sports Team	1 (14)	6 (86)
A Veterans Group	0 (0)	7 (100)
A Hobby Group or Club	2 (29)	5 (71)
Volunteer	3 (43)	4 (57)
Community	0 (0)	7 (100)
A Religious Community or Congregation	4 (57)	3 (43)
Other Group or Organization	4 (57)	3 (43)

Data Collection Procedures

Two focus groups with Strong Father program participants (N=7) took place in September and October 2021 via Zoom due to Covid-19 travel restrictions. One focus group was participants who were current program members (n=2), while the second group was former program members (n=5). At the start of each focus group, participants who hadn't already completed the web-based demographics questionnaire were given five minutes to complete it. The focus groups lasted approximately 90 minutes.

Measures

The focus group questions for the Strong Fathers Focus Group were developed by QIC-DVCW partners, aimed at understanding participants' (1) understanding of the impact of DV on adult and child survivors (e.g., what it means to be a good father, what hurts their children, and what hurts a relationship with an intimate partner, what feelings come up when they face that harm they have caused), and (2) experiences with and engagement of caseworkers with them as PUV within the case and other forms of support.

Analytic Approaches

After the audio recordings were transcribed, one Evaluation team member coded the two transcripts in Word documents using a priori codes based on the purpose of the focus group and the constructs embedded into the questions. Because there were only two transcripts, the initial coding process was abbreviated. Following coding, a matrix (Miles, Huberman, & Saldana, 2018) was used to examine code-based excerpts by participants within each focus group.

Covid-19

Strong Fathers Focus Groups took place via Zoom due to Covid-19 travel restrictions.

Case Record Review

The Case Record Review examined the documented practices and perspectives of child welfare case workers in respect to specific cases that have been identified for the presence of domestic violence.

Research Questions

The Case Record Review provides rich insight into the constructs embedded in the following research questions within the service delivery outcomes:

- 1.B.1.1. Were there significant differences between the intervention and comparison sample in CW practice planning, decision-making, & practice addressing Protective Factors for Survivors framework?
- 1.B.1.2.a. Were there significant differences between the intervention and comparison sample in CW practice early and ongoing identification and assessment of domestic violence?
- 1.B.1.3. Were there significant differences between the intervention and comparison sample in CW DV-informed, individualized, and dynamic practice?
- 1.B.1.5. Were there significant differences between the intervention and comparison sample in measures of CW-Partner communication and collaboration in case activities?

Samples and Recruitment

Two sites provided access to case files: Illinois allowed an in-person review of electronic and hard file case records, and Allegheny County, PA allowed a review of electronic records pulled from their online system. The Evaluation Team was unable to obtain access to case files for Massachusetts. First, we identified 30 cases per site (15 intervention and 15 comparison) using simple random sampling from a pool of completed surveys from the Family Survey, which verified the cases involved families experiencing co-occurring child maltreatment and domestic violence. Second, we obtained a final sample of 14 cases per site (7 intervention and 7 comparison) by purposively sampling from the initial sample for cases to prioritize those opened after the intervention started and to obtain a heterogenous pool of cases where DV was the reason for case opening, identified as an issue after opening, or one of many concerns identified within the case. As a result, we reviewed a total of 28 cases across two project sites.

Table 28. Case Record Review Family Demographics by Intervention & Comparison

Variable	Total *N* (%)	Intervention *n* (%)	Comparison *n* (%)
Adult Survivor Race/Ethnicity			
Any race, Latino/a	3 (10.7)	2 (14.3)	1 (7.1)
Black and not Latino/a	8 (28.6)	3 (21.4)	5 (35.7)
White and not Latino/a	17 (60.7)	9 (64.3)	8 (57.1)
PUV Race/Ethnicity			
Any race, Latino/a	4 (22.2)	3 (21.4)	1 (7.1)
Black and not Latino/a	8 (28.6)	4 (28.6)	4 (28.6)

Variable	Total N (%)	Intervention n (%)	Comparison n (%)
White and not Latino/a	15 (53.6)	7 (50.0)	8 (57.1)
Unable to Determine	1 (3.6)	0 (0.0)	1 (7.1)
Focal Child Race/Ethnicity			
Any race, Latino/a	4 (22.2)	3 (21.4)	1 (7.1)
Black and not Latino/a	8 (28.6)	3 (21.4)	5 (35.7)
White and not Latino/a	15 (53.6)	7 (50.0)	8 (57.1)
Multiracial	1 (3.6)	1 (7.1)	0 (0.0)
Primary Language (Case)			
English	26 (92.9)	12 (85.7)	14 (100.0)
Spanish	2 (7.1)	2 (14.3)	0 (0.0)
Family Structure @ Opening			
2+ Caregivers (AS + PUV)	20 (71.4)	13 (92.9)	7 (50.0)
2+ Caregivers (AS + Other)	1 (3.6)	0 (0.0)	1 (7.1)
Single Caregiver (AS)	7 (25.0)	1 (7.1)	6 (42.9)
Family Structure @ Most Recent			
2+ Caregivers (AS + PUV)	3 (10.7)	2 (14.3)	1 (7.1)
Single Caregiver (AS)	13 (46.4)	6 (42.9)	7 (50.0)
Children not in home	12 (42.9)	6 (42.9)	6 (42.9)

Notes. *N* = 28.

Table 29. Case Record Review Case Characteristics by Intervention & Comparison

Variable	Total N (%)	Intervention n (%)	Comparison n (%)
DV Primary Reason			
DV Primary	18 (64.3)	9 (64.3)	9 (64.3)
DV One of Many Reasons	9 (32.1)	4 (28.6)	5 (35.7)
DV Status Unclear	1 (3.6)	1 (7.1)	0 (0.0)
DVPO History			
Active	7 (25.0)	3 (21.4)	4 (28.6)
Inactive	4 (22.2)	3 (21.4)	1 (7.1)
No DVPO History	17 (60.7)	8 (57.1)	9 (64.3)
Child Removal during Case			
No	12 (42.9)	7 (50.0)	5 (35.7)
Yes	16 (57.1)	7 (50.0)	9 (64.3)

Variable	Total *N* (%)	Intervention *n* (%)	Comparison *n* (%)
Case outcome			
Family Intact w/ AS Only	8 (28.6)	5 (35.7)	3 (21.4)
Family Intact with AS & PUV	3 (10.7)	2 (14.3)	1 (7.1)
Removal, Reunification w/ AS	4 (22.2)	1 (7.1)	3 (21.4)
Removal, No Reunification	4 (22.2)	1 (7.1)	3 (21.4)
Removal, Placed with Kin	9 (32.1)	5 (35.7)	4 (28.6)

Notes. *N* = 28.

Data Collection Procedures

All case files were translated into electronic records and uploaded as PDFs to Dedoose for interactive coding. The research team conducted an intensive qualitative review of 1 case files per site (4 total) to create an initial codebook to assist coding a total of 14 case files per site.

To track case characteristics, the research team identified information documented within the case records and coded them as descriptors:

- Project Location
- Project Site
- Adult Survivor Race/Ethnicity
- Person Using Violence Race/Ethnicity
- Focal Child Race/Ethnicity
- Primary Language Spoken by Family
- DV Identified as a Primary Concern
- Child Removal
- DV Protective Order Status
- Family Structure at Case Opening
- Family Structure at Most Recent Case Plan
- Case Status/Outcome

The codebook was developed in consultation among a team of four researchers and then applied across administrative documents. Coders consulted with each other on a weekly basis to identify areas where the codebook needed to be further clarified to consistently apply codes across documents and contexts. The research team focused efforts on the following topics:

- Reasons for Case Opening
- DV Screener Results & Descriptions
- Documentation of Violence Type
- Description of Family Relationships
- No Contact Orders
- Case Plan Activities
- Adult Survivor Assessment of Strengths & Risks
- Adult Survivor Referrals
- Person Using Violence Identification
- Person Using Violence Engagement
- Person Using Violence Assessment of Strengths & Risks
- Person Using Violence Referrals
- Analytic Approaches

Manifest content analysis approaches were used to track the presence of categories and subcategories across cases by intervention and comparison sites. In addition, qualitative text is provided to exemplify areas that were more nuanced, such as description of family relationships.

Covid-19

There was no specific identified Covid-19 related impact.

Administrative Data

Research Questions

- 2.A.1. Were there significant differences between the intervention and comparison sample in measures of child survivor safety?
  - 2.A.1.1. Decrease maltreatment by person using violence and/or adult survivor
  - 2.A.1.2. Decreased exposure to DV
- 2.A.2. Were there significant differences between the intervention and comparison sample in child survivor permanency?
  - 2.A.2.1. Decrease Rate of Foster Care Removals
  - 2.A.2.2. Increased Reunification Rate
  - 2.A.2.3. Increased Stability

Data Sources

Three different administrative data sources were used. The Adoption and Foster Care Analysis and Reporting System (AFCARS), the National Child Abuse and Neglect Data System (NCANDS), and research specific data generated for the QIC-DVCW. Due to the specific nature of each analysis performed using the administrative data descriptions of the data sources are located under each relevant research question section.

Data Collection Procedures

Because two of the three QIC-DVCW projects, Massachusetts and Illinois, were contracted at the state department level (Massachusetts Department of Children and Families [MA DCF] and Illinois Department of Child and Family Services [IL DCFS]) all three administrative data types were delivered directly to the KU evaluation team via secure password protected data delivery pathways. To access state level data for the third project, Allegheny County, PA two strategies were used. First, the KU evaluation team applied for and received NCANDS files from National Data Archive on Child Abuse and Neglect (NDACAN). Second, the Pennsylvania Department of Human Services provided AFCARS elements as requested by the KU evaluation team. Data sharing agreements were secured with each entity.

Measures

Due to the specific nature of each analysis performed using the administrative data, descriptions of the measures are located under each relevant research question section.

Analytic Approaches

Due to the specific nature of each analysis performed using the administrative data, descriptions of the analytic approach are located under each relevant research question section.

Covid-19

There was no specific identified Covid-19 related impact.

METHODS: COST STUDY

In July 2021, the University of Kansas Center for Research, Inc. contracted with James Bell Associates to conduct a cost study to estimate the costs associated with implementing and maintaining the Approach in three Projects: Illinois (IL), Massachusetts (MA), and Allegheny County, Pennsylvania (PA), and to explore how these costs compare to the costs of practice as usual. Because the Approach required a collaborative, systems-level effort, the costs of implementing the Approach could not be isolated to a specific service or activity. Rather, the costs included the full operational costs of supporting the Approach within the child welfare service array for each locale. For comparison, operational costs of delivering child welfare services in those sites not implementing the Approach was gathered (business as usual).

Research Questions

The research question for the cost study was:

- What are the costs associated with the implementation and maintenance of an adult and child survivor-centered approach, and how do these costs compare to the costs of "business as usual"?

Data Used

A standardized approach and a consistent set of metrics were used to determine the costs of providing child welfare services in intervention and comparison sites for each locale during a 12-month period from July 1, 2020, through June 30, 2021. At each locale, programmatic and fiscal staff completed an Excel-based cost measurement tool called the Budget Assistance Tool (BAT) to estimate the full costs of delivering services in the intervention sites implementing the Approach, and in the comparison sites. The BAT has been used extensively to identify and collect costs of human services and home visiting programs nationwide (U.S. Department of Health and Human Services, Health Resources and Services Administration, 2020; Yarnoff et al., 2019). Specifically, the BAT captures cost data in eight key cost categories (see exhibit 1), which encompass most programmatic costs: labor, overhead and infrastructure, contracted services, tools and screening, training, consumables, non-consumables, and travel. The BAT also captures key service delivery characteristics, which tend to drive variations in costs, such as the number of households served. The evaluation team worked closely with each locale to complete a separate BAT for the intervention and comparison sites.

Data Collection Procedures

Staff at each locale received an intervention BAT and a comparison BAT to complete. The evaluation team provided training to programmatic and fiscal personnel on how to complete each section; the team developed a list of Frequently Asked Questions (FAQs) and offered ongoing support and technical assistance on how to complete the BATs. Staff at the intervention and comparison sites used past invoices and data on staff hours and annual salaries from the data collection window (July 1, 2020, through June 30, 2021) to identify labor and other programmatic costs. After the intervention and comparison BATs were completed and returned, the evaluation team used a checklist to systematically review the quality of data in the intervention and comparison BATs. The checklist was used to identify missing data, inconsistencies, and potential inaccuracies. The team followed up with each locale to clarify and correct data issues identified during the review.

Measures

A description of each cost category and the information to be compiled and recorded in each intervention and comparison BAT is provided below.

- **Labor – Personnel and salary.** Includes job titles of key staff providing or supporting the delivery of child welfare services (including those staff implementing the Approach for intervention sites), the number of full-time equivalent (FTE) staff, and full-time annual salaries. The BAT was tailored to capture estimates of the percentage time staff spent performing 12 key activities: 1) screening and intake; 2) investigations; 3) ongoing case management; 4) collaboration; 5) court/legal activities; 6) receipt of supervision; 7) participation in training; 8) program management and coordination; 9) supervising; 10) administration/data entry; 11) executive; and 12) other.
- **Overhead and infrastructure.** Indirect costs and shared overhead costs incurred to deliver child welfare services using the Approach (intervention) and practice as usual (comparison). Shared overhead costs include costs for resources that are used to support other services (e.g., website, liability insurance, payroll taxes), or includes other supportive staff who are not key to service delivery (e.g., administrative aide). Overhead and infrastructure also includes

costs related to office rent, utilities, and maintenance.

- **Contracted services.** Costs associated with outside contracts and consultants that were used when delivering services. Includes annual expenditures for contracted services related to data, service delivery, or other.
- **Tools and Screening.** Annual expenditures or costs for any fees for screenings, assessments, or tools.
- **Training.** Annual expenditures on initial and ongoing training and professional development, and for intervention sites this included the costs for QIC-DVCW training and monthly coaching calls.
- **Consumable supplies.** Costs of items or supplies purchased recurrently and that get used up or depleted (e.g., office supplies, cell phone data plans, etc.). Includes administrative supplies (e.g., printer ink, postage), staff support materials, or programmatic materials.
- **Non-consumable supplies.** Annualized costs of non-consumable equipment and supplies that have a useful life of 1 year or more and do not get depleted when used (e.g., computers, applications, cell phones). Includes items purchased before the reporting period that were used during this period.
- **Travel.** Annual costs associated with travel necessary to perform key activities and services.
- **Service delivery characteristics.** The BAT was tailored to capture the unique service delivery characteristics specific to the child welfare locales, including the number of years implementing the Approach, names of other service interventions implemented, number of contacts completed, number of households served, percentage of services provided in person, and the percentage of cases involving intimate partner violence (IPV).

In addition to the data recorded in the categories above, the BAT automatically calculates and provides a summary of site costs by category. The BAT uses data on the total number of households served to generate estimates of the cost per family.

Figure 11. Service Delivery Characteristics and Cost Categories Included in the BAT

Analytic Approaches

The cost study was applied using a program-level cost analysis approach to estimate the child welfare operational costs for intervention and comparison groups within each locale. Descriptive analyses were conducted to summarize spending patterns and activity costs for intervention and comparison groups within each locale. To calculate total operational costs for each group, the costs for each of the eight resource categories (i.e., labor, overhead and infrastructure, contracted services, tools and screening, training, consumable supplies, non-consumable supplies, and travel) were summed. An annualized cost estimate for non-consumable supplies (e.g., equipment) was calculated by dividing the purchase price of an item by its expected years of use. Cost per family served was calculated by dividing total operational costs by the total number of households served by each group. We examined the percentage of total costs for each resource category and

the percentage of labor costs allocated to each child welfare activity (i.e., screening and intake, investigation, ongoing case management, collaboration, court/legal, receiving supervision and participating in case reviews, receiving training/coaching, program management and coordination, providing supervision, administrative/data entry, executive, other).

Covid-19

The Budget Assistance Tool was completed via a Microsoft Excel workbook and no Covid-19-based modifications were needed to complete the cost study data collection.

SECTION 4. RESULTS: IMPLEMENTATION STUDY

The implementation study was oriented around an overarching research question that asked:

> *What factors are associated with successful implementation and sustainability of an adult and child survivor-centered approach?*

This component of the evaluation was informed by implementation science and the implementation frameworks discussed above. The concept of "successful implementation" was operationalized to include Implementation Outcomes of adoption, acceptability, feasibility, fidelity, penetration, and sustainability. (Cost is also included in the Proctor framework from which we draw implementation outcomes; however, costs are covered in the Cost Study section of this report). Table 30 outlines the implementation study research questions and crosswalks them with the Implementation Outcome and data source. Results are provided in order of research questions shown in this table.

Table 30. Crosswalk of Implementation Study's Research Questions, Implementation Outcomes, and Data Source

Implementation Study Research Question	Implementation Outcome	Data Source
To what extent did the Approach spread to sites?	Penetration (spread)	Training participation roster Coaching participation roster Fidelity checklists
How did implementation drivers change?	Adoption Sustainability	Drivers Assessment
How did fidelity to the Approach change?	Fidelity	Fidelity Checklists
How long did it take to implement and how complete was implementation?	Adoption Sustainability	Universal Stages of Completion
What contributed and inhibited successful implementation?	Acceptability Feasibility Sustainability	Key Informant Interviews Coaching Focus Groups

RESEARCH QUESTION: TO WHAT EXTENT DID THE APPROACH SPREAD TO SITES?

This research question relates to the implementation outcome of **penetration** (see page 10), which may also be referred to as intervention reach or spread. Ideally, measurement of spread would estimate the percentage of providers who used the Approach in their practice with children, adult survivors, and persons who use violence. Given our limits in observing the Approach in practice, we used several proxies to operationalize spread of the Approach. We considered three metrics to describe each sites' participation in training, coaching, and fidelity as follows:

- Percent of eligible caseworkers, supervisors, and community partners who participated in **training**
- Percent of eligible supervisors who participated in **coaching**

- Percent of eligible caseworkers for whom a **fidelity checklist** was completed

Table 31 provides percentages for each of the spread indicators. It shows the following:

- **Training:** Across Projects, 70% of eligible participants participated in QIC-DVCW training. Within sites this percentage ranged from 50% in Illinois to 79% in Massachusetts to 85% in Allegheny County. Another 5% (cross-site) participated in some of the training.
- **Coaching:** Across Projects, a slightly lower percentage of eligible participants participated in coaching – 67%. Within sites this percentage ranged from 56% in Illinois to 71% in Massachusetts and to 75% in Allegheny County.
- **Fidelity Checklists:** Across Projects, Fidelity Checklist completion spread the least at 27% of eligible participants. Within sites this percentage ranged from 18% in Illinois to 20% in Allegheny County, Pennsylvania to 40% in Massachusetts.

Taken together, these indicators of spread would suggest that the Approach penetrated the practice of those in direct service work with families at mainly moderate levels.

Table 31. Cross-Project Spread: Percent of Eligible People Who Participated in Training, Coaching, and Fidelity Checklist by Site

Key Implementation Activity	Allegheny County	Illinois	Massachusetts	Cross-Sites
Training				
Number of eligible participants	460	567	373	1,400
None	11%	46%	15%	25%
Partial (1 day or some of online)	4%	4%	6%	5%
Full (2 days or all online)	85%	50%	79%	70%
Coaching				
Number of eligible participants	33	36	46	115
Possible coaching sessions attended*	75%	56%	71%	67%
Fidelity Assessment				
Number of eligible participants	104	95	136	335
At least 1 Fidelity Checklist Completed**	20%	18%	40%	27%

Notes. N is the number of people eligible for the implementation activity. Percent is the percent of those eligible who participated in the implementation activity. * This sample includes attendees who were a part of the self-survey target sample, identified and tracked through monthly rosters sent from sites. The denominator adjusted for excused absences, defined by leave of absence, emergency conflict, or illness. This demonstrates individual engagement level for the sessions when they were able to attend.

** Only includes participants who consented to participate in Fidelity Checklist data collection.

RESEARCH QUESTION: HOW DID IMPLEMENTATION DRIVERS CHANGE?

This research question was concerned with the extent to which implementation drivers were in place across Projects and within each Project, aiming to describe the Implementation Outcomes of **adoption** and **sustainability**. Implementation drivers were assessed to demonstrate that the infrastructure needed to support the Approach was put in place. This infrastructure was conceptualized as comprising three main domains as measured by a Drivers Assessment survey:

- Competency drivers (6 items)
- Organization drivers (6 items)
- Leadership drivers (3 items)

As described in the Method section, participants rated items on a scale from 0 to 2 where 0 = not in place; 1 = partially in place; and 2 = in place. For the purpose of our analysis, an average score of 1.5 was considered high and represented "nearly in place" or "in place."

Drivers Assessment Completion

Table 32 shows completion rates for the Drivers Assessment survey in 2019, 2020, and 2021. A total of 174 Drivers Assessment Surveys were initiated, but not all were completed in full. Completion rates were highest at Time 1 with 77.3% of the surveys completed, and they decreased each year (Time 2 had 66.7% of survey completed; Time 3 had 34.4% of surveys completed). Additionally, the lower half of the table shows the number of surveys completed by site for each time point. In 2019, Drivers Assessment surveys were administered with Illinois (32.4% of 2019 surveys) and Massachusetts (67.6% of 2019 surveys). In 2020, the surveys were completed by all three sites - Allegheny County (68.2% of 2020 surveys); Illinois (15.9% of 2020 surveys); and Massachusetts (15.9% of 2020 surveys). The final Drivers Assessment survey was conducted in 2021 with two of the three sites – Allegheny County (59.1% of 2021 surveys) and Massachusetts (40.9% of 2021 surveys). Combining all three years, completed surveys represent 43.0% of the responses from Allegheny County, 18.0% from Illinois, and 39.0% from Massachusetts.

Table 32. Driver Assessment Survey Completion Rates by Year and Site

Completion & Project Info	Time 1 [2019] n (%)	Time 2 [2020] n (%)	Time 3 [2021] n (%)	Total N (%)
Survey Completion Rates				
Complete Survey	34 (77.3)	44 (66.7)	22 (34.4)	100 (57.5)
Incomplete Survey	10 (22.7)	22 (33.3)	42 (65.6)	74 (42.5)
Project-level Composition				
Allegheny County	0 (0.0)	30 (68.2)	13 (59.1)	43 (43.0)
Illinois	11 (32.4)	7 (15.9)	0 (0.0)	18 (18.0)
Massachusetts	23 (67.6)	7 (15.9)	9 (40.9)	39 (39.0)

Notes. N = 174 surveys initiated; N = 100 surveys completed.

Drivers Average Scores by Domain and by Year

Figure 12 visually displays the average scores for each driver domain, comparing these scores across the three years of 2019, 2020, and 2021. Additionally, Table 33 presents the domain and item level scores in a table format, providing average scores, standard deviations, and statistical test results. Overall, five distinct patterns were observed in comparing across domains and over time.

- Across domains, the **leadership** domain represented the highest average scores in all three years with only one exception (i.e., competency domain was at same level by 2021).
- Over time, the **leadership** domains' annual average scores were high and remained nearly constant across the three years (2019 = 1.52; 2020 and 2021 = 1.50). Statistical tests showed that the time specific average scores were not statistically significantly different than the overall average scores (p = .978), which would be expected in scores that remained nearly constant over time.
- Annual average scores over time on the **competency** domain steadily increased (2019 = 1.20; 2020 = 1.44; 2021 = 1.52), reaching the same level as the leadership domain by 2021. Statistical tests of the competency domain showed that the time specific average scores were statistically significantly different than the overall average scores (p = .019). In other words, the increase in the competency domain was statistically significant and indicated that the competency driver was seen as being "nearly in place" or "in place" by the final time period of assessment.
- The **organization** domain showed a notable increase over time with annual average scores increasing from 0.93 for 2019 to 1.26 for 2020, and then remaining at 1.26 for 2021. In other words, the organization domain started with a score that represented "not in place" in 2019 and increased to "partially in place" in 2021. Statistical tests of the organization domain showed that the time specific average scores were statistically significantly different than the overall average scores (p = .029). Still, the organization domain did not reach the same level as the leadership and competency domains, indicating that it was "partially in place" by the final assessment.
- All the driver domains' annual average scores showed either scores increasing or scores holding steady over time; in no case did the driver domains show a marked decrease in average scores.

Collectively, the annual Drivers Assessment survey data suggest that **the leadership domain was primarily viewed as being nearly or fully in place throughout the entire project period; the competency domain was viewed as improving over time and closer to being nearly or fully in place by 2021; and the organization domain, while increasing over the three years, was viewed as being partially in place by the final assessment in 2021.**

Drivers Item Level Analysis

Item level data are shown for each time point in Figure 13 (leadership domain), Figure 14 (competency domain), and Figure 15 (organization domain). Additionally, Table 33 presents the item level average scores in a table format, providing average scores, standard deviations, and statistical test results.

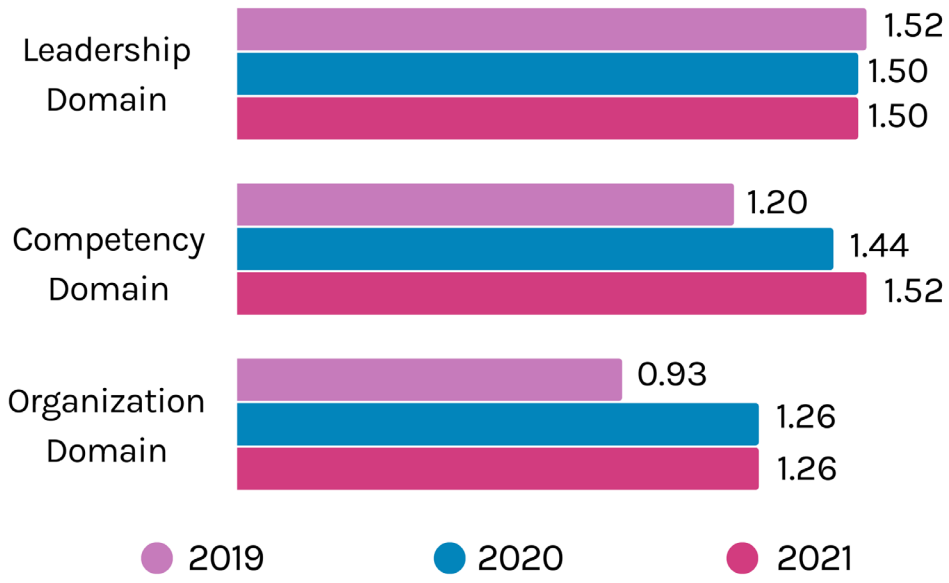
Highlights from Item-level Analysis:

- Items with consistently high ratings (defined as 1.5 or above) across data collection time points:
  - **Leadership - Technical:** Everyone in our collaborative group shares the same vision and agrees upon goals for the project.
  - **Competency – Training:** Staff at all levels are provided with training on the Approach.
- Items with consistently low ratings (defined as 1.0 or below) across data collection time points:

- **Organization – Facilitative Administration:** Organizational structures and roles have been changed as needed to support implementation of the Approach.

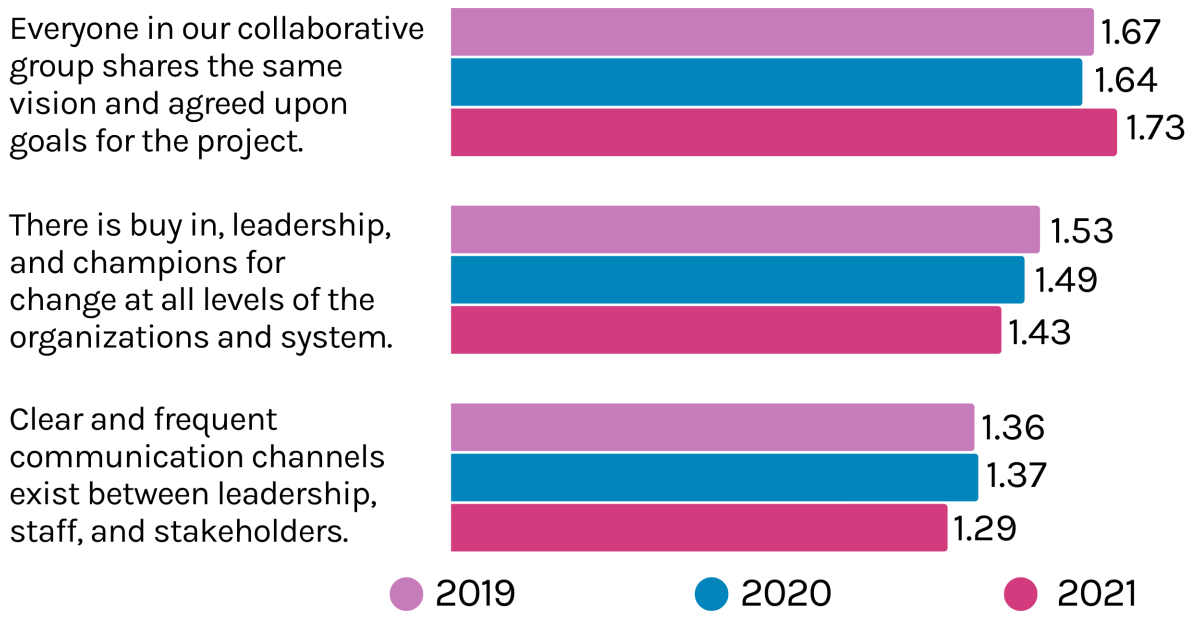
- Items with statistically significant higher ratings from 2019 to 2021:
  - **Competency – Coaching:** Coaching plans are developed and implemented for staff at all levels to support the integration of new skills related to the Approach (p = .003).
  - **Competency – Fidelity Assessment:** A mechanism is in place and is being utilized to assess the performance of staff carrying out the Approach (p = .002).
  - **Organization – Facilitative Administration:** Practices, policies, and procedures have been added or changed as needed to support and be aligned … the Approach (p = .012)
  - **Organization – Systems Intervention:** System wide structures have been added or adapted as needed to support implementation and shared accountability (p =.010)
  - **Organization – Systems Intervention:** Internal and external stakeholders are actively and consistently involved in planning, implementation, evaluation, and decision making (p < .001)

Figure 12. Implementation Driver Domains Mean Scores by Year



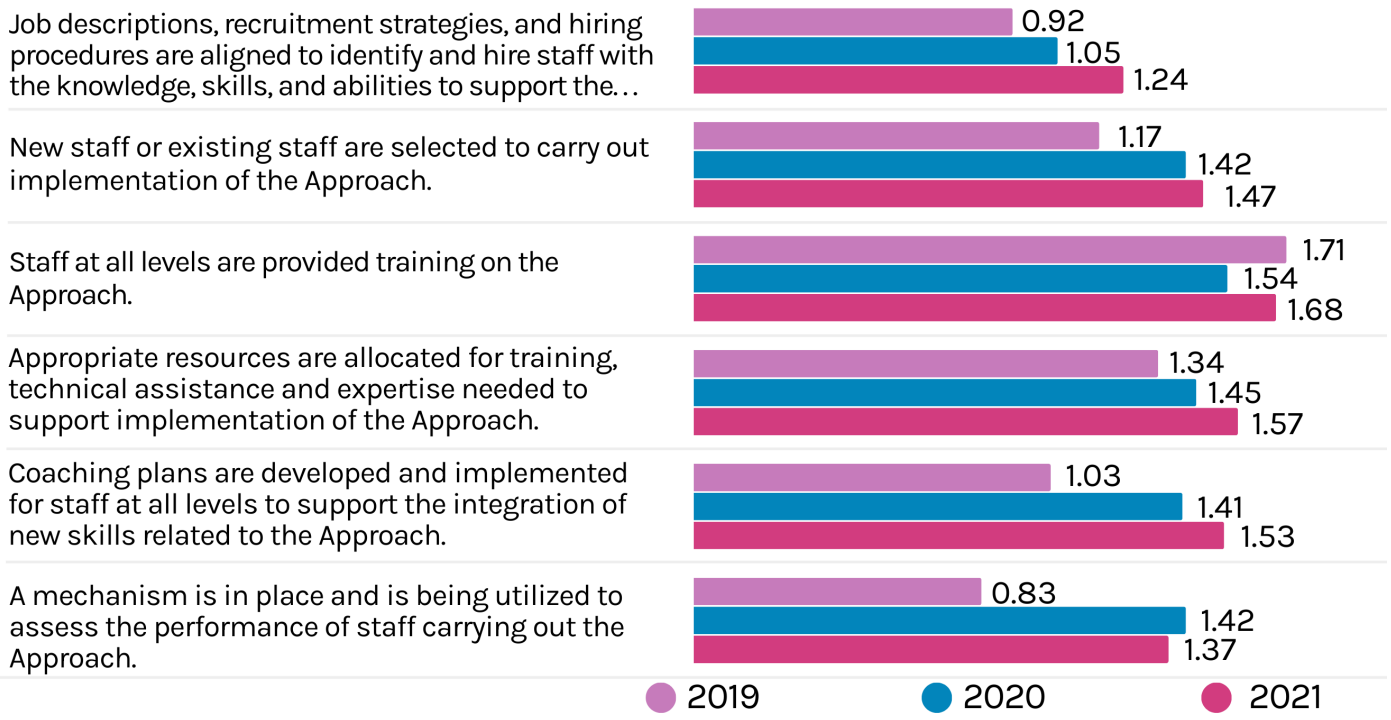
Notes. N = 100 completed surveys. Scores could range from 0 to 2 with 0 = not in place; 1 = partially in place; 2 = in place.

Figure 13. Leadership Driver Items Average Scores by Year



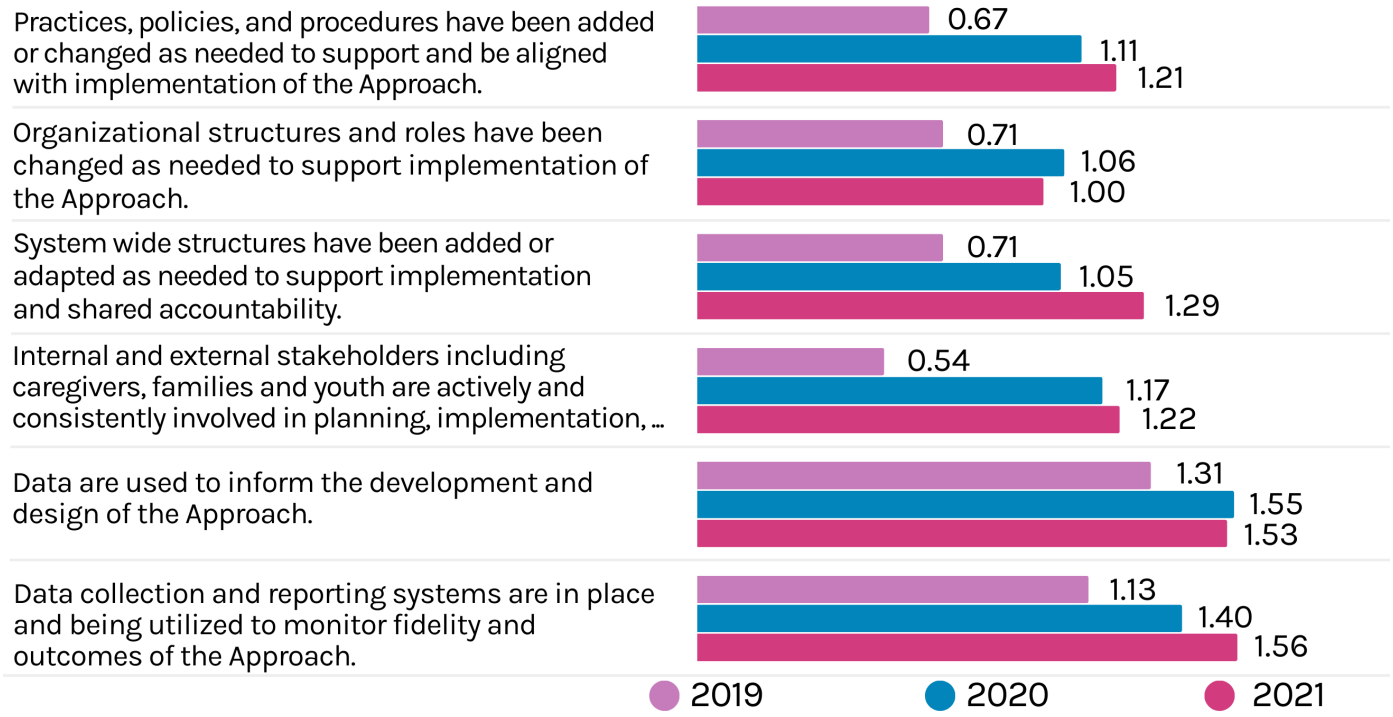
Notes. N = 100 completed surveys. The Leadership Driver domain comprised three items. Scores could range from 0 to 2 with 0 = not in place; 1 = partially in place; 2 = in place.

Figure 14. Competency Driver Items Average Scores by Year



Notes. N = 100 completed surveys. Scores could range from 0 to 2 with 0 = not in place; 1 = partially in place; 2 = in place. The Competency Driver domain comprised six items.

Figure 15. Organization Driver Items Average Scores by Year



Notes. N = 100 completed surveys. The Organization Driver domain comprised six items. Scores could range from 0 to 2 with 0 = not in place; 1 = partially in place; 2 = in place.

Table 33. Drivers Assessment Domain and Item Average Scores by Year

Drivers Assessment Item (Organized by Domain)	Time 1 M (SD)	Time 2 M (SD)	Time 3 M (SD)	F (p)
Leadership Driver	1.52 (0.52)	1.50 (0.41)	1.50 (0.42)	0.022 (0.978)
1. Everyone in our collaborative group shares the same vision and agreed upon goals for the project.	1.67 (0.54)	1.64 (0.49)	1.73 (0.46)	0.208 (0.812)
2. There is buy in, leadership, and champions for change at all levels of the organization and system.	1.53 (0.62)	1.49 (0.55)	1.43 (0.60)	0.195 (0.823)
3. Clear and frequent communication channels exist between leadership, staff, and stakeholders.	1.36 (0.74)	1.37 (0.58)	1.29 (0.56)	0.141 (0.869)
Competency Driver	1.20 (0.38)	1.44 (0.48)	1.52 (0.42)	4.140 (0.019)*
4. Job descriptions, recruitment strategies, and hiring procedures are aligned to identify and hire staff with the knowledge, skills, and abilities to support the Approach.	0.92 (0.76)	1.05 (0.72)	1.24 (0.66)	0.963 (0.387)

Drivers Assessment Item (Organized by Domain)	Time 1 M (SD)	Time 2 M (SD)	Time 3 M (SD)	F (p)
5. New staff, or existing staff, are selected to carry out implementation of the Approach.	1.17 (0.59)	1.42 (0.64)	1.47 (0.51)	1.991 (0.143)
6. Staff at all levels are provided with training on the Approach.	1.71 (0.53)	1.54 (0.67)	1.68 (0.48)	0.874 (0.421)
7. Appropriate resources are allocated for training, technical assistance, and expertise needed to support implementation of the Approach.	1.34 (0.61)	1.45 (0.71)	1.57 (0.51)	0.767 (0.468)
8. Coaching plans are developed and implemented for staff at all levels to support the integration of new skills related to the Approach.	1.03 (0.48)	1.41 (0.60)	1.53 (0.51)	6.275 (0.003)*
9. A mechanism is in place and is being utilized to assess the performance of staff carrying out the Approach.	0.83 (0.70)	1.42 (0.60)	1.37 (0.68)	6.527 (0.002)*
Organization Driver	0.93 (0.60)	1.26 (0.47)	1.26 (0.65)	3.676 (0.029)*
10. Practices, policies, and procedures have been added or changed as needed to support and be aligned with implementation of the Approach.	0.67 (0.64)	1.11 (0.57)	1.21 (0.79)	4.73 (0.012)*
11. Organizational structures and roles have been changed as needed to support implementation of the Approach.	0.71 (0.69)	1.06 (0.68)	1.00 (0.88)	1.685 (0.192)
12. System wide structures have been added or adapted as needed to support implementation and shared accountability.	0.71 (0.71)	1.05 (0.60)	1.29 (0.64)	4.911 (0.010)*
13. Internal and external stakeholders are actively and consistently involved in planning, implementation, evaluation, and decision making, ensuring the system change meets their needs and is culturally relevant.	0.54 (0.64)	1.17 (0.62)	1.22 (0.73)	9.523 (< 0.001)*
14. Data are used to inform the development and design of the Approach.	1.31 (0.69)	1.55 (0.65)	1.53 (0.62)	1.270 (0.286)
15. Data collection and reporting systems are in place and being utilized to monitor fidelity and outcomes of the Approach.	1.13 (0.82)	1.40 (0.63)	1.56 (0.62)	2.315 (0.105)

Notes. N = 100 completed surveys. N by time period: Time 1, n = 34; Time, n = 44; Time 3, n = 22.

M = mean/average score; SD = standard deviation.

Scores could range from 0 to 2 with 0 = not in place; 1 = partially in place; 2 = in place.

F is the F-statistic which is the value used from the ANOVA statistical analysis that indicates whether the time period's average scores were significantly different from the overall average score. The p-value reports the probability of observing a false positive (null hypothesis) to be true; statistically significant p-values are denoted by an asterisk (*).

Table 34. Drivers Assessment Domain Average Scores by Site & Time

Driver Domain & Time Period	Average (SD) Drivers Assessment Scores		
	Allegheny County (N = 43)	Illinois (N = 18)	Massachusetts (N = 39)
Leadership Driver			
Time 1	--	1.5 (0.3, 2.0)	1.7 (0.7, 2.0)
Time 2	1.7 (0.7, 2.0)	1.3 (1.0, 2.0)	1.7 (1.3, 2.0)
Time 3	1.3 (0.7, 2.0)	--	1.7 (1.0, 2.0)
Test Statistic (p-value)	167.500 (0.572)	37.500 (0.813)	0.010 (0.995)
Competency Driver			
Time 1	--	0.8 (0.7, 1.5)	1.3 (0.6, 2.0)
Time 2	1.5 (0.2, 2.0)	1.4 (0.8, 2.0)	1.6 (1.0, 2.0)
Time 3	1.3 (0.7, 2.0)	--	1.8 (1.0, 2.0)
Test Statistic (p-value)	167.000 (0.472)	62.500 (0.027)*	7.408 (0.025)*
Organization Driver			
Time 1	--	0.7 (0.0, 1.0)	1.2 (0.2, 2.0)
Time 2	1.3 (0.2, 2.0)	1.2 (0.2, 1.7)	1.2 (0.3, 1.6)
Time 3	1.0 (0.5, 2.0)	--	1.7 (0.0, 2.0)
Test Statistic (p-value)	162.500 (0.484)	59.000 (0.019)*	0.666 (0.717)

Notes. N = 100 completed surveys. N by time period: Time 1, n = 34; Time, n = 44; Time 3, n = 22.

Scores could range from 0 to 2 with 0 = not in place; 1 = partially in place; 2 = in place.

Median and (Minimum Value, Maximum Value) are reported for each time point.

Nonparametric analyses were used to test differences between groups for small samples. Mann-Whitney-U tests were used for Allegheny County and Illinois; Independent Samples Kruskal-Wallis tests were used for Massachusetts. The *p*-value reports the probability of observing a false positive (null hypothesis) to be true; statistically significant p-values are denoted by an asterisk (*).

RESEARCH QUESTION: HOW DID FIDELITY TO THE APPROACH CHANGE?

This research question focused on fidelity to the Approach and how fidelity varied across Projects and changed over time. Fidelity Checklists were completed by Supervisors of child welfare caseworkers and community partners associated with intervention sites, who were trained and coached. Fidelity was rated using a 9-point Likert scale where ratings of 1 to 3 indicated "needs work," ratings of 4 to 6 indicated "acceptable work," and ratings of 7 to 9 indicated "good work." Supervisors rated their supervisees' practice behaviors along five dimensions, including (1) Approach knowledge, (2) work with adult and child survivors, (3) work with person using violence and coercion, (4) principles practice, and (5) overall fidelity.

Fidelity Completion and Consent Status

Table 35 presents data on the number of Fidelity Checklists that were completed, showing them by consent status and completion status. Among 335 caseworkers in the three Projects that could have had Fidelity Checklist completed, 92 (27%) had at least 1 Fidelity Checklist completed and consented to participate in the study. This rate varied by Project with Allegheny County at 20%, Illinois at 18%, and Massachusetts at 40%.

Including caseworkers for whom Fidelity Checklists were completed but consent was not received, 183 checklists were completed (55% of the 335 caseworkers for whom Fidelity Checklists could have been completed). By Project the percentages were Allegheny County at 44%, Illinois at 47%, and Massachusetts at 68%.

Table 35. Fidelity Checklist Completion and Consent Status by Site

Consent and Completion Status of Fidelity Checklist	Caseworkers: N (%)			
	Allegheny County	Illinois	Massachusetts	Cross-sites
Consent Received				
At Least 1 Checklist Complete	21 (20%)	17 (18%)	54 (40%)	92 (27%)
No Checklist Received	28 (27%)	10 (11%)	13 (10%)	51 (15%)
No Consent Received				
At Least 1 Checklist Complete	25 (24%)	28 (29%)	38 (28%)	91 (27%)
No Checklist Received	30 (29%)	40 (42%)	31 (23%)	101 (30%)
Total	**104 (100%)**	**95 (100%)**	**136 (100%)**	**335 (100%)**

Table 36 presents information on average number of Fidelity Checklists per caseworker, grouping this information by consent status and Project. The average number of completed Checklists for caseworkers who consented to be in the study was about 5 per supervisee. This average for consented caseworkers varied slightly by site:

- Allegheny County average = 4.43 (SD = 3.88)
- Illinois average = 4.06 (SD = 2.82)
- Massachusetts average = 5.65 (SD = 4.54)

These data, combined with the completion data above, indicate that Massachusetts completed more Fidelity Checklists overall and per caseworker.

Across Projects, the number of Checklists completed ranged from 1 to 16 per caseworker for both consenting and non-consenting caseworkers. Regarding the differences between consented and non-consented caseworkers, the average number of Fidelity Checklists completed were significantly higher for caseworkers where consent was

received to be included in the study (M = 5.08, SD = 4.15) compared to caseworkers where consent was not received to be included in the study (M = 2.95, SD = 3.00) (F (1, 181) = 15.819, p < 0.001).

Table 36. Fidelity Checklist Average Number Completed per Caseworker by Site and Consent Status

Consent Status	Caseworkers: Average (SD) Fidelity Checklists Completed			
	Allegheny County (N = 46)	Illinois (N = 45)	Massachusetts (N = 92)	Cross-sites (N = 183)
Consent Received	4.43 (3.88)	4.06 (2.82)	5.65 (4.54)	5.08 (4.15)
No Consent Received	2.68 (3.42)	2.71 (1.90)	3.29 (3.39)	2.95 (3.00)

Notes. SD = Standard deviation.

Fidelity Average Scores

Table 37 displays Fidelity Checklist data for the three sites, using data from participants who consented to the study and showing the average scores in each domain and each year (2019 to 2021) for which the Project had fidelity data available. Figure 16 graphs the cross-site average fidelity scores by domain over the three time periods. Overall, a few patterns were observed in comparing cross-Project average scores across domains and over time.

- Across domains, the average fidelity scores consistently showed that one of the highest scoring domains was the Work with Adult & Child Survivors. By the third time period (2021), one other domain was observed to have similar average scores: Principles Practice.
- Two domains were consistently lower than the other domains: Approach Knowledge and Work with Person Using Violence & Coercion.
- In the third time period and final assessment (2021), the five domains were observed with all reaching the "good work" range. That said, there appeared to be two sets of domains: (1) Work with Adult & Child Survivors and Principles Practice were at an average score of 7.40, (2) and the other three domains (Approach Knowledge, Work with Persons Using Violence & Coercion, and Overall) were at an average score around 7.20.
- Over time, patterns of change in average fidelity scores showed increasing scores for three of the five domains. The exception to this pattern was observed with the Principles Practice and Overall domains. In these two domains, the average fidelity scores decreased in the second time period (2020) and then rose in the third time period (2021).

Statistical analysis of these Fidelity Checklist average scores by time period observed significant increases in fidelity scores for two domains: (1) work with person using violence, and (2) principles practice. In these two domains, average scores changed from acceptable [4-6] to good work [7-9]. Post-hoc analyses with Bonferroni correction identified that the differences between 2021 scores and the two prior years (2019 or 2020 scores) were statistically significant. While the statistical testing of the other domains of the Fidelity Checklist did not indicate statistically significant differences between the average scores of the three time periods and the overall average score, the descriptive data shows that in all domains the cross-Project average was at 7.2 or above, which represents fidelity in the "good work" range.

In sum, the **completion of Fidelity Checklists was taken up at a lower rate than desired or planned.** Among the Fidelity Checklists completed for consented participants, **the average scores generally increased over time. These increases were statistically significant for two domains: (1) Work with Person Using Violence & Coercion, and (2) Principles Practice.**

Table 37. Fidelity Checklist Average Scores by Domain, Site, and Year

Checklist Domain & Time Period	Caseworkers: Average (SD) Fidelity Score				p
	Allegheny County (N = 21)	Illinois (N = 17)	Massachusetts (N = 54)	Cross-sites (N = 92)	
Approach Knowledge					
2019	--	--	6.54 (1.32)	6.70 (1.40)	
2020	6.33 (1.72)	6.71 (1.54)	6.89 (1.37)	6.74 (1.47)	
2021	6.75 (1.22)	7.17 (1.59)	7.45 (0.78)	7.21 (1.15)	
Work with Adult and Child Survivors					
2019	--	--	6.77 (1.42)	6.91 (1.43)	
2020	6.80 (1.61)	6.92 (1.50)	7.02 (1.32)	6.96 (1.40)	
2021	6.92 (1.38)	7.75 (1.06)	7.48 (0.79)	7.40 (1.06)	
Work with Person Using Violence & Coercion					*
2019	--	--	6.37 (1.73)	6.33 (1.82)	
2020	6.08 (1.24)	6.21 (1.85)	6.59 (1.64)	6.41 (1.61)	
2021	6.56 (0.73)	7.33 (1.30)	7.42 (1.02)	7.20 (1.09)	
Principles Practices					*
2019	--	--	6.89 (1.16)	6.91 (1.24)	
2020	6.40 (1.50)	6.64 (1.69)	7.00 (1.14)	6.81 (1.34)	
2021	7.08 (1.17)	7.50 (1.09)	7.50 (0.59)	7.40 (0.89)	
Overall					
2019	--	--	6.77 (1.42)	6.91 (1.43)	
2020	6.80 (1.37)	6.69 (1.44)	7.07 (1.19)	6.94 (1.27)	
2021	6.83 (1.27)	7.33 (1.30)	7.42 (0.72)	7.25 (1.04)	

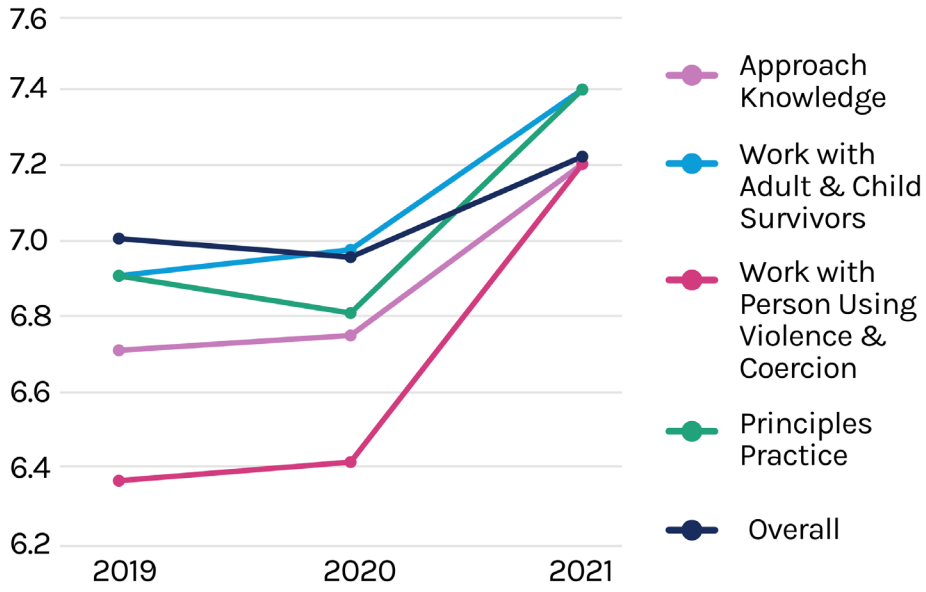
Notes. N = 92 fidelity checklists completed by supervisors on caseworkers, workers who consented to the study.

Counts were redacted for 2019 because 5 or less caseworkers had fidelity checklists completed; their scores would likely be unreliable and represent consenting workers and their supervisors, who were early adopters of the intervention.

Fidelity scores can range from 1 to 9 where 1-3 is *needs work;* 4-6 is *acceptable work*; and 7-9 is *good work*. SD = standard deviation.

* - Asterisk indicates test statistics were statistically significant for that domain that tested cross-site scores. It indicates that the domain's time-specific scores were significantly different than the overall score for that domain.

Figure 16. Fidelity Checklist Scores by Domain and Year



Notes. N = 92 fidelity checklists completed by supervisors on caseworkers.

Fidelity scores can range from 1 to 9 where 1-3 is *needs work;* 4-6 is *acceptable work*; and 7-9 is *good work.*

RESEARCH QUESTION: HOW LONG DID IT TAKE TO IMPLEMENT THE APPROACH AND HOW COMPLETE WAS IMPLEMENTATION?

This research question was addressed with data from the Universal Stages of Implementation Completion (Uni-SIC) tool. It connects to the Implementation Stages framework by examining duration and completion of implementation stages. It connects to Implementation Outcomes by providing information that relates to penetration and sustainability of the Approach.

Table 38 displays the aggregate data from the Uni-SIC tool.

- For the pre-implementation phase, it shows that duration ranged from 788 to 887 days. In all the differences in duration across Projects were modest. This data also indicates that all three Projects completed a high proportion of the implementation activities that comprised the pre-implementation phase.
- For the implementation phase, the Uni-SIC data indicates that duration ranged from 387 to 549 days. Again, these data also show that the vast majority (83% to 91%) of implementation activities of the implementation phase were completed.
- For the sustainment phase, these activities were not completed by any Project and thus there are no duration data and the proportion completed is 0% for all three Projects.

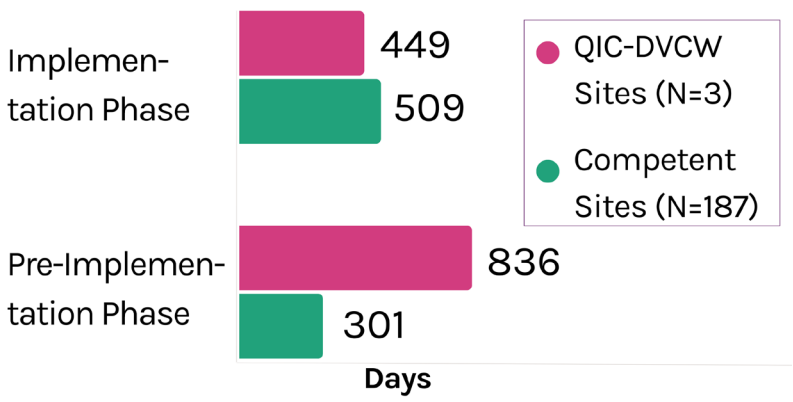
Table 38. Implementation Phase Duration and Proportion Completed by Project Site

Implementation Phase Implementation Stages	Project Site	Duration (# of days)	Proportion Completed (%)
Pre-Implementation Phase • Engagement • Consideration of Feasibility • Readiness Planning	Allegheny County	887	93%
	Illinois	832	100%
	Massachusetts	788	87%
	Cross-Project (average)	836	93%
Implementation Phase • Staff Hired & Trained • Fidelity & Adherence Monitoring Established • Services & Consultation • Ongoing Services, Consultation, Fidelity, Feedback	Allegheny County	412	83%
	Illinois	549	91%
	Massachusetts	387	83%
	Cross-Project (average)	449	86%
Sustainment Phase • Competency	Allegheny County	Not completed	0%
	Illinois	Not completed	0%
	Massachusetts	Not completed	0%
	Cross-Project (average)	Not completed	0%

Figure 17 shows the duration metrics for each implementation phase, comparing the QIC-DVCW cross-site average duration to the average for competent sites (i.e., sites that completed and sustained implementation).

- For the pre-implementation phase, competent sites' average duration is 301 days, compared to the QIC-DVCW cross-site's average of 836 days.
- *For the implementation phase, competent sites' average duration is 509 days compared to QIC-DVCW cross-site's average of 449 days.*
- *For the sustainment phase, no sites completed the activities identified for competency yet.*

Figure 17. Average Duration of Universal Sites that Achieved Competency Compared to QIC-DVCW Project Sites



RESEARCH QUESTION: WHAT CONTRIBUTED AND INHIBITED SUCCESSFUL IMPLEMENTATION OF THE APPROACH?

Multiple data sources were utilized to understand what contributed and inhibited successful implementation of the Approach; they were the Key Informant Interviews, the coaching focus group, and the training evaluations. The Key Informant Interview participants, who were all either management or implementation team members and/or project decision makers, were asked directly "what supported and what got in the way of the approach"; these interviews were conducted at the end of the project. The coaching focus groups shine light on the experience of the key implementation strategy participants. The training evaluations provide perspective on the role of the unique cross-systems Approach two-day training in the implementation of the Approach.

Key Informant Interviews

With the goal of understanding what supported and got in the way of the implementation of the Approach, Key Informant Interviews were conducted between August-October 2021 (See Methods section for more information). The following describes the key findings. It is important to note that there were many dialectical understandings of what supported and got in the way of the implementation of the Approach. For the sake of organization, the findings are shaped into what supported and what got in the way, with an additional section on the key changes in and the challenges related to collaboration and direct practice with families observed as a result of the Approach implementation. Discussion of the both-and quality of these findings will be taken up in the subsequent implications section.

What Supported the Implementation of the Approach?

Two main categories emerged from the participants' descriptions of what supported the implementation of the Approach. Those were (1) technical assistance and (2) agents of change. These are described below.

Technical Assistance

Technical assistance provided by the QIC-DVCW was identified by 21 participants as supporting the implementation of the Approach. The participants identified the following as specific aspects of technical assistance that, in part, supported the Approach (below, under "What got in the way of implementation, these same aspects are identified): (1) implementation and management teams, (2) coaching, and (3) training. Because project implementation and management teams were required by the QIC-DVCW based on the adoption of implementation science framework of teams as one of the four frameworks, these teams are included here as part of technical assistance.

Implementation and Management Teams. Out of the 21 participants who identified that the QIC-DVCW technical assistance supported the implementation of the Approach, nine expressed that the implementation and management teams were instrumental in creating change. In their descriptions of the teams' effectiveness, participants shared the teams created a focus, which was described in multiple ways, such as "call[ed] things what they were," and they helped people "c[o]me out of your silo." One participant described:

> *So, you'd have different people like I'd have. In my group, I'd have like a provider from the community, I'd have a supervisor from [CW]. So, you'd have these different people and their perspectives... [the meeting would have] an organized agenda and accountability for what's supposed to be accomplished by the next day, but also giving opportunities in smaller breakouts for people to build the relationships necessary to actually have the infrastructure work. Because I think you can have a plan and have accountability without people actually making the*

> *necessary relationships to really pull it off. (P20)*

In part the implementation and management teams' effectiveness to supporting the Approach implementation was attributed to time spent together focused on the Approach, as one participant expressed saying:

> *...our implementation and management team met every single month, and it was a large group, it was like 35 people that came every single month. And then some ad hoc work groups and stuff like that, like they just to be focused on one thing with that kind of dedicated time is an unusual advantage, I think, that we just don't have on other topic areas sometimes. (P8)*

Coaching. Six out of the 21 participants identified that QIC-DVCW coaching, one form of the QIC-DVCW technical assistance, supported the implementation of the Approach. Coaching, from the participants descriptions, helped to support the implementation because of the dedicated time to discuss DV related child welfare cases and dilemmas and apply the Approach. This was exemplified in this participant's description:

> *I found, every time that we have coaching sessions, one of us had to present on a case, and the person working with our family was carrying good recommendations, things that maybe we had not considered before. And because we did have coaches in the sessions, [de-identified] and [de-identified], they would find a way connecting them to the framework and how that was, "Oh, yeah, that's an example of this."*

In addition, participants described that the time and space provided by QIC-DVCW coaching meant that supervisors, who perform the key practice change role in the QIC-DVCW fields of practice, to deeply reflect on the intersection of DV and child welfare. For example, one participant stated:

> *...we don't always do we take the time to ask those questions. People who really are passionate about DV, and the people who are really passionate about doing this type of work, get it, but not everybody gets it. And I think that now, the supervisors who have been part of coaching, and have been part of the study, are taking the time to really see what this has to do with anything. (P9)*

Training. Six out of the 21 participants who identified that the QIC-DVCW technical assistance supported the implementation of the Approach named that the QIC-DVCW training was one of the factors. As the QIC-DVCW training was conducted with all project sites (initially in early 2019 and then multiple times for new staff), it was a core initial implementation event to set the stage for the Approach to be understood by those in the intervention offices. For example, one participant described,

> *those trainings where they really laid the foundation for all the parts of the project. They also included a piece about the people that use violence, and how the system was not... Besides punishing them, the system was not really providing any rehab for them. That sometimes families want to deal with things can turn ugly not involving outside authorities, because we know the person is a person of color, the justice system may not respond in the same way. (P18)*

One of the aspects of the training that stood out was that the training was cross-sectoral (e.g., child welfare, domestic violence, courts) and cross-roles (e.g., front line staff, specialists, advocates, managers, directors, judges, attorneys). This was illustrated in a participant's response who stated "I think that there's shared understanding about one another's services and roles, but also challenges... And I think people were better able to do that in like post training, than they were pre-training." (P13)

Agents of Change

One of the key implementation drivers identified by the key informant participants was the agents of change within the project sites, namely the individuals who facilitated the implementation of the Approach. While not all participants identified specific change agents, out of the 26 key informant interview participants, 23 did. Within the Implementation Drivers framework, these agents of change are best described as Facilitative Administration and Leadership drivers. Per participants descriptions, these agents of change clustered into three groupings ordered by frequency across participants: project managers, individuals that were not explicitly child welfare employees, and individuals that were explicitly child welfare employees.

Project Managers. Of the 23 participants that identified specific change agents that supported the implementation of the Approach 12 named Project managers. Several aspects of the project manager role with the QIC-DVCW were common across the participants' descriptions: (1) facilitation of meetings, (2) created space during the meetings, (3) relationship connector within/across systems. This first skill of meeting facilitation is an important function within Facilitative Administration and Leadership drivers when implementing an innovation particularly as complex as the Approach. Within the QIC-DVCW project sites, Project managers played an explicit leadership role, including managing the QIC-DVCW project-level implementation and management teams. In expressing the way Project managers facilitated meetings, one participant stated: "I think just the structure and the accountability, the implementation teams and management teams meeting separately, but we had [de-identified] running our meetings, and being sort of always had an agenda, who was always prepared" (P20). The second aspect of Project managers skills as change agents, creating space, was interconnected with meeting facilitation, although more emotional skill focused. One participant reported,

I think [project manager], [other project manager], [TA lead] they created a space that felt safe, they created a space that people feel comfortable, it was no like, type of criticism whatsoever. So, it's great in managing meetings like that, and [project manager] was able to be supportive understanding without minimizing the feelings that other people were having, the same with [other project manager], so the space felt safe. So, people felt comfortable talking, and I think that says a lot about them. (P23)

The third aspect of Project managers as change agents was their role as relationship connector. Participants' descriptions of them included a "mover of mountains" and "a hub." One participant stated the Project manager was "crucial to us being able to accomplish what we've done…when she was not in a position to know or understand anything about what she was being asked to do, and she just did it, she did best of her ability, because she was so dedicated to this" (P4).

Individuals That Were Not Explicitly Child Welfare Employees. In addition to Project managers as change agents, eight participants also reported that individuals who were not explicitly child welfare employees also supported the implementation of the Approach. These roles included (1) father engagement staff, (2) judges, (3) DV agency staff.

The father engagement staff were described as fundamental to intentional engagement strategy, as defined in the Relational and Systemic Accountability Framework, of people who use violence and linked to that engaging fathers (who are most commonly also the people who use violence). These father engagement staff were described as "consistent" and "supportive," further one participant stated, they "really have us thinking about different ways of engaging fathers."

Judges also were identified as change agents within the Approach implementation, although in a limited way compared others in this category. One of the ways judges were helpful to the Approach implementation was in the way they could hold child welfare accountable; one participant exemplified this stating "the judges in [our project site] have really seen this an opportunity to go back to child welfare and say

you're not doing your jobs, this, that and the other when you bring these cases to court. And I think part of that is because they have been involved in this and learned more about what should be done." (P4)

Lastly, DV agency staff were also identified as change agents that supported the implementation of the Approach. The main mechanism participants described was the integral way DV agency staff inspired Approach infused practice change. For example, in describing one DV agency staff member, a participant said "She can go in and deal with the father, but she can back out and test the child and embrace the mother. Also, has some tough love when needed," and adding "I could hire her, I would pay her whatever she asks me. I think she's a jewel. I think their whole department is" (P17). In another example of DV agency staff supporting the Approach, a participant recalled how the DV staff helped focus on the importance of engaging the person using violence because of the impact they have on the child's well-being. They shared how the DV staff "really held our feet the fire" on this issue, stating:

> *...the children or the child are having contact, with visitation, with overnights with this person, and the whole reason that kid is here is because of whatever kind of behavior that person has engaged in it felt like there was a big piece of the pie missing in our clinical approach if we couldn't find a way to integrate the person who uses violence. (P13)*

All together, these non-child welfare individuals were part of the Facilitative Administration and Leadership drivers of the Approach implementation.

Individuals That Were Explicitly Child Welfare Employees. Lastly, seven participants reported there were individuals who were child welfare employees (other than the project managers, IPV specialists, or DV advocates) that supported the Approach implementation. These individuals included high level administrators responsible for child welfare units, and individual unit supervisors and managers. The main mechanism of supporting the Approach implementation by these change agents was in participants' experience of support, this included both participants in multiple sectors (i.e., not just child welfare or DV). Some participants described that it was seeing all managers of the participating offices present at QIC-DVCW meetings that facilitated their experience of support. One participant illustrated this saying, "the presence and the commitment that they made by sort of being visible there, I think, made a huge difference. Having that level of people in the agency actively in a part of it, I think, made a big difference" (P8). Sometimes one specific person within a child welfare unit stood out in participants' experience of what supported the Approach. For example, one DV agency staff participant described this support stating, "there has been numerous times where [one specific CW agency manager] has backed us up" (P26). However, these individuals sometimes stood out to participants in contrast to the other child welfare individuals who did not support the Approach implementation. For example, one participant who was a DV agency staff shared "I had one supervisor that was great...she would try to utilize me. And actually, she basically had my all attention, because all the other supervisors would not use me that much." (P10)

What got in the Way of the Implementation of the Approach?

Several central barriers arose from participants' descriptions of what got in the way of the Approach implementation. The most prominent barrier category was the environmental barriers, and the second central category of what got in the way of the Approach implementation was aspects of technical assistance. These are further described below.

Environmental Barriers

Environmental barriers impeded implementation of the Approach at Projects, encompassing the following (1) Covid-19 related challenges, and less dominantly (2) lack of leadership buy-in.

Covid-19 Related Challenges. Participants (13/26) vividly described the impact that Covid-19 had on the implementation of the Approach, characterized within the Systems Intervention implementation driver, using words like "huge influence," "pandemonium," "overwhelming," "vulnerable," "survive." First, Covid-19 related challenges created barriers to the Approach implementation due to agency level stress combined with individual impacts. One participant described this agency level plus individual level Covid-19 related challenges like this:

> *...a lot of stuff stopped for a moment in time, like the world kind of stopped for like, three months before we actually got on a roll like Zooms and things of that nature, the in person meetings, I feel like once the pandemic hit, and things kind of changed a lot of stuffs shifted, a lot of stuff being more virtual, a lot of stress on people from all the various things that the pandemic brought upon us. (P26)*

The transition to online, remote work was very difficult and took a lot of time and dedication, which one participant said plainly "So, that got in our way" of the Approach implementation (P9). In addition, participants tied Covid-19 related challenges as directly distracting from the Approach, and limited "capacity" and "resources" to the QIC-DVCW project overall. To illustrate the impact of Covid-19 on capacity to the Approach implementation, this participant reported, "it is very challenging to learn anything new under those - sort of the trauma of the past two years, and the overwhelming nature of what everyone's been experiencing, and seeing what families have been experiencing" (P12). Others described how Covid-19 impacted coaching, one of the key Approach implementation mechanisms:

> *...we were kind of meeting regularly, the coaching was off the ground, people were really starting to understand what coaching was...And then when Covid-19 happened, it just stopped, and then we picked it back up again, but honestly, the focus was, how are we going to do the work this way? How are we going to survive?...for a lot of people I think, just fell off the radar, the ones that already started thinking about the Approach. (P6)*

Lack Of Leadership Buy-In. Of all the 26 participants, eight reported that lack of leadership buy-in got in the way of the Approach implementation, categorized in the Systems Intervention and Leadership implementation drivers. Since the key informant interview participants were individuals chosen because of their role with the QIC-DVCW project, including being decision makers, the perception, limited as it was, of the lack of buy-in is noteworthy. Particularly, child welfare participants described this lack of buy-in by leadership using terms like, "tentative," "sporadic," "not important," and it showed up both in their supervisors and in who didn't participate in the implementation and management teams. In an example of how lack of administrator buy-in in the QIC-DVCW surfaced in supervision, a participant reported:

> *I will have supervision and there will be no questions about the process, right, how's it going? How are you feeling about it? What does it look like? Like none of that. So, I just feel like it's not important and when things aren't important on the administrative level, yep, then it falls to the wayside. So, it's up to us as [child welfare direct administrative positions] to be intentional and keep this work, with our families. (P25)*

And in describing how the lack of leadership buy-in appeared at the overall project implementation, one participant expressed that more buy-in was needed:

> *I really wish that we had more individuals and leadership, high level leadership positions, being more actively involved in the implementation work. We had some folks, but it was really sporadic involvement, but not enough to say, "Yes, they're there all*

> *the time. They're pushing this forward. They're driving this forward." And it's really unsettling what a lot of times our DV partners have said, "I've asked for these six times, can you guys please follow up?" (P2)*

Barriers Related to Technical Assistance

While aspects of the QIC-DVCW technical assistance was clearly identified as a supporter of the Approach implementation by key informant interview participants, some of the same aspects were identified as challenges, namely: (1) implementation and management teams' functionality, (2) coaching, and (3) training. Another technical assistance related barrier category could be described as more "meta" or what the participants identified as how QIC-DVCW implementation itself got in the way of the Approach implementation.

Implementation and Management Teams' Functionality. A majority of participants (15/26) named that the functionality of the implementation and management teams impeded the Approach implementation. Functionality here defined as a variety of influences shaping the effectiveness of the teams to achieve the goal of facilitating, guiding, problem solving to assist in the implementation of the Approach; in implementation drivers framework, teams are understood as been part of the Facilitative Administration driver. Team challenges, as described by participants, clustered into three interconnected veins: (1) who was at the team "table"; (2) the ability to actually bring about practice change; and (3) the technical functioning of the teams, such as when they met, how organized they were, etc.

Who was at the implementation and management teams' tables was identified as a barrier to the implementation for several reasons. First, some participants described that who was attending the teams' meetings was a barrier. For example, the lack of sustained community partners participation and a lack of knowledge to facilitate collaboration among community partners was identified in some project sites, reported by a participant here:

> *...we actually watched community partners fall off from the management and implementation team, [names of community partner orgs] off the grid. So, I hear there was a reason, but I was never told the reason, and then we have [names of community partner orgs] not on the same page, something as simple as knowing who each of us are serving... there's no one fostering collaboration anywhere. (P 22)*

One judge identified the teams' meeting time impacted the ability for judges to participate, because they were in court. In addition, there was limited concerns expressed regarding the dominance of white women on the teams and how this impacted the teams' effectiveness. One Black participant stated:

> *Most of what I'm talking about, I can say, "Look around. I think it's been hard. If this side of the room is all [CW], and there's no Black managers. In this side I got the Black people, and then from [DV agency], and me and a couple other local organizations. Then what does that tell us? What does that say?"...when you go into the room and it's all white women, and you're trying to make a point from a vantage point of my lens, I'm not heard well. (P17)*

Additionally, there was doubt that the number of people attending the teams meeting was adequate to bring about multi-systems change. One participant described it like this "max that's 30 people meeting once a month, who have sustained contact with one another...that's a drop in the bucket to put it generously, when thinking about, like the sites in their entirety, and then the statewide system." (P3)

The second vein in how the implementation and management teams got in the way of the Approach is the experience that as mechanisms they were less effective at changing the practice

status quo. These observations of ineffectiveness of teams took many forms. First, participants described the lack of the teams' skill at effectively creating change to address racial justice with the child welfare/DV intersection. One participant illustrated this stating, "I felt like at times we talked a lot about racial stuff, and never really came up with a plan for it…nothing has really even come out of any of those conversations that I've been a part of" (P26). Second, participants described how resistant people were to change how they practiced and how this showed up specifically in the implementation and management teams, ironically the places that were tasked with being the guides/problem solvers for the Approach implementation. For example, one participant stated: "So when I'm listening to the grandiose conversations [at the management team meeting] …yet I'm thinking like when the meeting ends…I haven't been able to experience the work moving" (P22). Another participant added that one of reasons she thought it was hard for the implementation and management teams to be effective at creating practice change was the nature and culture of child welfare system, "They go out of their way to be so nice, and to have no conflict with each other, that they can't have real conversations," and "I think of the fear and being under siege, I don't know how else to say it, [it] creates a system that doesn't ever allow anyone from the outside, even try to support them." (P4)

The third vein of the implementation and management as barriers to the Approach implementation was the technical functioning of the teams, such as when they met, how organized they were, etc. This was expressed by many participants in a variety of ways, however a common thread expressed was the sense of "confusion," "miscommunication," as one participant described this impacted the desire to engage: "It's like, what - I couldn't really ever figure out like what was happening. And so I just - I just got really disengaged with the process…It was tough, it was really tough" (P27). Additionally, some participants wondered about the use of the implementation and management team time, illustrated here:

> *We never not have time to do what we've been given and from the talk about the actual meat of what they had in mind, but yet, I've already mentioned that everybody go around in a word… I'm sure there's, there's a theory, that, well, if you warm up crowd, and you get everybody to say something out loud, and they're gonna be more likely to say another thing out loud and communicate. I do understand that, at the same time, you only have so much time. You've got us here to have these. I mean, as attorneys, and the exact same thing goes for the caseworkers, everybody in this process, we have a limited time in our day and year. That was three days of an attorney's year, those hours in that room, with them…let's go! (P19)*

This experience of dysfunctionality was not fixed for all participants; some reported that it changed over time. As one participant reported:

> *I have to admit that every time I went to an implementation meeting or management meeting, I was confused and really didn't know what was going on. However, when [de-identified] started kind of leading the implementation team, it started to -- should be more clear, right, we had goals and action steps, so that shift became a positive shift. But before it was just like, why am I in this meeting? (P25)*

Coaching Got in the Way. Again, while coaching was identified by participants as supporting the Approach implementation, it was equally described as being a challenge (6/21 for both supported and got in the way). One way coaching was identified as getting in the way of the Approach implementation was the specific process of the coaching as not being a generative learning space. For example, one participant shared, "I felt like, sometimes, the coaching was just like, 'No, that's not going to work, like no, that's not going to work, no, probably not'" (P27),

leading the participant to feel unmoored with how to operationalize the Approach effectively.

> *One of the places that this came up the most, and it was voiced by both me and other people involved was with the coaching sessions...it felt like it was a point of frustration for almost two years, where the coaching sessions seem to be more focused on if I had to pick one of the principles, sort of the relational approach with people in the coaching sessions, rather than sort of pushing them (us) to get down to brass tacks. And having a framework to go over cases, and guide them in thinking differently about it, rather than just waiting to see what the participants had to say. (P8)*

Training Logistics Got in the Way. More people (9/21) identified challenges with the logistics of training (e.g., format, frequency, delivery, participation) than people who identified that the training supported (6/21) the Approach implementation. Participants described many challenges related to training logistics. One challenge identified was that the core Approach training, although it was a full two days, did not provide enough time to go deeply into the issues related to DV and child welfare. This challenge of depth and therefore the idea of increasing training opportunities, such as a "refresher," was illustrated by this participant who shared:

> *...perhaps what would have been helpful is to have more opportunities to go through the original training...and maybe build in some kind of refresher or... training, so okay, we did this at this time, let's go back to this particular piece, because with trainings like that, there was a lot that was done. So that's touching the surface. And there should be ongoing opportunities. Now, from what I understand child welfare gets a ton of training, but I don't think it's training necessarily that gets at the heart of domestic violence or that there are much more complex issues than one parent hurting the kid. (P4)*

Relatedly, another training logistics challenge to the implementation of the Approach was the lack of completeness of training all professionals working within the intervention sites. This challenge was generally expressed in the key informant interviews; however certain participants uniquely described how (in response to Covid-19) the QIC-DVCW virtual training format exasperated the challenge (given Covid-19 precluding in person trainings, the QIC-DVCW moved to virtual training platform that combined synchronous and asynchronous content delivery). One manifestation of the move to virtual was that it made tracking who has participated or not an unknown to other staff, as a participant explains here:

> *And then that was that and of course then people again came and went so fast that even if they, even if we got a virtual training, I don't know you know how that would have went... When it all started, we had a certain group of workers, and I thought at least one of them was still up there and she's still up there now had been trained so I started to work with her, but I'm then I'm I figured out she hadn't been trained. And then I'm like, "Okay well, that that didn't work." (P21)*

Overall, the training logistics, not the content, got in the way of the Approach implementation.

QIC-DVCW Implementation Itself Got in the Way. In addition to the specific TA categories of barriers to the Approach implementation, there emerged an overall barrier classified here as the QIC-DVCW implementation itself got in the way. Participants described three aspects of this barrier: (1) the sheer complexity of the Approach, (2) that the Approach isn't yet a "practice," and (3) the way the QIC-DVCW as a project conducted the implementation.

The first aspect, the sheer complexity of the Approach, was described by participants using expressions such as "it was a lot," "it is squishy," "challenging," "aspirational," "a little too theoretical," "too big," "too much." These expressions were used to describe the Approach Principles (six) and two frameworks (Protective Factor and Relational and Systemic Accountability Frameworks), the practice-based structure of the QIC-DVCW. Participants described that because of this complexity, it made putting the Approach into practice a challenge.

For example, one participant shared:

> *I know our team struggled with internally is like there was too much here. Like the principles, the protective factors, the – it was just like – and trying to think about like what does this mean for my individual case work, and what does this mean for this as like our system approach to cases. It was a lot to handle. (P13)*

Another participant reported how they needed more operationalization:

> *... more defined places or opportunities to draw out one of the protective factors or one of the principles and say, alright, here's this large thing, and here's what it means in your daily practice, here's how you can help your worker think about using this concept in their daily work, what does it look like to pay attention to connectedness, what does collaboration actually mean, and how do we develop that. Relational and systemic accountability framework, like that's a really beautiful title, but it's the hardest thing people have a challenge with, and it's squishy. For child welfare going up to do an interview with someone who's used violence, we don't have substance for them, or we didn't through the [QIC-DVCW] project. (P8)*

Another described, "So, how do you make this palatable and practical? And I feel like that is like kind of where we've fallen short a little...I mean, so like that is, like, the disconnect a little bit, it's a little too theoretical" (P12).

Related to this first aspect, the sheer complexity of the Approach, the second aspect of how the QIC-DVCW got it the way of the Approach implementation is best described by a quote from a participant, "The Approach is not a practice; it needs to become a practice" (P3). This participant went on to say how they learned how impactful this barrier is implementation:

> *...one of the most valuable lessons I'm taking away from all this, it's that it, it needs to be concrete and tangible, in order for it to be relevant. And it still might not be relevant, but like, you could have the best theory or matrix of frameworks and approaches in the world, but if it stays up here, and like, never gets brought down to the ground, like if we don't land the plane, like no one is going to care about it, because people don't have time to. (P3)*

Another participant described this barrier to Approach implementation, saying "...the struggle is that you have to take these abstract ideas and apply them to real people" (P19). Finally, another participant stated: "I think all of the sites were saying it, is like 'These principles sound nice, but how do you put it into practice? Like what does that look like?' Like how to apply – like it was just like – it was just too much" (P16).

The third and last aspect of how the QIC-DVCW got in the way of the Approach implementation by the way the implementation worked at a communication and structural level.

> *And so, they [the QIC-DVCW] changed language on things, and like, there were these tweaks that happened. And things that were created. That one, it was frustrating to have happen in the middle of us trying to do it, but two happened without engaging us about it...land on something and stop playing with it, like it's a research project, and*

changing some of the parameters in the middle of it isn't a good idea for the research, and it's frustrating for the people who are trying to apply it. So, if there was going to be some changes, or something developed, engage us because we're the ones out there doing it, but also at some point stop changing it. (P8)

Another participant shared frustrations in this response:

And for so long, we were messaged like, 'well, we [the QIC-DVCW] don't want to be prescriptive, well, we don't want to tell you what to do, you need to figure out how to make meaning out of it.' And like, that was a such a huge lost opportunity. I think people could have been brought things and like, reviewed them and tried them on and it could have been iterative in that way, but like, we spent so much time spinning around like meaning making. (P3)

Coaching Focus Groups

The aim of conducting focus groups was to understand the experience of the Approach coaching from the perspectives of the coaching cohorts, made up of supervisors and managers at the project sites. Ten focus groups, organized by project site cohorts, were conducted in June 2021 (See Methods section for more information). The following describes the key finding themes: (1) what was gained in the coaching space, (2) perceptions of supervision change, (3) perceptions of practice change, (4) perception of coaching related barriers that impeded Approach implementation, and (5) suggestions to improve.

What Was Gained in The Coaching Space

All focus groups described what they gained in the coaching space, which is conceptualized here as both the creation of emotional and structural environment present within the coaching sessions. Two main clusters surfaced in the descriptions of what was gained in the coaching space (1) time for peer support and relationship building, and (2) the tools, experience, and skills of the coaches.

Time For Peer Support and Relationship Building

Across all project sites and in all 10 focus groups, participants reported that one of the key benefits gained from Approach coaching was the time for peer support and relationship building. Although it was clear that in the role of supervisor and managers, there was less opportunity afforded them to meet with peers in a learning space, and therefore, there was something uniquely valuable about the time and space of the Approach coaching. This unique value clustered around two main constructs (1) shared experience with peers and (2) space for learning/not knowing.

Shared Experience with Peers. Approach coaching provided space for a shared experience with peers who were also responsible for implementing the Approach within their units or agencies. Again, given the role of the coaching participants of manager and supervisor, being in a space with peers – other managers and supervisors – the focus groups identified that hearing others' experiences and strategies to "adapt the Approach" was helpful and provided them with a "better grasp" on the Approach. Participants also described that part of the shared experience with peers was knowing that they shared struggles. This was identified as a "comfort" and "extra layer of support," knowing that "I am not the only one," "realizing we're all in it together, we all share very similar struggles." Given that coaching sessions duration (2019-2021) overlapped with Covid-19 and the national racial reckoning, focus groups expressed that the shared experience with peers provided by coaching sessions was reassuring stability during "unstable times." Additionally, this shared experience with peers was unique because they didn't need to be "in charge" of the coaching sessions, so they could enter into it fully as learners with their peers.

Space For Learning/Not Knowing. The second construct within the time for peer support found was that the Approach coaching provided space

for learning and not knowing. These two aspects, learning and not knowing, were connected in the coaching experiences, and at the same time discrete. First, the space for learning in the coaching sessions was described as the experience and permission to show up as learners; participants expressed in this way "we are here to learn and grow" and "we are trying to learn a whole other way to think about DV," which reflects focus group participants awareness and interest in the purpose of the Approach. This learning space was facilitated by open discussion, time for strategizing together about difficult cases, and how to apply the Approach in supervision to create practice level change. Second, the space for not knowing in coaching was described by focus group participants as it was a "less judgement space" and the feeling that "I'm not going to be judged if I talk about not knowing." Participants also expressed that space to hear peers talk about struggles was helpful and reassuring, "we are on the right track."

Tools, Experience, and Skills of the Coaches

The second of the key benefits gained from Approach coaching across all project sites and in nine of the 10 focus groups was the broad category of coaches' tools, experience, and skills provided. Focus groups identified that what the coaches brought to the coaching sessions in turn created opportunities for the coaches to learn and apply the Approach with their staff. This process of experience benefits in the Approach coaching sessions helped them self-regulate and model self-regulation and Approach knowledge and skills for their staff. Descriptions of these effective tools, experiences, and skills of coaches that facilitated learning and applying the Approach clustered into four buckets, presented in order of prominence in the findings: (1) concrete tools provided by coaches, (2) skill of "less judgment," (3) facilitation skills, and (4) coaches' prior experiences.

Concrete Tools, Resources, Informal Training Provided by Coaches. In eight out of the ten focus groups, and across all project sites, concrete tools provided by Approach coaches were identified as being helpful for learning and applying the Approach. Focus group participants listed these concrete tools explicitly: (a) Fidelity Checklist information and sharing, including time to complete during coaching sessions; (b) coaches set task to define a "goal/work for the month" and then report back; (c) giving homework assignments; and (d) identifying 1 or 2 questions to practice when meeting with staff. Focus group participants explicitly listed these concrete resources shared by coaches: handouts (supervisor questions and Protective Factors for Survivors framework); inviting coaches to an agency meeting, such as unit meetings. Lastly, these examples of areas of informal training and information provided by coaches were identified: implicit bias, managing stress and self-care, and how to model these skills for staff they supervise.

Skill of "Less Judgment." The skill of "less judgment possessed by Approach coaches was identified as being helpful for learning and applying the Approach in six out of the ten focus groups, but not across all project sites. This "less judgmental" stance identified by some focus groups connects directly to the prior finding that the Approach coaching provided a space for learning and not knowing. In part, focus groups that identified coaches as being less judgmental attributed the coaches as responsible, at least in part, for creating that learning space. As one participant illustrated the benefit of the coaches' less judgmental stance in this way, "So, that kind of helped me feel like, okay, great, it's okay for me not to know something. Often times, as supervisors were put in a position to always have the answer or know the answer to a situation." (FG 2)

Facilitation Skills. While less than half of the focus groups (4/10) identified facilitation skills of the coaches, it was one of the four buckets of findings clustered around what coaches brought that the supervisors and managers in turn used to learn and apply the Approach with their staff. Specifically, the focus group reported appreciation of coaches' skills of "agility" and "flexibility" when facilitating the coaching session. An example of the facilitation skill of agility was pivoting from

the agenda to what needed to be discussed based on the cohort's need. An example of flexibility was reworking the coaching meeting schedule to meet the needs of the cohort.

Coaches' Prior Experiences. Lastly, a handful (3/10) of focus groups reported appreciation for the prior experiences of the coaches and their perception that this experience was an asset to their learning and applying the Approach with their staff. Further, it was identified that the "outsider" perspective coaches processed brought insight into the local systems that was beneficial and "put things into perspective."

Perceptions of Supervision Change

Building on the previous finding that the coaching space created the individual/cohort level opportunity to learn to apply the Approach, all focus groups perceived a transfer of learning from their participation in Approach coaching to modeling and applying that learning with their staff. Two clusters of this transfer of learning process emerged from the focus groups: (1) Approach coaching applied to work with staff – the Approach what and why for direct practice and (2) permission and space to slow down. As this transfer of learning from supervisor/manager to staff was core to the design and decision made by the QIC-DVCW, this finding is particularly noteworthy, and quotes from focus group participants are included to illustrate more fully.

Approach Coaching Applied to Work with Staff. One aspect of this transfer of learning expressed by four of the focus groups was how they directly applied the Approach coaching to their work/supervision with staff. Specifically, the Approach coaching helped strengthen their knowledge of the Approach what and why for direct practice change that they could then apply in their work with staff, to help staff see how to apply the Approach in practice. One participant illustrated this here:

> *So, when you're in supervision, like asking them questions about like this particular protective factor and being able to like measure for those and assess for those specific things within a family. I know as a caseworker; I didn't have those things. So, it's more about like, this is what I think versus what I'm seeing, but being able to like draw it and connect it to the, like actual Approach itself, to like, to influence decision making, especially when it comes to working with individuals who use violence, because I think at least for me, I can't speak for other supervisors, but having this like preconceived notion that the only way to keep your family safe was to like separate them. So, being able to like combat that and look for other creative ways. That's, I think, the biggest impact that it had on my personal practice and my coaching of my caseworkers. (FG 6)*

Permission and Space to Slow Down. Three of the 10 focus groups expressed that the permission and space to slow down was one of the mechanisms that supported the transfer of Approach learning to their work with staff. Descriptions included this, "it gave me pause, like to take a minute to think, maybe more, to think about, like, if it's, you know, a domestic violence situation and it involves let's say a mom, it's usually the moms, um, you know, to think about, like, 'How do I give her agency? How do we kind of come approach her?'" (FG 6). Additionally, this permission to slow down learned with the Approach coaching space had direct transferability in how a supervisor applied the Approach when supporting staff working specifically with families of color:

> *When we had cases that we had incidences where this is a family of color, it took, it allowed me to have a conversation with my team to say, 'Guys, before we go out let's take a pause.' This is a man…he's been highlighted as a very, you know, aggressive man, in the state that we're in, how are you guys feeling about that? You guys are white going out, we would, we named it. And what we did, we*

pivoted in the sense of maybe we have somebody else of color to partner up with us to go out together. (FG 7)

Perception Of Coaching Related Barriers

Many types of barriers to coaching surfaced that focus groups described as impeding Approach implementation, including workforce, logistical (coaching scheduling), leadership buy-in, personal, Covid-19, and perceptions of relevance or purpose. Barriers to coaching were identified across all project sites and focus groups. Specific barriers clustered into the following: (1) coaching participation and (2) coaching session content and/or process.

Coaching Participation: "Kind of Like Going to the Gym"

The first barrier to coaching participation identified across all project sites and eight out of 10 focus groups was how coaching participation was a struggle and for some cohorts it waned over time. This coaching participation barrier clustered into two connected but distinct areas: (a) workload and time issues impediments, (b) logistical issues, (c) Covid-19 pandemic (re) defined participation.

Workload and Time Issues Impediments. Eight of the 10 focus groups, across all project sites, described that workload and time issues created impediments to coaching participation. These descriptions included statements about being "really busy," "our jobs get so overwhelming," feeling "pressure," and having competing "urgent meetings" at the same time as coach, and feeling "you are always out of time." One focus group participant used the metaphor it "kind of like going to the gym" to described what it felt like to participate in Approach coaching; they knew it would be good for them, but motivation to attend considering other competing priorities made it hard; described here:

> *And I have to say, I didn't always come thinking, I can't wait to do this…Yeah, I have to say, you know, I felt sometimes very burdened by it trying to count, even this morning, just in, you know, no knock against the coaches, they were great. I just, I think you just get so busy and you're so pressed for time, and it just felt like, you know, it would be like one more thing on my list, but then once I got here, that was when the shift would happen, because then I would realize, well, I really don't have to do another thing for this hour and a half, I can actually take a minute and check in with myself and my brain, my body, like what's going on, and so it would shift once I got here, the struggle to get here was real…Kind of like going to the gym. (FG 4)*

In addition, focus groups expressed that workload issues meant that those supervisors and managers who were supposed to be at coaching, were not. Illustrated here:

> *What screamed at me and still screams at me is that many of the supervisors in [office] became case managers because of not having enough staff. And so, they weren't able to go to coaching. They weren't able to complete the fidelity checklist. They were just running to put out fires. So, that was a huge barrier. I also think that there were some managers who were to be coached, and unfortunately, did not know how to prioritize this meeting in their busy schedule already. (FG 8)*

Covid-19 Pandemic (Re)Defined Participation. The second coaching participation barrier identified by six out of the 10 coaching focus groups, across all project sites, was the way the Covid-19 pandemic (re)defined participation and the experience of Approach coaching overall. Specifically, focus groups described the impact due to the shift from in person to remote meetings (i.e., Zoom) in March 2020 at the onset of the Covid-19 pandemic. As Approach coaching began in 2019 in person, with coaches traveling to the project sites, the shift to remote meetings was a change, but overall, all professionals, in every role including coaches, had some level of disruption

to their work lives (even when because of their "emergency worker" status required them to continue to meet families in person) and the personal lives, which rippled back to create more upheaval their work lives. The remote coaching meetings impacted the Approach coaching participation experience in multiple arenas, including not working with their individual learning preferences, their experience of the cultural norms of the cohort, and their perceptions of the coaching delivery losing focus.

At the individual level, some focus group participants acknowledged that remote settings do not work well for their learning style. This is exacerbated by the reality that for many individuals Covid-19 forced changes to remote work was the first time they had used platforms like Zoom or Teams to meet with other professionals and families they serve. For these individuals the learning curve was high and for some led to diminished effective learning experience at the Approach coaching session. An example of this experience was demonstrated here:

> *"I'm not blaming anybody that it's again Covid-19 but a big wrench in all of that. I don't learn well in certain ways. I know my gifts and talents and how I learn and receive information. So, I could have been stuck. So, if it felt like I wasn't participating when I should, it's because I was lost" (FG 2).*

In person Approach coaching for some felt different to some at the cohort level, specifically that cohort members were less attentive and committed to participating when coaching shifted to remote; as one focus group participant described, "It was much more of a sacred place, we were in person, there was much more of a commitment to not be interrupted" (FG 10). This description gets at the shared cultural experience of Approach coaching that was impacted when the sessions moved to a remote platform.

In addition, focus group participants described their perception that the Approach coaching lost focus, and this impacted their participation, as illustrated here:

> *…once it went virtual I, I have to say it fell off the tracks a lot. And I, and I for one, I don't know if I lost track of what the outcomes were, of what we're all trying to work towards, and I didn't really find the time as valuable as it could have been. That we are all displaced and doing virtual work, and trying to keep all of our collective staff together to do the work every day, especially from a child protective welfare agency, right? So, I'm all about outcomes, I'm all about my time not being wasted, and I, and I think there are some, there are sometimes when there was a lot of circular conversations about things that weren't really routed to what this study is about, and what this project was about. (FG 7)*

Logistical Issues. The third and last coaching participation barrier, in half of the focus groups and across all project sites, were logistical issues with the Approach coaching. These were issues around scheduling (e.g., having the right date, right Zoom link), the length and frequency of coaching sessions, and Zoom as a meeting platform when the Covid-19 pandemic forced in person meetings to move online. As an example of the issues around scheduling logistics, one focus group reported shared:

> *[Participant one]: So, that to me was very confusing sometimes to the different cohorts. And then like, I think like [one coach] would send out an invite and then like was it [another coach name], who would send on another invite and I was just boggled.*
>
> *[Participant two]: I'm right there with you [Participant one name], I can't tell you. And then on my screen what would come up at first will be QIC. And I'd be like, whoa, your coach, you're this, I'm like which QIC is it, I don't know. What am I here for today? (FG 2)*

As an example of the logistical issue of the length and frequency of meetings as a barrier to Approach coaching, another focus group reported:

> *...when we first started, we were doing in-person every month, I think, for two hours. And then, we got to – every other month, for two hours. And then, we went down to every month for one hour, which I felt was a little bit more helpful. When we were at the two-hour mark, it was a lot of chit chat... 'Play this ice breaker, and let's just have a general conversation about the weather and where you want to go on vacation', stuff like that. And so, it was almost like we would waste an hour of the time, and then, we would really just dive in deep for the next hour. (FG 3)*

Taken together, these logistical issues were a significant barrier to the Approach coaching for half of the coaching focus groups.

Coaching Session Content and/or Process.
The second barrier, identified by three of the ten focus groups, was the coaching sessions' content and process. This coaching content and process related barrier included descriptions that the Approach coaching did not always align with expectations, did not feel relevant, and was not concrete enough, with participants using words like "fuzzy" and "squishy." For example, in one focus group a participant described moving from a comparison to an intervention office, saying:

> *I came over and I was like, "I'm going to learn the thing they're doing," and I thought it was going to be like, "Step one, step two, step three, hear this new thing." And it was probably the first couple of months that I would, like on the side [ask one of my fellow coaching participants] be like, "What is it?" (FG 5)*

For another focus group participant, this lack of concreteness in content but also in process in the coaching sessions bled over into the experience of the Approach generally.

> *...we're all, you know, checking in with each other, and making sure we're okay, and everyone's feeling good, yadda, yadda, yadda, but okay, well, you know, that's not why we're here, that's not how this is supposed to work. So, anyway, you know, it's been a good experience, but as far as the blunt instrument aspect of what [CW] does, you know, we can be more informed, you know, when we have those individual interactions we can have it, but it's not a treatment plan, we never came up with a way to actually implement it. Not that I saw, I mean maybe I missed that session, but you know, we didn't come up with a way. (FG 7)*

They still experienced the QIC-DVCW as meaningful experience, however there a clear critique about the success of the implementation of the Approach.

See Section 10 for a summary and a discussion of the implementation study results.

SECTION 5. RESULTS: OUTCOMES STUDY

RESEARCH QUESTION: HOW DID SERVICE DELIVERY OUTCOMES CHANGE? (CONSEQUENT PRACTICE BEHAVIORS)

1.B.1. Enhanced Child Welfare Practice

1.B.1.1. Were there significant differences between the intervention and comparison sample in CW practice planning, decision-making, & practice addressing Protective Factors for Survivors framework?

Two data sources were used to answer this question, the Caseworker and Supervisor Self Survey, and the Adult Survivor Field Survey. The Case Record Review provided evidence of differences between intervention and comparison documentation of CW practice planning, decision-making, and practice addressing the Protective Factors for Survivors framework.

In the Caseworker and Supervisor Self Survey we observed **a time x intervention interaction where CW practice planning, decision-making, and practice addressing Protective Factors for Survivors framework increased over time at the intervention sites but not at the comparison sites (p = 0.002).** In addition, we observed the protective factor practice beliefs significantly correlated with how well-prepared a respondent felt about using the Approach with adult and child survivors (p = 0.001). See Table 39.

Reported estimates did not differ when controlling for training completion, coaching participation, respondent demographics, and respondent experiences. These controls were removed from the final model for parsimony.

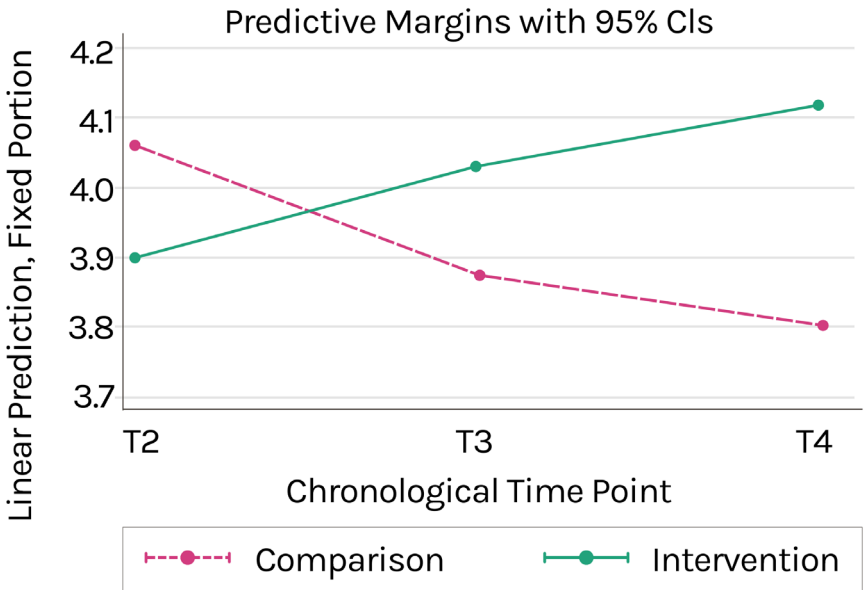
Table 39. (Self-Survey) Linear Mixed Model using Intent-to-Treat Child Welfare Sample Comparing Average Protective Factor Practice Behaviors between T2 and T4

	Protective Factors Practice Behavior		
	B (SE)	*p*	FMI
Group Assignment			
Comparison	reference		
Intervention	-0.16 (0.11)	0.137	0.338
Time			
2-Mo F/U (T2)	reference		
1-Yr F/U (T3)	-0.18 (0.14)	0.205	0.702
2-Yr F/U (T4)	-0.25 (0.12)	0.028*	0.548
Group X Time			
T2 x Intervention	reference		
T3 x Intervention	0.31 (0.17)	0.073	0.672
T4 x Intervention	0.47 (0.15)	0.002*	0.550
Prepared to Use the Approach with Family	0.29 (0.09)	0.001*	0.715

	Protective Factors Practice Behavior		
	B (SE)	*p*	FMI
Primary Role			
Caseworker	reference		
Supervisor	0.02 (0.09)	0.792	0.340
Site			
Allegheny County	reference		
Illinois	0.10 (0.11)	0.337	0.358
Massachusetts	0.22 (0.09)	0.022*	0.310
Random Effects Parameter (ID: Respondent)			
Constant	0.54 (0.05)		0.611
Residual	0.70 (0.04)		0.804

Notes. *N* = 431 unduplicated respondents; 1,293 observations over T2 to T4. Sample was imputed using MICE with 100 datasets.

Figure 18. (Self-Survey) Estimate of Protective Factor Practice Behaviors from T2 to T4 for Intent-to-Treat Child Welfare Samples by Project Sites



Notes. *N* = 431 unduplicated respondents; 1,293 observations over T2 to T4. Sample was imputed using MICE with 100 datasets. Significant differences between intervention and comparison sites were observed in change of protective factors practice behaviors between Time 2 and Time 4. Specifically, we observed protective factors practice behaviors increased over time within the intervention site while they decreased overtime within the comparison sites.

In Adult Survivor Field Survey, we observed no significant difference between the intervention and comparison sample in CW planning, decision-making, and practice addressing Protective Factors for Survivors framework. See Table 40.

Table 40. (ASFS) Adult Survivor Ratings of Child Welfare Caseworker Practice Behaviors with Adult & Child Survivors

Caseworker Practice with Survivors	N	Intervention Median (Min,Max)	Comparison Median (Min,Max)	Mann-Whitney U test	*p*
Planning, decision-making, & practice address protective factors framework [1 = not at all to 5 = extremely]	96	3.0 (1.0, 5.0)	2.2 (1.0, 5.0)	806.500	0.391
Support dealing with challenges faced by family	95	2.0 (1.0, 5.0)	3.0 (1.0, 5.0)		
Support adult/child survivors to believe that they can overcome challenges their faced with	96	2.0 (1.0, 5.0)	2.0 (1.0, 5.0)		
Support of adult survivor reaching out to other people for support about the domestic violence DV	96	3.0 (1.0, 5.0)	2.0 (1.0, 5.0)		
Provide useful services or resources for children	95	3.0 (1.0, 5.0)	2.0 (1.0, 5.0)		
Encourage adult survivor efforts to make positive change	96	3.0 (1.0, 5.0)	2.5 (1.0, 5.0)		
Practice is DV-informed, individualized, & dynamic [1 = not at all to 5 = extremely]	96	2.7 (1.0, 5.0)	2.6 (1.0, 5.0)	878.000	0.791
Help adult survivor develop realistic goals as part of case plan	96	3.0 (1.0, 5.0)	2.0 (1.0, 5.0)		
Frequency of incorporating adult survivor ideas into safety plan	96	2.0 (1.0, 5.0)	2.0 (1.0, 5.0)		
Frequency of trying to understand child's perspective on adult survivor's safety	96	2.0 (1.0, 5.0)	2.0 (1.0, 5.0)		
Frequency of agreeing with adult survivor about what is best for child	54	3.0 (1.0, 5.0)	3.0 (1.0, 5.0)		

Notes. *N* = 96; intervention *n* = 70, comparison *n* = 26. (1 = *not at all/never* to 5 = *extremely often)*

- Average score for "planning, decision-making, & practice address protective factors framework" was composed of 5 items that demonstrated a very good reliability at *a* = 0.928.
- Average score for "practice is dv-informed, individualized, & dynamic" was composed of 5 items that demonstrated a very good reliability at *a* = 0.931.

In the Case Record Review (noting again that this data was only from project sites IL and AC), we observed a lack of substantive differences in documentation of Protective Factors for adult survivors between intervention and comparison case files.

Across the files, we observed most case files reported on both risks and strengths observed for the adult survivor, which we tended to see as examples of nurturing parent-child relationships. Substantive differences in approach were not observed across intervention and comparison case files; often these statements were written in response to explicit prompts asking caseworkers to report on risks and strengths for different

family members. Table 41 provides a detailed breakdown with example documentation language for varying conditions. Strengths and risks were typically oriented around documentation of the adult survivor's ability to maintain safety of children, which aligns with the purpose of the documentation to build a case for parent progress towards child welfare goals. For example:

Appendix A "Mother appears to be bonded with the children and protective of the children. Mother ensures all the children's needs are met" (Allegheny County, Comparison)

Appendix B "M puts children's needs first" (Illinois, Intervention)

Appendix C "M lacks supervision and protective skills to care for the children to ensure safety." (Allegheny County, Comparison).

Table 41. (CRR) Documentation of Adult Survivor Strengths and Risks within the Case File

Variable	Intervention n = 14 n (%)	Comparison n = 14 n (%)
Strengths Only	3 (21%)	5 (35%)
Risks Only	2 (14%)	2 (14%)
Both Strengths & Risks	8 (57%)	6 (43%)

In some cases, Case Record Review documentation positioned adult survivor Protective Factors that offset initially identified safety risks: "M appears to still be active in her substance abuse addiction. M tested positive for illegal substances after being released from the hospital … M is smart, caring, compassionate, dedicated, motivated as she wants to do better for her son, loves her baby and committed to her baby, kind, strong bit of empathy for herself and others … accomplished a lot of things when she's put her mind to it, including recovery in the past, has completed her undergraduate degree and has the ability to stick with a task…" (Illinois, Intervention). Other examples demonstrate how identified safety concerns were resolved using family strengths and planning with the survivor: "The 1st floor of the home has become unorganized again, but mother explains that this is due to the high stress of having minors home all the time due to Covid-19. The minors' rooms continue to lack cleanliness and mother reports she is trying to get them to but that this is difficult…The family has reached a consensus that the old way of managing the household in regard to routines, cleanliness, and finances, so a new plan is needed to keep minors safe." (Illinois, Comparison).

Within the case files, one site had a form that prompted workers to report adult survivor strategies that can be supported or strengthened to protect children. The evaluation team observed a mixture of documentation across both intervention and comparison sites; that being said, documentation was typically brief and decontextualized across case files. Typically, caseworkers just documented a simple "No" without any further context (Illinois, Intervention & Comparison, Domestic Violence Screening). More supportive comments were still limited in scope and decontextualized: "Yes. Mother has called the police." (Illinois, Intervention, Domestic Violence Screening).

The Case Record Review found that approximately 57% of intervention cases and 57% of comparison cases documented the nature of parent-child relationships. The exact nature of the parent-child relationships varied by specifics related to the case and including descriptions that were

nurturing, conflictual, and/or distant. When documented, relationships between parent and child were documented in ways that ranged from simple reporting of visitation logistics to more extensive documentation of encounters. More detailed but still general documentation of behavior was present in several cases with a focus on healthy attachment and supportive behaviors: "CW observed a loving, secure attachment between C and M. C is able to explore and interact with CW during the visit but continues to utilize M as a safe base." (Allegheny County, Intervention). When relationship was rooted in conflict, case files demonstrated equal amount of detail describing interactions: "Minor talks back to Mother terribly and Mother does not seem to appropriately discuss things with minors. It has been reported that minor is a very angry child and is aggressive." (Illinois, Comparison).

1.B.1.2 Were there significant differences between the intervention and comparison sample in measures of CW practice planning, decision-making, & practice addressing RSA Framework?

Two data sources were used to answer this question, the Caseworker and Supervisor Self Survey, and the Adult Survivor Field Survey. The Case Record Review provided evidence of differences between intervention and comparison documentation of CW practice planning, decision-making, and practice addressing the RSA framework. The Coaching Focus Groups provided additional insight into the perceived changes in the intervention sites. While the Strong Fathers focus groups provided perspectives from men who have used violence about their experience with the CW system.

In the Caseworker and Supervisor Self Survey, **we observed a time x intervention interaction where RSA practice behaviors increased over time at the intervention sites but not at the comparison sites ($p = 0.021$).** In addition, we observed the RSA practice beliefs significantly correlated with RSA practice behaviors ($p < 0.001$). Reported estimates did not differ when controlling for training completion, coaching participation, respondent demographics, and respondent experiences. These controls were removed from the final model for parsimony. See Table 42.

Table 42. (Self-Survey) Linear Mixed Model using Intent-to-Treat Child Welfare Sample Comparing Average RSA Practice Behaviors between T2 and T4

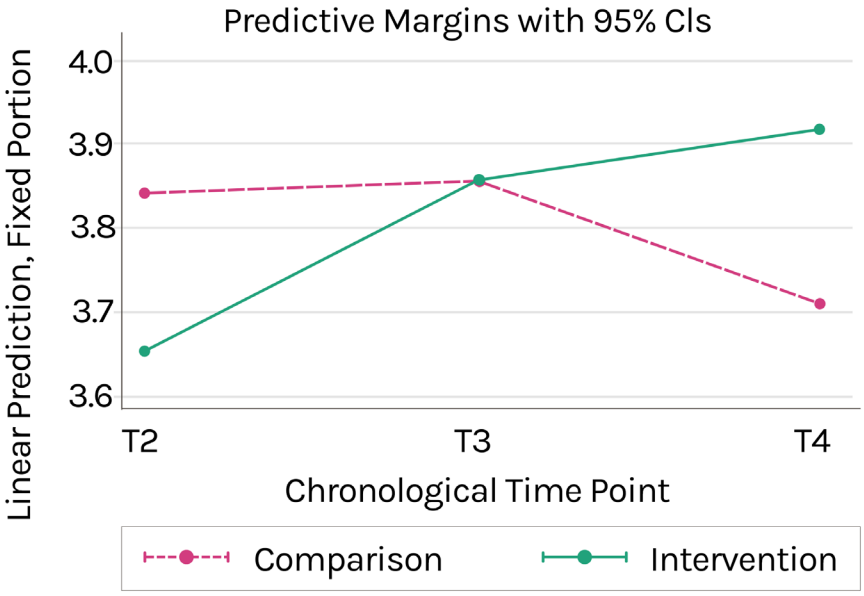
	RSA Practice Behavior		
	B (SE)	*p*	FMI
Group Assignment			
Comparison	reference		
Intervention	-0.19 (0.13)	0.145	0.428
Time			
2-Mo F/U (T2)	reference		
1-Yr F/U (T3)	0.01 (0.14)	0.917	0.589
2-Yr F/U (T4)	-0.13 (0.13)	0.315	0.539
Group X Time			
T2 x Intervention	reference		
T3 x Intervention	0.19 (0.19)	0.332	0.680

	RSA Practice Behavior		
	B (SE)	*p*	FMI
T4 x Intervention	0.39 (0.17)	0.021*	0.575
Belief score about RSA as part of job	0.38 (0.10)	< 0.001*	0.736
Primary Role			
Caseworker	reference		
Supervisor	0.10 (0.10)	0.291	0.317
Site			
Allegheny County	reference		
Illinois	0.23 (0.12)	0.070	0.444
Massachusetts	0.31 (0.11)	0.005*	0.405
Random Effects Parameter (ID: Respondent)			
Constant	0.56 (0.07)		0.760
Residual	0.78 (0.05)		0.857

Notes. *N* = 431 unduplicated respondents; 1,293 observations over T2 to T4.

Sample was imputed using MICE with 100 datasets.

Figure 19. (Self-Survey) Estimate of RSA Practice Behaviors from T2 to T4 for Intent-to-Treat Child Welfare Samples by Project Sites



Notes. *N* = 431 unduplicated respondents; 1,293 observations over T2 to T4. Sample was imputed using MICE with 100 datasets. Significant differences between intervention and comparison sites were observed in change of RSA practice behaviors between Time 2 and Time 4. Specifically, we observed RSA practice behaviors increased over time within the intervention site while they decreased overtime within the comparison sites.

In the Adult Survivor Field Survey, we observed no significant differences in RSA-related practices between respondents served by intervention and comparison sites. See Table 43.

Table 43. (ASFS) Adult Survivor Ratings of Child Welfare Caseworker Practice Behaviors associated with RSA Framework

Planning, decision-making, & practice address RSA framework	N	Intervention n (%)	Comparison n (%)	X^2(df)	*p*
Ever asked if adult/child survivors feels safe?				0.035 (1)	0.851
No	38	28 (40.0)	10 (38.5)		
Yes	57	41 (58.6)	16 (61.5)		
Declined to respond	1	1 (1.4)	0 (0.0)		
RSA practice behaviors [1 = *none of the time* to 5 = *all of the time*]	**N**	**Median** (Min, Max)	**Median** (Min, Max)	**Mann-Whitney U test**	***p***
Frequency of taking action to help adult/child survivor feel safer.	57	4.0 (1.0, 5.0)	4.5 (1.0, 5.0)	303.000	0.637
Frequency of holding PUV accountable by developing goal that they must complete in case plan.	87	1.0 (1.0, 5.0)	1.0 (1.0, 5.0)	579.000	0.144

Notes. *N* = 96; intervention *n* = 70, comparison *n* = 26.

The Case Record Review provided evidence of differences between intervention and comparison documentation of CW practice planning, decision-making, and practice addressing the RSA Framework. Two additional data sources described the construct of measures of CW planning, decision-making, and practice addressing RSA Framework within the intervention groups, those were the Final Coaching Assessment and the Strong Fathers Focus Group.

In the Case Record Review, we examined the documentation of accountability aligning with the RSA Framework by intervention and comparison groups. First, the evaluation team did not observe cases open in the name of the person who uses violence, unless this person happened to be the mother of the child. One of the sites explicitly communicated that it is standard protocol within their system to open the case under the name of the mother of the child, regardless of status; this did not change during the duration of the intervention. Larger scale policy change would be required to alter documentation at this level.

Second, identification of the person who uses violence was not always initially clear within early case documentation. Approximately 79% of intervention cases and 71% of comparison cases clearly identified the person who uses violence. There were a handful of cases where the person who uses violence was unclearly identified due to "concerns of IPV and drug use by both parents" (Allegheny County, Comparison, Investigation Summary). In most case files, we observed this identification was resolved over time with use of domestic violence assessment services and more in-depth understanding of family dynamics.

Overall, we observed a relatively high proportion of engagement of the person who uses violence within the service plan, if they were clearly identified within the case file (when the PUV was identified on the case plan, the case

plans auto-populated individual-specific case plan fields); this did not substantively differ between intervention and comparison case files. Table 44 provides a detailed breakdown of the identification and engagement proportions by intervention group. Several of the case files across both intervention and comparison sites demonstrated the person who uses violence actively engaging in services and a part of the service plan: "F started attending M/H … He is currently participating in mental health programs … in Individual work weekly … D/A evaluation and D/A treatment is not needed at this time." (Allegheny County, Intervention, Family Service Plan). There were also cases where caseworkers provided service referrals to the person who used violence, but the person who uses violence did not engage with the caseworker: "F did not show up … for an assessment. No contact with CYF, despite attempts to engage." (Allegheny County, Intervention, Family Services Plan). We observed similar types of documentation across intervention and comparison offices for both partnership sites.

Table 44. (CRR) Identification and Engagement of PUV by Intervention Group

Variable	Total N = 28 n (%)	Intervention n = 14 n (%)	Comparison n = 14 n (%)
PUV Identification			
Not identified within file	4 (14%)	1 (7%)	3 (21%)
Unclear identification	3 (11%)	2 (14%)	1 (7%)
Clear identification	21 (75%)	11 (79%)	10 (71%)
PUV Engagement			
No Engagement	6 (21%)	3 (21%)	3 (21%)
Contact with No Services	3 (11%)	2 (14%)	1 (7%)
Contact with Services	19 (68%)	9 (64%)	10 (71%)

Notes. PUV=Person who uses violence.

When compared to reporting within the Adult Survivor Field Survey, in the Case Record Review we observed individual caseworker reports of identification and subsequent engagement with the person who uses violence was lower than what was observed within the case files. This is partially explained by high caseworker turnover; several of the cases had multiple caseworkers assigned to the case over time and engagement with the person who uses violence may vary over the course of a case and across workers.

Finally, the case records illuminated several ways that caseworker documented use of protective orders and of domestic violence incidents. One project site had a specific tool that asked about potential risk for harm. Documentation of protective order was often unclear; however, we were able to consistently code (a) if protective orders were present and (b) whether the order was externally encouraged by a court mandate or child welfare recommendation or was survivor-initiated. Refer to Table 45 for details. In sum, use of protective orders was similar across intervention and comparison sites; however, case files aligned with intervention sites identified protective orders being survivor-initiated with a higher frequency than case files aligned with comparisons sites.

Table 45. (CRR) Protective Order by Intervention Group & Source of Initiation

Variable	Total N = 28 n (%)	Intervention n = 14 n (%)	Comparison n = 14 n (%)
Any Protective Order Documented	13 (46%)	7 (50%)	6 (43%)
Externally Encouraged/Mandated	5 (18%)	2 (15%)	3 (21%)
Survivor-initiated	7 (25%)	5 (36%)	2 (14%)

In the Coaching Focus Groups, CW practice change with the PUV did surface across all project sites, with eight out of 10 focus groups describing how they observed practice change with people that use violence. However, there was variability in how extensively this change occurred. Few focus groups described clear certainty that the change was extensive, expressing statements such as "So, I'd say that definitely changed" while other cohorts used more qualified descriptors such as "a little bit" when describing the change. For example, here are focus group descriptions of the change being on the "little bit" end of the scale:

> *I would say it brought up the question more of how to work with the perpetrator of violence, although I can't say that it necessarily changed the way that we do...depending on the history of the people involved, and there's a lot of stuff that probably goes into it and, you know, just having the mindset that we've had for so long and trying to change it, but it did at least make us talk about it a little bit more. (FG 4)*

Another "a little bit" example from another focus group was

> *...incorporating the father a little bit or the, whoever the perpetrator is, I don't want to say father. Father and mother a little bit in regards to, you know, what kind of parent they want to be, and the impact that their volatility, and is having on the family at that point in time. So, a little bit more engagement on that end. (FG 7)*

Across all project sites, but not all focus groups, we heard clearly that it was **the Approach's focus, as reiterated during the coaching sessions, that helped create the change or the awareness that change in approaching people who use violence was needed**. This was described in different ways including the Approach helping to use a strengths approach, and backing off from seeing the person who uses violence as one dimensional (only as a risk), including changing from "batterer" language to PUV. This was illustrated here:

> *...it was more of – instead of just having these open discussions, "Oh, yeah, I know he's an offender," or like, "Yeah, let's continue work with him. What services has he completed?" It was more like – it gave me more the ability to drill down and really focus what really changed. It was really looking at the strength-based aspect of it, and how to utilize those strengths to help mitigate issues, that we're having. So, I think, instead of just looking like at service - what service is going throughout them, how can we work with them, but also, having – being able to have that open dialogue with them too because realistically, two and a half years ago, if you would have asked me, "Okay, how do you work with DVs people?" We would just go into a meeting and say, "Okay, you got to leave him. He offends against you, you've had X amount of police contact, this won't work, you can't get your kids home." So, I think having that open – the realization, that you can, and it could work, you just need to be able to dive deep into them. (FG 3)*

In summary, while identification of practice change with people that use violence was described by the coaching focus groups, this type of practice change was still a learning edge for many at the end of the project, as was reported in one focus group, "And that's another thing too that I kind of struggle. And I'm working on it because we always think of the abuser as the male, and so that's kind of been a shift for me as well, so it's just a lot of this awareness" (FG 1).

Additionally in the Strong Fathers Focus Groups, there was range of experience with caseworkers' practice with them (i.e., as PUV) across the focus group participants from "happy" to so poor that the father was taking legal action. Those (two participants in FG2) that were happy with DCF shared descriptions of being helped, being referred to programs, and having good communication with their caseworker. One of these participants described that as a man who was on parole, he was grateful that DCF was working with him, giving him custody of his youngest child. He reported: "DCF has helped me so much going through the programs, different programs the DCF has offered, I mean, has assisted me so, so much. So I'm extremely happy that they are still in my situation, because they've helped me so much" (FG2, P5). The other participant stated, "I'm very happy with the way they are getting the status and talk to me and listen to me and probably get those details properly written in a notice, get back to the court" (FG2, P2).

In contrast the Strong Fathers Focus Group participants who described being happy, others expressed that their experience with DCF and their caseworker specifically had been fraught with uncertainty and misaligned expectations. One participant shared he feels like "the end zone moves" giving him the experience that he never knows where he stands in relation to his case. This experience was echoed by another participant who used the expression "there always another concern." A different participant described his experience with his caseworker as a "two faced interaction," but one that resulted in him being labeled inconsistent:

> *...they're like, oh yeah, I totally understand, I got it blah, blah, blah, whatever, whatever. Cool. But then like at the next court hearing or whatever it is not that they're using it against me...I had to cancel a couple of visits with my son, because a couple of people who were close to me ended up with Covid-19. And I was in close contact, if not the same room talking to them and stuff and I was labeled as inconsistent. (FG, P1)*

A second discrete caseworker issue that emerged from multiple Strong Fathers Focus Group participants was their experience that their caseworker cannot make decisions; they always have to talk with supervisor. One participant described this phenomenon, with the consequence being delayed reunification with his family for reasons he did not understand:

> *We've had the same caseworker for over two years, on and off. It seems to me that our caseworker is only someone who collects information who makes no decisions. So, as I've pleaded, talk to, explained to the caseworker, it's always taken up to his supervisor, and their legal team and their clinical team, which is this whole nebulous of people, and then I always come back to, well, the meeting didn't go the way that I thought it would go. (FG2, P1)*

Another participant built on that saying:

> *I'm experiencing a lot what [de-identified] has gone through where your caseworker can't make a decision on their own, it's almost like they are little puppets. Every conversation we have, every email I have, I have to get back to you, let me talk to my supervisor. Okay, why can't you make a decision? (FG2, P3)*

Having to wait for or wade through the decision-making process caused participants to feel

unsupported by their caseworker.

Some of the Strong Fathers Focus Group participants with dissatisfaction expressed that "DCF has so much power," this power kept them from their goals of being reunited with their kids (and partner in some cases). One participant described that analysis like this:

> *DCF has so much power, that is absolute ridiculous. When this whole thing first started, I'm an email junkie, I will write an email like crazy. And it just seemed like the more emails I wrote, the more like, they were doing the bare minimum, all right, bare minimum. I went from having three, four visits, I was having like two or three phone calls a week, then all of a sudden, they dropped it down to the bare minimum. One phone call a week, 10 minutes, and one hour a week, so for a total of four. And then when we talk about the action plan, all right, well, we're supposed to get more time more this more that, like, why can't we go back to this? (FG2, P3)*

One Strong Fathers Focus Group participant was so dissatisfied with his experience with DCF, and how much power they have, that he got legal involvement to address that his "parental rights" were being violated:

> *Well, I really don't have a lot of high things to say for DCF…I've actually tried getting a lawsuit against them… DCF would never respond back to me, I always had to email my lawyer, and my lawyer would email her, and then I would get a response. And then by the time that would come in, then everything was too late or had to be processed again. They have very good intentions behind why DCF is there, I personally think that they have a little too much power under certain circumstances…I did a video Zoom chat with my lawyer, and she admitted right there to my lawyer about violating my parental rights. (FG2, P4)*

Strong Father focus group participants reported that case requirements (or "suggestions") included (in order of prevalence) Strong Fathers, therapy, and drug treatment evaluation. It is noteworthy that no participants mentioned being asked to attend a battering intervention program (nor did anyone mention they did so at their own initiative). Additionally, while some participants identified that the Strong Fathers program was a case requirement, it was not in others; this was pointed out one participant, as an example how they went beyond with the goal of demonstrating their effort to DCF so they could be reunited with their children and wife.

While participants did identify these specific requirements made to them, they also expressed the desire for more clarity about what really needs to be done. One participant described:

> *…it's just nebulous, it's like, well, if you have concerns, then add something to the action plan, and I'll do it, I'm more than happy to comply, and it's not just checking boxes, if there's something else I need to learn, if there's something else I need to grow in, if there's something else that you guys need to see me do so that you feel comfortable bringing our kids home…And the DCF lawyer and our social worker, are not even on the same page, the DCF lawyer is like, still like oh, well, we still have concerns where as the DCF social Worker tells me, I want to give you the kids back today. You work for the same organization, how can you not figure this out. (FG2, P1)*

In addition to this desire for more case driven expectations, participants who had these difficulties also expressed frustrations about the caseworker communication and relationship overall. One participant described his experience with his caseworker's communication about case requirements:

...she's been okay, been polite, definitely be a little pushy with oh, you got to do this, you got to do the group and sometimes they can be like [de-identified] had said, they can make things look bigger or worse than they actually are...they wanted me to start right away and at the moment. (FG 1, P2)

1.B.1.2.a. Were there significant differences between the intervention and comparison sample in CW practice early and ongoing identification and assessment of domestic violence?

In the Family Survey, the data source used to answer this question, we observed no significant difference between the intervention and comparison sample in measures of CW early and ongoing identification and assessment of domestic violence. For the Family Survey results, see Table 46. In the Family Survey intervention group, the top evaluation (of PUV risk toward AS) approaches at Time 2 included: (1) use of adult survivor's self-reports, (2) used criminal records or law enforcement reports, and (3) used report of treatment providers. In the comparison group, the top evaluation (of PUV risk toward AS) approaches at Time 2 included: (1) used criminal records or law enforcement reports, (2) used adult survivor's self-reports, and (3) used reports of child/family members.

Table 46. (Family Survey) Caseworker Estimate of Frequency of PUV Risk Towards Adult Survivor in the Past 6 Months

Risk Assessment Conducted	Intervention Group			Comparison Group			r (p) between pre-test & post-test
	n	Pre-test M (SD)	Post-test M (SD)	n	Pre-test M (SD)	Post-test M (SD)	
Pre-test observed	80	59.1 (37.4)		69	63.3 (34.3)		
Post-test observed (9 Mo F/U)	46		19.5 (36.5)	32		15.9 (31.8)	
Both pre-test & post-test observed	26	64.3 (39.6)	19.6 (34.6)	21	58.6 (37.6)	12.7 (31.0)	0.127 (0.572)
Analytic sample	174	55.5	29.5	139	61.4	36.1	

Notes. *N* = 313 unduplicated cases. Caseworkers reported how they conducted a risk assessment with the PUV on a slider scale from **0 (Never) to 100 (Always)**. Due to planned missingness design, not all items were answered across cases resulting in variation in complete cases observed by item. Analytic sample used Multiple Imputation for Chained Equations (MICE) using the PCAux package in R; pooled means across 100 imputed data sets are reported for the analytic sample.

In the Case Record Review, which provides case documentation context by intervention and comparison groups, no differences in the reasons for opening cases were observed, with more than 50% in both intervention and comparison being opened for DV concerns, see Table 47.

Table 47. (CRR) Reason for Case Opening by Intervention Group

Variable	Total N = 28 n (%)	Intervention n = 14 n (%)	Comparison n = 14 n (%)
Neglect			
Domestic violence concerns	15 (54%)	8 (57%)	7 (50%)
Mental health concerns	2 (7%)	1 (7%)	1 (7%)
Substance misuse concerns	12 (43%)	6 (43%)	6 (43%)
Other concerns	1 (4%)	1 (7%)	0 (0%)
Physical Abuse			
Domestic violence concerns	4 (14%)	2 (14%)	2 (14%)
Mental health concerns	0 (0%)	0 (0%)	0 (0%)
Substance misuse concerns	1 (4%)	0 (0%)	1 (7%)
Other concerns	0 (0%)	0 (0%)	0 (0%)

Notes. Categories are not mutually exclusive; cases can be opened for several reasons.

In the Case Record Review, documentation of violence was also variable across case files. Five (36%) of the intervention case files did not document any type of violence, and four (29%) of the comparison case files did not document any type of violence. When documentation was present, case files from both intervention and comparison sites focused primarily on documentation of physical violence or threats of physical violence. Table 48 provides description of case files that demonstrated clear documentation of domestic violence incidents by type of violence.

Table 48. (CRR) Documentation of Type of Violence by Intervention and Comparison Group

Variable	Total N = 28 n (%)	Intervention n = 14 n (%)	Comparison n = 14 n (%)
Any type of DV documented:	19 (68%)	9 (64%)	10 (71%)
Economic	1 (4%)	1 (7%)	0 (0%)
Emotional	1 (4%)	1 (7%)	0 (0%)
Physical	16 (57%)	9 (64%)	7 (50%)
Sexual	2 (7%)	0 (0%)	2 (14%)
Stalking	1 (4%)	0 (0%)	1 (7%)
Threats of Violence	8 (29%)	3 (21%)	5 (36%)

Notes. Categories are not mutually exclusive; multiple types of violence may be documented within a case file.

1.B.1.2.b. Were there significant differences between the intervention and comparison sample in CW practice survivor-informed engagement, accountability, and support for person using violence?

The Family Survey was the data source was used to answer this question. In the Family Survey, using the analytic sample (*N* = 313 using MICE), intervention PUV contact ratings at Time 2 were significantly lower than comparison PUV contact frequency on average (b = -5,48, SE = 2.42, *p* = 0.024), controlling for baseline contact and project site (see Table 49). The observed treatment effect was extremely small for between group differences (partial eta^2 = 0.002). There was also a significant interaction observed where intervention contact frequency was more likely to converge with comparison contact ratings as baseline contact frequency increased (b = 0.40, SE = 0.16, *p* = 0.013). The interaction effect was small (partial eta^2 = 0.023).

Table 49. (Family Survey) Caseworker Estimate of PUV Meetings

How Often CW met with PUV	Intervention Group			Comparison Group			*r* (*p*) between pre-test & post-test
	n	Pre-test M (SD)	Post-test M (SD)	*n*	Pre-test M (SD)	Post-test M (SD)	
Pre-test observed	129	8.7 (10.7)		112	10.5 (12.1)		
Post-test observed (9 Mo F/U)	68		7.5 (11.9)	48		6.6 (11.1)	
Both pre-test & post-test observed	41	5.9 (7.7)	7.5 (11.2)	32	10.9 (13.4)	6.5 (11.4)	-0.138 (0.248)
Analytic sample	174	9.2	13.07	139	10.9	14.7	

Notes. *N* = 313 unduplicated cases. Caseworkers reported how often they met with the PUV on a slider scale from 0 (Never) to 100 (Always**)**. Due to planned missingness design, not all items were answered across cases resulting in variation in complete cases observed by item. Analytic sample used Multiple Imputation for Chained Equations (MICE) using the PCAux package in R; pooled means across 100 imputed data sets are reported for the analytic sample.

1.B.1.2.c. Were there significant differences between the intervention and comparison sample in the extent the adult survivor was engaged by CW relative to the person who used violence?

The Family Survey was the data source was used to answer this question. The Adult Survivor Interview describes participants' perceptions related to the construct of the extent the AS was engaged by CW relative to PUVs.

Using the Family Survey analytic sample (N = 313 using MICE), no significant treatment effect was observed for PUV meetings relative to AS meetings, all else being equal. See Table 50.

Table 50. (Family Survey) Caseworker Meetings with Person Using Violence Relative to Meetings with Adult Survivor

How Often CW met with PUV compared to AS	Intervention Group			Comparison Group			r (p) between pre-test & post-test
	n	Pre-test M (SD)	Post-test M (SD)	n	Pre-test M (SD)	Post-test M (SD)	
Pre-test observed	83	35.6 (23.4)		79	37.5 (24.7)		
Post-test observed (9 Mo F/U)	32		39.6 (34.0)	21		34.0 (27.8)	
Both pre-test & post-test observed	21	38.1 (28.4)	33.7 (32.5)	13	35.1 (24.8)	33.9 (30.7)	0.227 (0.265)
Analytic sample	174	35.6	44.4	139	37.9	50.6	

Notes. *N* = 313 unduplicated cases. Caseworkers reported how often they met with the PUV compared to the adult survivor on a slider scale from **0 (Much less often) to 100 (Much more often)**. Due to planned missingness design, not all items were answered across cases resulting in variation in complete cases observed by item. Analytic sample used Multiple Imputation for Chained Equations (MICE) using the PCAux package in R; pooled means across 100 imputed data sets are reported for the analytic sample.

In the Adult Survivor Interviews, participants expressed doubt that CW can really do anything to change PUV or to help her. Overall, 14 participants when describing the PUV and construct of CW "helping" to change the PUV or to help her in the context of DV, identified some way that CW did not help. Most often, these participants described that CW could not or would not help/support her in regards to the DV/CW intersection in which the PUV played a central role. Additionally, three participants described that CW didn't help the PUV or her. However, there were some outliers, which are important to highlight, considering the intervention.

To illustrate <u>can't help PUV/can't help her:</u>

> …she did try to help him with giving him counseling for his alcoholism, um, she did multiple different things to try to help. He couldn't be helped in the end, but she did her best to try, and so she ended up working more with me, which I feel that he kind of just got kind of off the hook at the end, he didn't really have to **account** for anything after. (Coriander)

To illustrate <u>can't help her:</u>

> I was trying to get away from my ex which was my child's father at that time, and nobody would kind of help me. They just kind of told me to go to domestic violence counseling, and he wouldn't get out of my house. I actually had to force him out of the house by calling cops on him and having the cops break into my house to go arrest him. So that was like the only way that I could like get away from him. (Drorit)

Another participant describing how CW can't help her within the DV/CW context:

> You can't expect me to be a [fair person] when I'm living with my abuser. I'm trying to keep myself safe, keep my abuser happy. Make safety plans. I'm dealing with my kids and you just can't or why can't you just leave and go like. Okay, what can you do to help me? (Charlee)

In fact, for a few participants, they worried that CW might believe the PUV's excuses and blame of the survivor.

While almost half of participants shared ways that CW couldn't help, there were some that did describe help to the PUV specifically, which will be

reported here. One participant described:

> *Yeah. he's been getting through [group classes]. I mean, that they also put - I don't want to use the word, but for us to work everything now? For him...Yeah, they send him referral for substance abuse to check. And he's going to get some classes, he's going to go in, he's going to get parenting classes (Jimena)*

Another participant reported:

> *Interviewee: Yeah, so I did domestic violence classes.*
>
> *Interviewer: Okay.*
>
> *Interviewee: It was a 10-week class.*
>
> *Interviewer: A 10-week class.*
>
> *Interviewee: Yeah, it was a 10-week class.*
>
> *Interviewer: Okay. And was your husband required to do anything?*
>
> *Interviewee: Yeah, he was required to do it as well.*

One of the important outliers was Lily, who described a practice change based on her two experiences of CW involvement's approach to engaging her ex-partner. She used the expression "completely changing their approach":

> *Interviewee: I guess the - so, what really stands out to me, I think, would be the second time around, we got the same caseworker, and she's completely changing their approach. She said, whereas before like they don't feel like we're a high-risk family, so we would just get the one-month phone call in - and anyway, the second time around she said she's gotten her supervisor involved. And her supervisor is a man, so she has him in the conversation with my son's dad. She just feels like he just - he never would answer the phone before, and they would just not really do anything about it, as long as I answered, and they had contacted me it was fine. But they didn't - so now, they're kind of approaching it in a more, like, aggressive way, I guess.*
>
> *Interviewer: Uh-huh.*
>
> *Interviewee: You know, like their approach the first time was like, "We don't tell him he's the abuser, we try to hear him and listen to him, and hear his side so that we can get on a good side with him. But at this point, they're like being very direct with him, so.*
>
> *Interviewer: And that's been helpful to you?*
>
> *Interviewee: It's new, so they've - we've only had one - they've only talked to him one time since they got reopened, so, we'll see.*
>
> *Interviewer: Yeah.*
>
> *Interviewee: We will see.*
>
> *Interviewer: It sounds like maybe they are doing things to hold him accountable, that they may have ignored in the past?*
>
> *Interviewee: Right.*
>
> *It is important to note, the participant is tracking whether this completely new approach with the holding the PUV accountable is going to last, as she says, "we will see."*

1.B.1.3. Were there significant differences between the intervention and comparison sample in DV-informed, individualized, and dynamic CW practice?

The Adult Survivor Field Survey was the data source used to answer this question. Additionally, the qualitative findings from the Adult Survivor Interviews and the Case Record Review findings are also relevant to the understanding the construct of DV-informed, individualized, and dynamic CW practice.

In Adult Survivor Field Survey, we observed no significant difference in measures of DV-informed, individualized, and dynamic CW practice between the intervention and comparison sample. See Table 40.

In the Adult Survivor Interviews, the participants expressed that the DV relationship most prominently influenced their CW experience. The relationship between the adult survivor participants and the person that used violence against them surfaced as the one of most profound influences in their experience within the child welfare system. All participants (as a reminder were women and their identified partners were men) described this influence in some fashion (because of this explicit gender identification and relationship status, we will use she/mother and he/father when describe these findings). Although this finding's prominence may not be surprising given the participants were all DV survivors, it is noteworthy that this occurred despite the fact that the interview questions did not in any way contain inquiries into their experience with abuse or the relationship with the person that uses violence. This organic emergence speaks directly to the insidious influence of the abusive relationship, and particularly the role of the person that uses violence plays, on the adult survivors' experiences, not excluding their CW experience, with the direst outcomes – the surveillance of their parenting and the possible (or eventual) removal of their children. Two clusters influence described by participants related to this research question were: (1) being a DV survivor means being at risk or losing children, and (2) PUV harms adult survivor within CW.

Being a DV Survivor Means Being at Risk of or Losing Children. Almost all participants described that they experienced that being an adult survivor meant being at risk of or losing their children. This was described as a causal process, first the person using violence (PUV) causes harm to adult survivor and then when CW gets involved, causing the children to be at risk of being removed from mother. Most participants attributed the PUV as being responsible for the harm and in some ways worse, for the participants, the awful circumstance of having their children being at risk for removal. As one participant stated succinctly,

> *I would say it was more so terrifying because they were trying to like take the kids away from me and the domestic didn't come because I was abusing the kids. They came from a domestic relationship with the kids' father. It was more so terrifying because I didn't want to lose my kids at all. (Kaliyah)*

> *The person using violence was identified as the cause, and he was also identified as the parent who CW did not hold accountable. Many participants questioned, why did CW not investigate the father, the person who had harmed her, and ultimately put the child in harm's way, either directly (i.e., child exposure to DV) or indirectly, by prompting CW report. One participant asked these questions about getting fathers involved and not holding the mothers responsible:*

> *I just hope they stop putting in people that didn't do anything, that are domestic violence survivors, like stop putting them in a hot plate, like go for the dad, you know, like, have the dad take some kind of, get dads on [CW Department]. Why aren't dads on [CW Department]? Why is it just mom? (Iqra)*

The person using violence impacts the survivor – within CW. The descriptions of harm perpetrated by the persons using violence that pre-dated CW or prompted CW involvement were horrific. Again, while the descriptions of violence were not the aim of these interviews, they are presented to demonstrate the intensity and sheer pain the participants endured, sometimes while pregnant. He was "threatening to burn the house down if I took the girls." "He literally stole everything from me, and that's what it took for me to leave." "I know that's his motive, and that he wants to hurt me." "He took my (3-year-old) daughter to a park and assaulted her." "I tried to put my key in the door and he had glued it shut. I freak out. I call 911.

He goes out the back door. They were already in the car, and he took off with my daughter."

Participants descriptions of how the PUV impacted them, their children, which led to CW involvement in a variety of ways. One participant, who was Black, identified how her partner who was white, used racism as an additional way to threaten and control her that impacted her experience with CW.

> *And he always brought up the race thing, like when I was pregnant. He tried to get me to have a miscarriage. He used to put his hands on me. It's like he put his hands on me. I guess he didn't want the baby or something like that. I don't know. But he used to put his hands on me, and I was at high risk of pregnancy. I had a stressful pregnancy. My whole pregnancy was so stressful…I felt like he was there to see me and my child to die. The doctor told me that, "Yeah. You and your son might not make it." And it was very stressful. He's always put his hands on me. And so, I started fighting back. And then, he almost called police, so you know that you're going to go to jail because you're Black and I'm White and this. He was always cruel. (Aria – comparison)*

These descriptions of the participants lived experience with DV again ground the rest of the findings, identifying the lived experience of adult survivors (and their child survivor children) who were in the QIC-DVCW offices.

In the Adult Survivor Interviews, the participants also described their adult experiences with the child welfare system, which included both their distinct relationships with their caseworkers (often more than one) and the system overall. Considering the desired outcome of having case worker practice to move toward DV-informed, individualized, and dynamic, the participants' descriptions were not conclusive that this was their experience. Several findings emerged related to caseworker relationship: (1) experiences included the range from neutral to very negative, (2) "They say jump, you got to say how high?" and (3) didn't get desired resources.

Caseworker Relationship. The caseworker relationships were as complex as the cases themselves, with participants reporting ones that were very poor and emotionally harmful to ones that provide some level of support and resources. However, there was always the undercurrent of the reality that the basis of that relationship was still predicated on child removal.

Experiences Ranged from Neutral to Very Negative. All adult survivors identified that in some way, their relationship with their caseworker(s) included a negative or neutral (i.e., not positively described) element. Overall, when analyzed for severity of neutral to very negative, the experiences were closer to very negative. Unlike some of the other DV specific challenges adult survivor described, the caseworker relationship woes or neutrality was not mostly attributed to the DV nature of the case, but instead overall issues.

Caseworker experiences participants described in neutral terms included lack of sharing resources and that the worker was not harmful, but not helpful either. For example, one participant shared:

> *Like she understands, we don't get like real too deep into stuff, but like I said, I haven't had any problems with her…I've asked…multiple times, like if she's had like resources for like, you know, to help with like, legal stuff, or like around my restraining order against my ex or like for family court, for stuff and there was nothing. She's like, "we don't really have any, like connections or you know, like available things for you" but she said, she Googled the stuff for me though and she was like, "I didn't really find much, you probably looked up the same things I did." (Shania)*

Another participant identified that she was certain that her caseworker was not helping her, but that she was uncertain if it was intentional or not, saying:

> *My social worker, I know more about the services that she can provide me that she knows. It's sad...So I don't know if she genuinely doesn't know or she just doesn't want to help me. And it could be either that's the problem and it shouldn't be that way. It doesn't matter if you like me or not, you're my caseworker and you're supposed to be helping me. (Maya)*

Regardless of the why, all participants had some neutral experiences with caseworkers.

In sharp contrast to the neutral descriptions of caseworker relationships, most participants identified negative to very negative experiences with caseworkers. The participants' negative experiences with the caseworker were often rooted in experiences of the caseworker having power over them. One participant paralleled the relationship dynamic of her abusive partner to her caseworker, saying:

> *I always felt like they were trying to control me in my domestic relationship, people controlling, and that really at some point had me depressed and down. I don't want to be controlled. I just want to be my own person. That is how I feel is best. (Kaliyah)*

Another participant shared the perception of her worker:

> *...it's like she gets off on like, putting us like, through this and seeing the pain in our eyes...she kind of had this air about her that was just really demeaning towards me, I thought especially, and I don't know, she just was not a very nice person at all. (Meta)*

For at least one participant, their dissatisfaction with the caseworker led them to file written complaints against the caseworker:

> *She got taken off of my case, and put on lighter duty, because of my complaints. Over years, I had to make complaints. So, she wasn't doing her job very well...I went all the way up to the director of [CW Department], wasn't getting anywhere. That's when I started [filing with the complaint's unit within the CW department], which is like a police for [CW Department]. So, they would do the investigations, and at least it would be on a record. It might not have got anything done about it. At least we have a record that...So, I became really good friends with my [complaint's unit] worker. (Arienne)*

Another issue identified by more than half of the participants was the experience of the caseworker as being "missing in action" and "ghosting" the adult survivor. Descriptions of the ghosting experience included not returning phone calls, texts, and emails; going on vacation without informing them; not providing information/ resources they promised to provide. They experience a lot of waiting and wondering what was happening based on the lack of caseworker contact.

For participants with this ghosting experience, the impact on their caseworker experience was great. One participant described the uneven nature of her caseworkers' engagement, saying about her caseworker, "You want to be in my life so bad, but when I need you, you're not there," and then she countered how caseworker can be available, on their terms, "as soon as they need something from you or something is wrong, they're right at your door" (Nena). Another participant expressed how the minimum caseworker check in is not enough support and communication:

> *She wouldn't even contact me to like maybe three weeks later. So, I've been yeah, I understand you're busy, but you listen...but you aren't that damn busy that you can't return [a] call. It was back and forth emails I sent to her, text her, called her. [She] never responded. Even one time she was on vacation. She never told me. (Xiomara)*

"They Say Jump, You Got to Say How High?" Most adult survivors reported that they experienced their caseworker as a mechanism to remove children and then a barrier to get kids back, and that they shared what they learned about dealing with that reality. They also shared how they responded to caseworkers' case requirements and other demands. One participant illustrated this dynamic like this:

> *She said, if I got those lists of things done, that she would possibly, but most likely not have to make another visit. If I got it all done, she probably wouldn't have to. So, I made sure I got everything done because I wanted to get off that as soon as possible. Interviewer: And what ended up happening? Interviewee: She closed the case. We were good for a while. (Iqra)*

However, for some participants who had lost custody of their children, they described their caseworkers as being cavalier or immovable about adult survivor requirements needed to return their children into their care. One participant shared this example of a cavalier approach:

> *...they decided that they want to observe longer, observe me continuing my therapy and domestic violence counseling. And I call this to my therapist and I tell them my domestic violence counselor and they say, "[CW agency] hasn't even checked in with us since October." So, they're adding more time for me to be away from my girls, to see that I'm doing my services yet, they don't check in. They haven't checked in. So, actually, just last week, she finally checked in with all my services (Brenna)*

Another participant described her caseworker's complete block of her even knowing what it would take to be reunified with her children:

> *She won't even acknowledge the thought of me having my kids back with me. That's not going to happen. That's the response that I get, every time. The department is not okay with you getting your kids. That's where we stand. She can't even have a conversation with me, about what I need to do to get them back. (Maya)*

Caseworker Didn't Help Get Services, Required or Desired. The third cluster of neutral to negative experiences with a caseworker was that the adult survivor did not get the desired services to support them and their children. This echoes other experiences described by adult survivors, including what actions they take to care for their children, when CW doesn't pull through on providing needed resources or referrals.

> *...the strongest memory that I have was like pretty much them just kind of not helping me when I needed help...[The worker] pretty much showed me that like, I needed to get away from him, and then she gave me the domestic violence counseling number and stuff and said that I had to complete that and then that ended up being a requirement. She pretty much told me that if I didn't get away from him that I wasn't gonna have [my daughter] back. So I kind of just had to figure it out on my own. (Drorit)*

This example illustrates the frustration of adult survivors when a case requirement is set but the experience of their caseworkers is a lack of support to accomplish those requirements.

CW Doubted the Participants' Love for or Protection of Their Children. In the Adult Survivor Interviews, more than half of adult survivor interview participants believed that CW and specifically their caseworkers doubted the participants' love for or protection of their children. The participants who described this belief experienced that CW instead of understanding how much they loved their children saw them as choosing to stay in the relationship with the PUV or choosing themselves (i.e., the adult survivor) over their children's safety. This was often experienced as the system blaming the survivor in one way or another. One participant described it like this:

> *...they just continue to see me as - I don't know, I guess just this monster. And I guess, what their biggest thing is they - I feel like, how they view it is that I don't love my children, because I couldn't stop using or I couldn't leave their father. And, my thing is, it has nothing to do with my love for my children. I love them very much. I had everything to do with the fact that I didn't love myself enough and that's where they're wrong. (Maya)*

This belief translated into a fear that they would lose or re-lose their children to foster care, as exemplified here, "I'm kind of like anxious how is this gonna work, like, they might ask it for years, my daughter just got returned, and is she gonna like, next week is, are they gonna rip her back away from me, you know, like...(participant emotional)" (Rabha). Another participant explained that her case worker assumed blame of her because the PUV had reported that she was the aggressor and had endangered their child:

> *She came to introduce herself, but come to find out reason why she was there, is because he filed a violent case on me. And they were basically investigating reasons why she was there, because the video that he had of me supposedly - I was protecting myself, protecting me and my son. And I had held a knife and I waive against him. I wasn't actually kind of like stab him or anything. But he kept pushing me. He bumped me in everything. And I was trying to leave. (Aria)*

In these experiences, participants struggled to develop working relationships with their workers who started out with assumptions and blame about their children's safety.

At the same time, participants identified that they too wanted CW to keep children safe; they saw alignment in that goal, however, they expressed that they wanted CW to expect this and therefore approach them, as DV survivors whose safety was also a priority. For example, this participant expressed this desired both/and approach, what is Approach Principle 2: Connectedness, "the safety and well-being of child and adult survivors of DV are inextricably linked":

> *I would expect them to do their job, obviously, you know, my kid comes first. You know, I'll do what you got to do, observe, talk to him, you know, and then talk to me. But you know, also talk to me about what's going on, in a deeper step of what's going on in my life to understand what got me to the point where I'm at sitting in front of them kind of thing. (Iqra)*

Another participant shared her "devastation being without them," waiting for CW to return them to her:

> *I mean, I always considered myself an exceptional mother, like never on my phone, while I play with the girls. So, I don't think it makes me appreciate the time more than I have with the girls, because I already was always absorbed in their love all the time. So, I just think that the devastation being without them. I feel like, I could have gotten all these services in place. I mean, I've had all these services in place, pretty much a week after I got out of the hospital. So, there is no need for my kids to be gotten gone this long enough. (Hennie)*

Helpful Experiences with Caseworker. Although the predominant case worker experience was neutral to very negative, some (13/31) adult survivors did also express that they had helpful experiences. For some of those adult survivors the caseworkers' personality or way of being, such as "very nice," "respectful" and "kind" was what they experienced as helpful. Helpfulness was described by participant Key, who shared:

> *...you could tell that she really does want to help out actually. You can spot the difference when someone's just doing their job, because it's their job. And from her, I didn't get that. I got like, "Wow.*

> *She's really interested in wanting to know everything." You could tell that she wants the best interest, not only for me, but for my kid as well. (Key)*

Descriptions of helpful caseworker personalities or ways of being were always paired with helpful actions taken by the caseworker that led to the adult survivor interview participants' assessment of helpfulness. As one participant expressed "I have confidence with him. So, if he tells me, "Hey, I'm going to walk up to the door," I always leave my door - my both doors open. So then, he just walks in. He's been very kind to me and my children. He's helped me out with a lot of things" (Rabha). This example illustrates it is the combination of the caseworker's attitude ("very kind") and their behavior ("helped me out") that fueled the adult survivor's assessment of helpfulness. It sometimes was the case that the helpful caseworker interaction came as a result of the adult survivor strongly advocate for themselves, illustrated by this participant, "I told her what my needs were":

> *...the first caseworker...she told me she couldn't help me. So, I had explained to her, "There was really nothing that you could do to help me? Then, there was no need for us to even be in contact with each other." And that's when she had explained to me, she understood my situation. And there was a program that she helped me move. And that's what we began to focus on. (Leona)*

In relation to the descriptions of neutral and very negative experiences with caseworkers, the conclusion is that **having a positive attitude is not enough for adult survivors to feel supported or helped by a caseworker; actions and behaviors taken by the caseworker to support the adult survivor and her children are also necessary.**

Additionally, helpful experiences with caseworkers described by adult survivor interview participants also included how competent the caseworkers were in understanding or relating to DV. Participants identified DV-informed practice competency in the following areas: having a survivor mindset, safety planning, homelessness, not making the survivor "feel crazy" for taking actions to protect themselves, didn't push survivor to end relationship, and connecting to DV resources. Each of these areas was identified by usually one but not by more than two participants, which echoes the Approach understanding that for child welfare practice to be DV-informed it is individualized, and driven by survivor input and engagement, as their needs are unique.

CW System: "Like credit card math. You never know...what you might owe in the end." While adult survivors' direct experience with the child welfare system that was delivered by the caseworkers and other professionals within and adjacent to the CW system (e.g., department attorneys, judges, guardians ad litem) surfaced as the dominant factor, participants also reported system level factors. Specifically, participants expressed confusion about the purpose of the CW system based on their experience. Fundamentally, the participants' experience of the system's purpose was that it was less about helping the adult survivor and more about removing or threatening to remove children. One participant brought up state law to corroborate her understanding that the CW system was supposed the help, but was not: "The law in [deidentified state name] states, they're a resource agency there to help preserve the family. That's not what they do...they just want to remove." (Maya)

> *Like it weighs on you, and it makes you feel really bad, and like, mmh mmh I don't, honestly, I don't want to deal with [CW system] again, it's so frustrating that everything from start to finish... it wasn't horrible up until the end, when I felt like I got lied to the whole time. (Brenna)*

Lastly, it was the severe consequence of children's removal from their care that fueled adult survivor criticism and concern about the CW system, as illustrated by this participant:

> *...my caseworker told me that my son was going to be gone for only three days. And he was gone for a whole month. So,*

like I think that's just the only thing that's very scary and very nerve-racking. You never know what the time limit is. It's kind of like credit card math. You never know...what you might owe at the end. (Key)

The Case Record Review provided an additional data source to examine differences between intervention and comparison case documentation in the areas of individualized safety and case planning and referrals.

Overall, in the Case Record Review we did not see major divergence in how family case/service plans were documented, acknowledging that many of these forms use drop down menus with standardized fields and write-in comments on client progress. It may be that implementation of these service plans varied across sites; the following information only highlights how information was documented within the case files.

Table 51 provides a breakdown of types of service referrals by adult family member (i.e., adult survivor and PUV) and study group (i.e., intervention and comparison). The majority of adult survivors were engaged in case planning and provided with referrals to services; those without service referrals include where the adult survivor had disengaged from case planning and services. Cases without referrals for adult survivors widely varied in reasons. For example, the previously identified adult survivor was arrested for the last physical altercation with her partner in one case. In another case, the mother had subsequently died of a drug-related overdose. Alternatively, one case was closed before services were provided because the family had addressed safety issues and the person who uses violence was reported to be incarcerated.

Table 51. (CRR) Types of Service Referrals by Study Group & Adult Family Member

Variable	Adult Survivors		Persons who Use Violence	
	Intervention n (%)	Comparison n (%)	Intervention n (%)	Comparison n (%)
No service referrals	3 (21%)	0 (0%)	3 (21%)	3 (21%)
Domestic Violence Assessment	2 (14%)	3 (21%)	5 (36%)	4 (29%)
Domestic Violence Services	5 (36%)	8 (57%)	N/A	N/A
Anger Management	N/A	N/A	1 (7%)	3 (21%)
Batters Intervention Program/ Responsible Fathers Program	N/A	N/A	2 (14%)	3 (21%)
Economic Support	2 (14%)	7 (50%)	1 (7%)	2 (14%)
Mental Health Support	7 (50%)	10 (71%)	7 (50%)	5 (35%)
Substance Use Disorder Tx	6 (43%)	6 (43%)	7 (50%)	7 (50%)
Parenting Classes/Coaching	6 (43%)	4 (29%)	4 (29%)	1 (7%)
Other	2 (14%)	2 (14%)	0 (0%)	1 (7%)

Notes. *N* = 28; intervention *n* = 14, comparison *n* = 14. Categories are not mutually exclusive; multiple types of referrals may be documented within a case file.

Comparison site case files provided more service referrals for adult survivors on average for all types of services, except for parenting. Referrals ranged from 0 to 6 types of referrals offered with an average of 3 referrals per adult survivor. Typical activities documented for adult survivors within case files aligning with comparison sites included mental health support (71%), domestic

violence services (57%), economic support (50%), and substance use disorder treatment (43%). At intervention sites, service referrals for adult survivors were predominantly focused on mental health supports (50%), substance use disorder treatment (43%), parenting classes/coaching (43%), and domestic violence services (36%). When collecting data, the evaluation team observed that one of the Illinois contracting agencies (POS) within the comparison site had in-house domestic violence services to which families were regularly referred, which may have contributed to a higher rate of DV services provided within the comparison sites.

Across sites, 21% of persons who used violence were not provided with services or included in case planning. Types of referrals provided ranged from 0 to 6 with an average of 2 types of referrals per person who uses violence. Among the persons who used violence who were engaged into services, typical activities documented within case files aligning with comparison sites included substance use disorder treatment (50%), mental health support (35%), domestic violence assessment (29%), anger management (29%), and BIP/RFP (21%). At intervention sites, service referrals were predominantly focused on substance use disorder treatment (50%), mental health supports (50%), domestic violence assessment (36%), parenting classes/coaching (29%), and BIP/RFP (14%).

The Case Record Review also illuminated several ways that caseworker documented use of protective orders and of domestic violence incidents. One of the two projects (AC and IL) had a specific tool that asked about potential risk for harm. While documentation of protective order was often unclear, we did observe (a) if protective orders were present and (b) whether the order was externally encouraged by a court mandate or child welfare recommendation or was survivor-initiated. Refer to Table 52 for details. In sum, use of protective orders was similar across intervention and comparison sites; however, case files aligned with intervention sites identified protective orders being survivor-initiated with a higher frequency than case files aligned with comparisons sites.

Table 52. (CRR) Protective Order by Intervention Group & Source of Initiation

Variable	Total n (%)	Intervention n (%)	Comparison n (%)
Any Protective Order Documented	13 (46%)	7 (50%)	6 (43%)
Externally Encouraged/Mandated	5 (18%)	2 (15%)	3 (21%)
Survivor-initiated	7 (25%)	5 (36%)	2 (14%)

Notes. *N* = 28; intervention *n* = 14, comparison *n* = 14.

1.B.1.4. Were there significant differences between the intervention and comparison sample in CW practice actively working toward racial, ethnic, and gender equity in their practice as well as in families' access to resources and services?

Two data sources were used to answer this question, the Caseworker and Supervisor Self Survey, and the Adult Survivor Field Survey.

While in the Caseworker and Supervisor Self Survey **we observe an upward trend in equity practice behaviors within intervention sites by Time 4, these trends did not significantly differ from trends observed within the comparison site over time.** See Table 53. While we see divergences between the project sites between T3 and T4, large variation in responses within sites contribute to a lack of significance. The main variable explaining equity practice behaviors over time was a respondent's self-rating of how well prepared they felt to actively engage in equity and collaborative practice (p = 0.015). Specifically, individuals who reported feeling more well-prepared to actively engage in equity practice also reported higher equity-oriented practice behaviors.

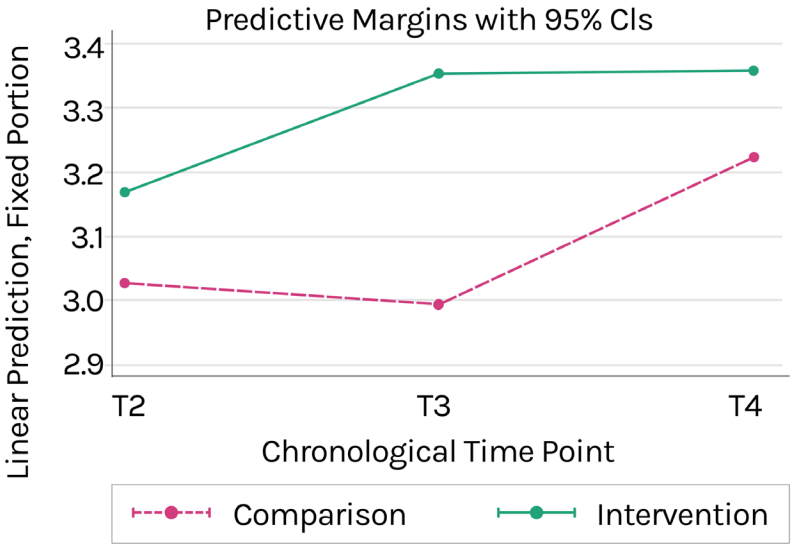
Table 53. (Self Survey) Linear Mixed Model using Intent-to-Treat Sample Comparing Equity-oriented Practice Behavior and Average Preparation to Engage in Equity & Collaborative Practice between T2 and T4

	Preparation to Engage in Equity Practice			Equity Practice Behaviors		
	B (SE)	*p*	FMI	B (SE)	*p*	FMI
Group Assignment						
Comparison	reference			reference		
Intervention	0.13 (0.07)	0.067	0.375	0.06 (0.17)	0.648	0.323
Time						
2-Mo F/U (T2)	reference			reference		
1-Yr F/U (T3)	-0.04 (0.08)	0.601	0.550	0.06 (0.17)	0.717	0.613
2-Yr F/U (T4)	0.19 (0.07)	0.006*	0.437	-0.16 (0.16)	0.333	0.582
Group X Time						
T2 x Intervention	reference			reference		
T3 x Intervention	0.22 (0.10)	0.020*	0.556	-0.06 (0.21)	0.769	0.612
T4 x Intervention	0.00 (0.09)	0.961	0.509	0.37 (0.23)	0.099	0.651
Prepared for equity practice	--	--	--	0.27 (0.11)	0.015*	0.737
Belief score about equity as part of job	0.32 (0.06)	< 0.001*	0.704	0.07 (0.12)	0.568	0.664
Primary Role						
Caseworker	reference			reference		
Supervisor	-0.11 (0.06)	0.057	0.344	0.10 (0.12)	0.430	0.367
Site						
Allegheny County	reference			reference		
Illinois	-0.03 (0.07)	0.678	0.400	0.12 (0.13)	0.354	0.377
Massachusetts	-0.05 (0.06)	0.444	0.316	0.09 (0.12)	0.430	0.373
Random Effects Parameter (ID: Respondent)						
Constant	0.35 (0.03)		0.656	0.61 (0.09)		0.781
Residual	0.45 (0.02)		0.780	0.94 (0.06)		0.830

Notes. N = 431 unduplicated respondents; 1,293 observations over T2 to T4. Sample was imputed using MICE with 100 datasets.

Interestingly, we observed a significant treatment effect for how well-prepared respondents felt to actively engage in equity practice. Specifically, we observed respondents within interventions sites report a significantly higher change in behaviors in the time between Time 2 and Time 3 relative to comparison sites. However, we observe an increase in these feelings of preparations across all respondents between Time 3 and Time 4, regardless of Project site location. See Figure 20.

Figure 20. (Self-Survey) Estimate of Preparation to Actively Practice Equity Practices from T2 to T4 for Intent-to-Treat Child Welfare Samples by Project Sites



Notes. *N* = 431 unduplicated respondents; 1,293 observations over T2 to T4. Sample was imputed using MICE with 100 datasets.

In Adult Survivor Field Survey, we observe no significant difference between the intervention and comparison sample in CW actively work toward racial, ethnic, and gender equity in their practice as well as in families' access to resources and services. For Adult Survivor Field Survey Results, see Table 54.

Table 54. (ASFS) Adult Survivor Ratings of CW Caseworker Practice Behaviors associated with Equity & CW-Partner Communication & Collaboration in Case Activities

Actively work toward racial, ethnic, and gender equity in their practice	N	Intervention Median (Min,Max)	Comparison Median (Min,Max)	Mann-Whitney U test	*p*
Equity Average Score [1 = not at all to 5 = extremely]	96	3.0 (1.0, 5.0)	3.1 (1.0, 5.0)	845.000	0.591
Respectful towards adult survivor	96	4.0 (1.0, 5.0)	3.5 (1.0, 5.0)		
Understands adult survivor and their experience	96	2.0 (1.0, 5.0)	3.0 (1.0, 5.0)		
Support adult/child survivors overcoming barriers, such as not having transportation or not having an interpreter for an important meeting or conversation?	94	2.0 (1.0, 5.0)	2.0 (1.0, 5.0)		
Frequency of ensuring AS can communicate in first language (if applicable)	15	5.0 (3.0, 5.0)	4.5 (2.0, 5.0)		

Actively work toward racial, ethnic, and gender equity in their practice	N	Intervention Median (Min,Max)	Comparison Median (Min,Max)	Mann-Whitney U test	p
CW-Partner collaboration in case activities [1 = not at all to 5 = extremely]					
Helpful in working together with other agency professionals on adult survivor's behalf	95	2.0 (1.0, 5.0)		736.000	0.224

Notes. *N* = 96; intervention *n* = 70, comparison *n* = 26. Average score for "equity" was composed of 4 items that demonstrated adequate reliability at *a* = 0.714.

1.B.1.5. Were there significant differences between the intervention and comparison sample in CW-Partner communication and collaboration in case activities?

Two data sources were used to answer this question, the Caseworker and Supervisor Self Survey, and the Adult Survivor Field Survey. The Case Record Review provided evidence of differences between intervention and comparison documentation of CW-Partner communication and collaboration in case activities.

In the Caseworker and Supervisor Self Survey, **we observed no significant changes in collaborative practice behaviors over time for either intervention sites nor comparison sites.** Reported estimates did not differ when controlling for training completion, coaching participation, respondent demographics, and respondent experiences. See Table 55. These controls were removed from the final model for parsimony. See Figure 21.

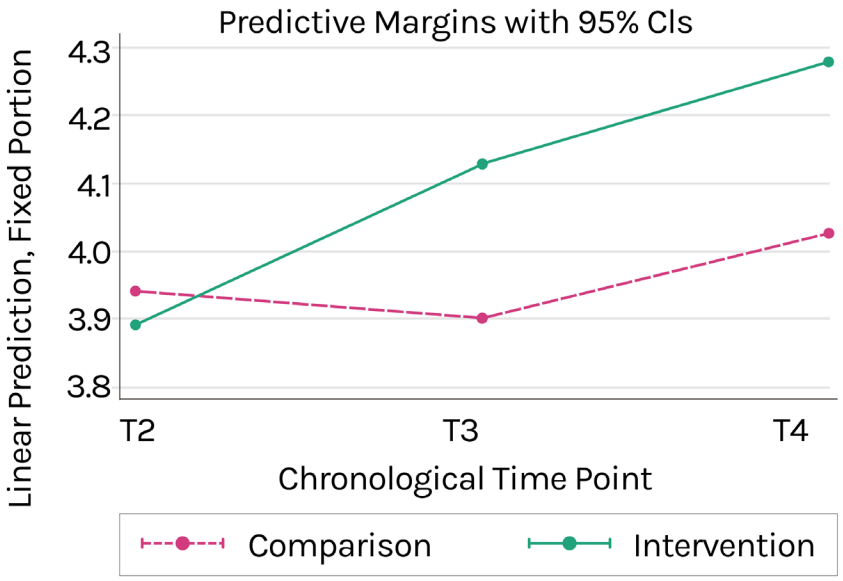
Table 55. (Self Survey) Linear Mixed Model using Intent-to-Treat Child Welfare Sample Comparing Average Collaborative Practice Behaviors between T2 and T4

	Collaborative Practice Behavior		
	B (SE)	*p*	FMI
Group Assignment			
Comparison	reference		
Intervention	-0.05 (0.11)	0.660	0.433
Time			
2-Mo F/U (T2)	reference		
1-Yr F/U (T3)	-0.04 (0.14)	0.775	0.660
2-Yr F/U (T4)	0.08 (0.12)	0.481	0.489
Group X Time			
T2 x Intervention	reference		
T3 x Intervention	0.27 (0.20)	0.167	0.708
T4 x Intervention	0.30 (0.15)	0.052	0.517
Primary Role			

	Collaborative Practice Behavior		
	B (SE)	*p*	FMI
Caseworker	reference		
Supervisor	0.25 (0.08)	0.002*	0.395
Site			
Allegheny County	reference		
Illinois	0.04 (0.10)	0.699	0.422
Massachusetts	0.04 (0.08)	0.601	0.357
Random Effects Parameter (ID: Respondent)			
Constant	0.35 (0.08)		0.756
Residual	0.75 (0.04)		0.746

Notes. *N* = 431 unduplicated respondents; 1,293 observations over T2 to T4. Sample was imputed using MICE with 100 datasets.

Figure 21. (Self-Survey) Estimate of Collaborative Practice Behaviors from T2 to T4 for Intent-to-Treat Child Welfare Samples by Project Sites



Notes. *N* = 431 unduplicated respondents; 1,293 observations over T2 to T4. Sample was imputed using MICE with 100 datasets.

In the Adult Survivor Field Survey, we observe no significant difference between the intervention and comparison sample in CW-Partner communication and collaboration in case activities. For Adult Survivor Field Survey results, see Table 54 and Table 56.

In the Case Record Review, systems coordination was not explicitly documented across the case files; however, systems level coordination was evident across both sites through documentation of contact between providers, external assessments and monthly reports, and notes

embedded within family case/service plans about compliance with service activities. The following is a typical example of the extent of this documentation: "The worker has made attempts to reach out to [person who uses violence] probation officer to confirm this information but has not been successful" (Illinois, Intervention Office, Family Service Plan). As a result, the documentation provided within case files were not comprehensive enough to consistently evaluate the nature or extent of cross-system communication and coordination.

Table 56. (ASFS) Composition of Providers Serving Adult Survivor Respondents

Providers working with AS	N	Intervention n (%)	Comparison n (%)	X^2	df	*p*
CW Worker Only	44	31 (44%)	13 (50%)	0.249	1	0.618
CW Worker and Advocate	52	39 (56%)	13 (50%)			

1.B.2. Enhanced Community Partner Practice

1.B.2.1. Were there significant differences between the intervention and comparison sample in community partner planning, decision-making, & practice addressing Protective Factors for Survivors framework?

Two data sources were used to answer this question, the Community Partner Self Survey and the Adult Survivor Field Survey. In the Community Partner Self Survey, we **observed a time x intervention interaction where protective factor practice behaviors increased over time at the intervention sites between T2 and T3 ($p = 0.007$). However, any observed differences between comparison and intervention sites disappeared by Time 4.** In addition, we observed the protective factor practice beliefs significantly correlated with how well-prepared a respondent felt about using the Approach with adult and child survivors ($p = 0.003$). See Table 57.

Table 57. (Self Survey) Linear Mixed Model using Intent-to-Treat Community Partner Sample Comparing Average Protective Factor Practice Behaviors between T2 and T4

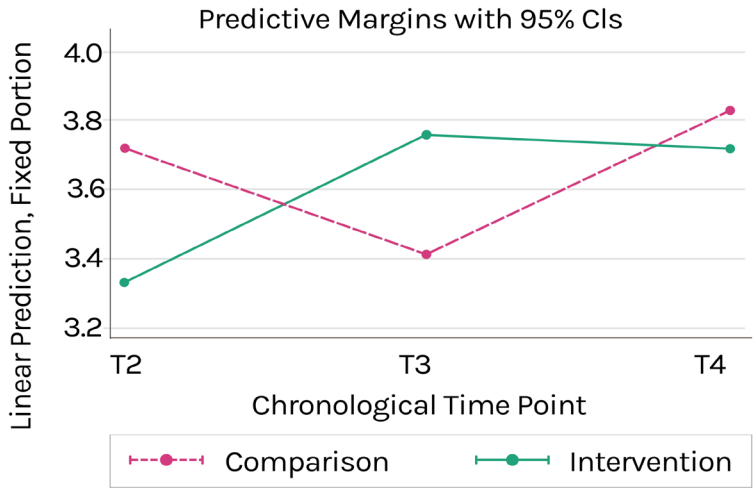
	Collaborative Practice Behavior		
	B (SE)	*p*	FMI
Group Assignment			
Comparison	reference		
Intervention	-0.05 (0.11)	0.660	0.433
Time			
2-Mo F/U (T2)	reference		
1-Yr F/U (T3)	-0.04 (0.14)	0.775	0.660
2-Yr F/U (T4)	0.08 (0.12)	0.481	0.489
Group X Time			
T2 x Intervention	reference		
T3 x Intervention	0.27 (0.20)	0.167	0.708

	Collaborative Practice Behavior		
	B (SE)	*p*	FMI
T4 x Intervention	0.30 (0.15)	0.052	0.517
Primary Role			
Caseworker	reference		
Supervisor	0.25 (0.08)	0.002*	0.395
Site			
Allegheny County	reference		
Illinois	0.04 (0.10)	0.699	0.422
Massachusetts	0.04 (0.08)	0.601	0.357
Random Effects Parameter (ID: Respondent)			
Constant	0.35 (0.08)		0.756
Residual	0.75 (0.04)		0.746

Notes. *N* = 431 unduplicated respondents; 1,293 observations over T2 to T4. Sample was imputed using MICE with 100 datasets.

Reported estimates did not differ when controlling for training completion, coaching participation, respondent demographics, and respondent experiences. These controls were removed from the final model for parsimony. See Figure 22.

Figure 22. (Self-Survey) Estimate of Protective Factor Practice Behaviors from T2 to T4 for Intent-to-Treat Community Partner Samples by Project Sites



Notes. *N* = 159 unduplicated respondents; 477 observations over T2 to T4. Sample was imputed using MICE with 100 datasets.

In the Adult Survivor Field Survey, we operationalized "community partner planning, decision-making, & practice addressing Protective Factors for Survivors framework" using the adult survivors' perception of their DV advocate (or IPV specialist) practice behaviors. No significant differences were observed in ratings of practice behaviors between intervention and comparison groups (See Table 58). However, regardless of group assignment, adult survivors report advocate scores that are more aligned with Approach practice behaviors than CW workers. The median scores of the practice behaviors should also be noted were all 3.5 or above, with the maximum score being 5, and the minimum being 1.

Table 58. (ASFS) Adult Survivor Ratings of Community Partner Practice Behaviors with Adult & Child Survivors

Advocate Practice with Survivors	N	Intervention Median (Min,Max)	Comparison Median (Min,Max)	Mann-Whitney U test	p
Planning, decision-making, & practice address protective factors framework [1 = not at all to 5 = extremely]	52	4.4 (1.0, 5.0)	4.2 (1.0, 5.0)	250.000	0.940
Support dealing with challenges faced by family	52	4.0 (1.0, 5.0)	5.0 (1.0, 5.0)		
Support adult/child survivors to believe that they can overcome challenges their faced with	52	5.0 (1.0, 5.0)	5.0 (1.0, 5.0)		
Support of adult survivor reaching out other people for support about the domestic violence DV	52	5.0 (1.0, 5.0)	5.0 (1.0, 5.0)		
Provide useful services or resources for children	52	4.0 (1.0, 5.0)	4.0 (1.0, 5.0)		
Encourage adult survivor efforts to make positive change	52	5.0 (1.0, 5.0)	5.0 (1.0, 5.0)		
Practice is DV-informed, individualized, & dynamic [1 = not at all to 5 = extremely]	52	4.0 (1.0, 5.0)	4.0 (2.3, 5.0)	252.000	0.974
Help adult survivor develop realistic goals as part of case plan	52	5.0 (1.0, 5.0)	5.0 (1.0, 5.0)		
Frequency of incorporating adult survivor ideas into safety plan	33	5.0 (1.0, 5.0)	4.0 (3.0, 5.0)		
Frequency of trying to understand child's perspective on adult survivor's safety	32	4.0 (1.0, 5.0)	3.5 (1.0, 5.0)		
Frequency of agreeing with adult survivor about what is best for child	52	4.0 (1.0, 5.0)	5.0 (3.0, 5.0)		

Notes. *N* = 52; intervention *n* = 39, comparison *n* = 13. We observed no significant differences in PFF-related practices between respondents served by intervention and comparison sites.

- Average score for "planning, decision-making, & practice address protective factors framework" was composed of 5 items that demonstrated a very good reliability at *a* = 0.931.
- Average score for "practice is dv-informed, individualized, & dynamic" was composed of 5 items that demonstrated adequate reliability at *a* = 0.706.

1.B.2.2. Were there significant differences between the intervention and comparison sample in community partner planning, decision-making, & practice addressing RSA Framework?

Two data sources were used to answer this question, the Community Partner Self-Survey and the Adult Survivor Field Survey.

In the Community Partner Self-Survey, we observed no significant difference between the intervention and comparison sample in community partner planning, decision-making, & practice addressing RSA Framework. That being said, we observed the RSA practice beliefs significantly correlated with RSA practice behaviors ($p < 0.001$). See Table 59.

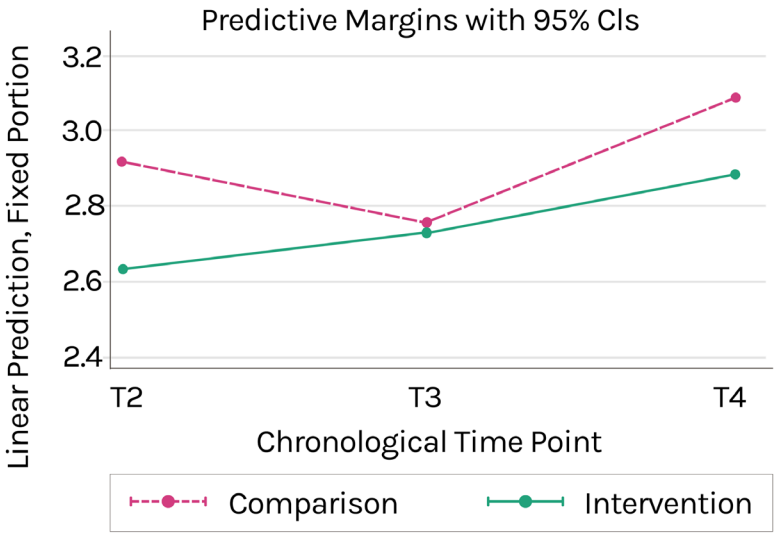
Table 59. (Self-Survey) Linear Mixed Model using Intent-to-Treat Community Partner Sample Comparing Average RSA Practice Behaviors between T2 and T4

	RSA Practice Behavior		
	B (SE)	*p*	FMI
Group Assignment			
Comparison	reference		
Intervention	-0.30 (0.23)	0.196	0.318
Time			
2-Mo F/U (T2)	reference		
1-Yr F/U (T3)	-0.18 (0.25)	0.467	0.453
2-Yr F/U (T4)	0.16 (0.33)	0.614	0.677
Group X Time			
T2 x Intervention	reference		
T3 x Intervention	0.28 (0.31)	0.365	0.438
T4 x Intervention	0.08 (0.38)	0.841	0.632
Belief score about RSA as part of job	0.52 (0.09)	< 0.001*	0.742
Site			
Allegheny County	reference		
Illinois	-0.13 (0.23)	0.576	0.413
Massachusetts	0.10 (0.20)	0.602	0.374
Random Effects Parameter (ID: Respondent)			
Constant	0.55 (0.12)		0.587
Residual	1.00 (0.08)		0.754

Notes. *N* = 159 unduplicated respondents; 477 observations over T2 to T4. Sample was imputed using MICE with 100 datasets.

Reported estimates did not differ when controlling for training completion, coaching participation, respondent demographics, and respondent experiences. These controls were removed from the final model for parsimony. See Figure 23.

Figure 23. (Self-Survey) Estimate of RSA Practice Behaviors from T2 to T4 for Intent-to-Treat Child Welfare Samples by Project Sites



Notes. *N* = 159 unduplicated respondents; 477 observations over T2 to T4. Sample was imputed using MICE with 100 datasets. We observed no significant differences in community partner reports of RSA practice behaviors between intervention and comparison sites over time.

In the Adult Survivor Field Survey, we observed no significant differences in practices related to the relational and systemic accountability framework between respondents served by intervention and comparison sites. See Table 60.

Table 60. (ASFS) Adult Survivor Ratings of Community Partner Practice Behaviors associated with Relational and Systemic Accountability (RSA) Framework

Planning, decision-making, & practice address RSA framework	N	Intervention n (%)	Comparison n (%)	X^2 (df)	*p*
Ever asked if adult/child survivors feel safe?				0.495 (1)	0.664
No	7	6 (15.4)	1 (7.7)		
Yes	45	33 (84.6)	12 (92.3)		
Declined to respond	0	0 (0.0)	0 (0.0)		
RSA practice behaviors [1 = *none of the time* to 5 = *all of the time*]	**N**	**Median** (Min, Max)	**Median** (Min, Max)	**Mann-Whitney U test**	***p***
Frequency of taking action to help adult/child survivors feel safer.	44	5.0 (1.0, 5.0)	5.0 (1.0, 5.0)	187.000	0.880

Notes. *N* = 52; intervention *n* = 39, comparison *n* = 13.

1.B.2.3. Were there significant differences between the intervention and comparison sample in DV-informed, individualized, and dynamic community partner practice?

The Adult Survivor Field Survey was the data source used to answer this question. We observed no significant difference between the intervention and comparison sample in DV-informed, individualized, and dynamic community partner practice. See Table 58.

1.B.2.4. Were there significant differences between the intervention and comparison sample in community partner practice actively working toward racial, ethnic, and gender equity in their practice, as well as in families' access to resources and services?

Two data sources were used to answer this question, the Community Partner Self Survey and the Adult Survivor Field Survey.
In the Community Partner Self Survey, **we observed downward trends in equity practice behaviors within both intervention and comparison sites over time; however, these trends did not significantly differ over time.** The main variable explaining equity practice behaviors over time was a respondent's self-rating of how well prepared they felt to actively engage in equity and collaborative practice ($p = 0.015$). Specifically, individuals who reported feeling more well-prepared to actively engage in equity practice also reported higher equity-oriented practice behaviors. See Table 61 and Figure 24.

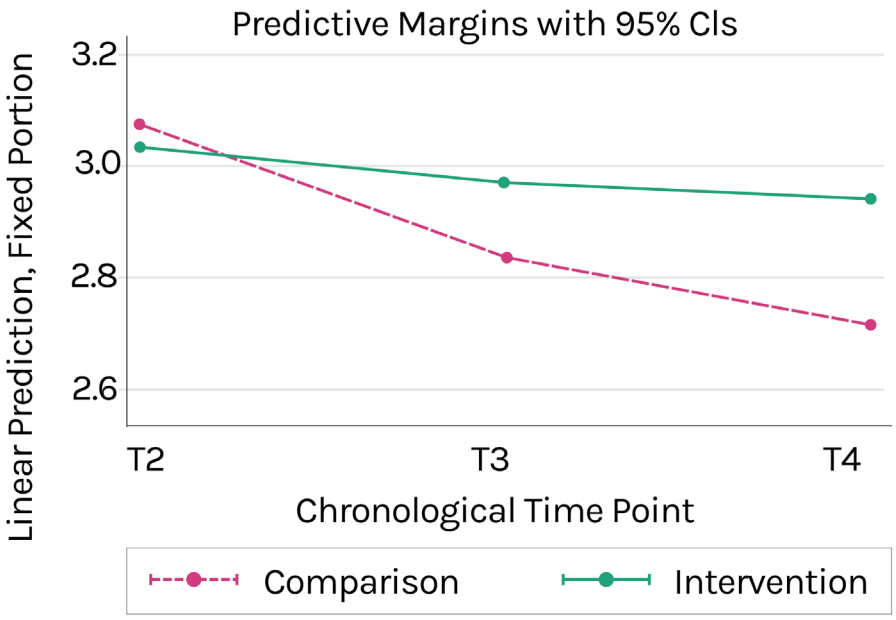
Table 61. (Self-Survey) Linear Mixed Model using Intent-to-Treat Sample for the Community Partner Sample Comparing Equity-oriented Practice Behavior and Average Preparation to Engage in Equity & Collaborative Practice between T2 and T4

	Preparation to Engage in Equity Practice			Equity Practice Behaviors		
	B (SE)	*p*	FMI	B (SE)	*p*	FMI
Group Assignment						
Comparison	reference			reference		
Intervention	-0.15 (0.11)	0.177	0.326	-0.03 (0.22)	0.886	0.255
Time						
2-Mo F/U (T2)	reference			reference		
1-Yr F/U (T3)	-0.37 (0.11)	0.001*	0.462	-0.22 (0.26)	0.398	0.475
2-Yr F/U (T4)	-0.20 (0.13)	0.132	0.638	-0.35 (0.27)	0.206	0.541
Group X Time						
T2 x Intervention	reference			reference		
T3 x Intervention	0.54 (0.14)	< 0.001*	0.465	0.15 (0.32)	0.640	0.456
T4 x Intervention	0.38 (0.15)	0.015*	0.576	0.24 (0.34)	0.483	0.522
Prepared for equity practice	--	--	--	0.37 (0.15)	0.019*	0.597
Belief score about equity as part of job	0.23 (0.06)	< 0.001*	0.571	0.23 (0.12)	0.062	0.525

	Preparation to Engage in Equity Practice			Equity Practice Behaviors		
	B (SE)	*p*	FMI	B (SE)	*p*	FMI
Site						
Allegheny County	reference			reference		
Illinois	0.16 (0.12)	0.186	0.395	0.15 (0.23)	0.532	0.421
Massachusetts	0.15 (0.10)	0.122	0.311	0.24 (0.34)	0.143	0.323
Random Effects Parameter (ID: Respondent)						
Constant	0.35 (0.04)		0.491	0.54 (0.12)		0.559
Residual	0.43 (0.03)		0.684	1.00 (0.06)		0.607

Notes. *N* = 159 unduplicated respondents; 477 observations over T2 to T4. Sample was imputed using MICE with 100 datasets. Reported estimates did not differ when controlling for training completion, coaching participation, respondent demographics, and respondent experiences. These controls were removed from the final model for parsimony.

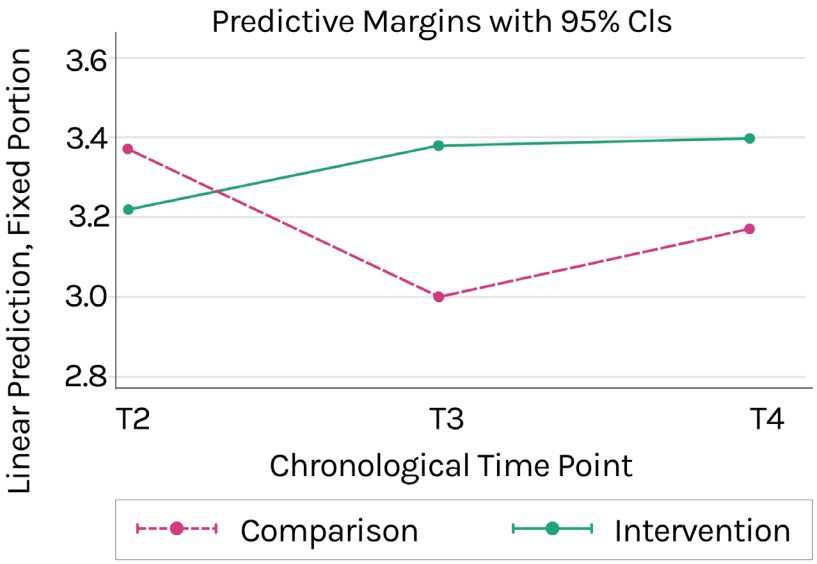
Figure 24. (Self-Survey) Estimate of Equity-oriented Practice Behaviors from T2 to T4 for Intent-to-Treat Community Partner Sample by Project Sites



Notes. *N* = 159 unduplicated respondents; 477 observations over T2 to T4. Sample was imputed using MICE with 100 datasets.

Interestingly, we observed a significant treatment effect for how well-prepared respondents felt to actively engage in equity practice. Specifically, we observed respondents within interventions sites report a significantly higher change in behaviors in the time over time relative to comparison sites. See Figure 25.

Figure 25. (Self-Survey) Estimate of Preparation to Actively Practice Equity Practices from T2 to T4 for Intent-to-Treat Community Partner Sample by Project Sites



Notes. N = 159 unduplicated respondents; 477 observations over T2 to T4. Sample was imputed using MICE with 100 datasets.

In the Adult Survivor Field Survey, we observed no significant difference between the intervention and comparison sample in community partner actively working toward racial, ethnic, and gender equity in their practice, as well as in families' access to resources and services. See Table 62.

Table 62. (ASFS) Adult Survivor Ratings of Community Partner Practice Behaviors associated with Equity & CW-Partner Communication and Collaboration

Actively work toward racial, ethnic, and gender equity in their practice	N	Intervention Median (Min,Max)	Comparison Median (Min,Max)	Mann-Whitney U test	p
Equity Average Score [1 = not at all to 5 = extremely]	52	4.3 (1.7, 5.0)	4.7 (1.0, 5.0)	223.000	0.510
Respectful towards adult survivor	52	5.0 (1.0, 5.0)	5.0 (1.0, 5.0)		
Understands adult survivor and their experience	52	5.0 (1.0, 5.0)	5.0 (1.0, 5.0)		
Support adult/child survivors overcoming barriers, such as not having transportation or not having an interpreter for an important meeting or conversation?	49	4.0 (1.0, 5.0)	4.0 (1.0, 5.0)		
Frequency of ensuring AS can communicate in first language (if applicable)	18	5.0 (1.0, 5.0)	4.5 (4.0, 5.0)		

Actively work toward racial, ethnic, and gender equity in their practice	N	Intervention Median (Min,Max)	Comparison Median (Min,Max)	Mann-Whitney U test	*p*
Advocate-Partner collaboration in case activities [1 = not at all to 5 = extremely]					
Helpful in working together with other agency professionals on adult survivor's behalf	51	4.0 (1.0, 5.0)	5.0 (1.0, 5.0)	225.000	0.613

Notes. *N* = 52; intervention *n* = 39, comparison *n* = 13.

- Average score for "equity" was composed of 4 items that demonstrated adequate reliability ata = 0.705.

1.B.2.5. Were there significant differences between the intervention and comparison sample in measures of CW-Partner communication and collaboration in case activities from the perception of community partners?

Two data sources were used to answer this question, the Caseworker and Supervisor Self Survey, and the Adult Survivor Field Survey.

In the Community Partner Self Survey, **we observed no significant changes in collaborative practice behaviors over time for neither intervention sites nor comparison sites.** See Table 63. Reported estimates did not differ when controlling for training completion, coaching participation, respondent demographics, and respondent experiences. These controls were removed from the final model for parsimony. See Figure 26.

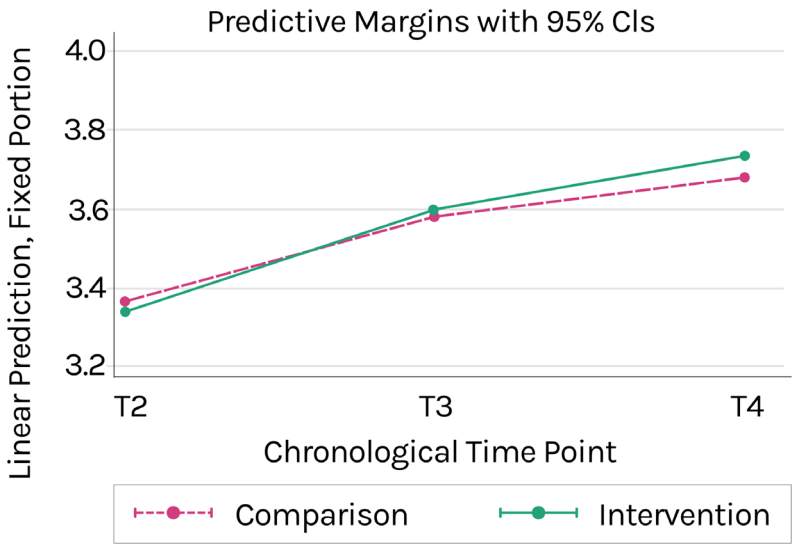
Table 63. (Self-Survey) Linear Mixed Model using Intent-to-Treat Community Partner Sample Comparing Average Collaborative Practice Behaviors between T2 and T4

	Collaborative Practice Behavior		
	B (SE)	*p*	FMI
Group Assignment			
Comparison	reference		
Intervention	-0.02 (0.20)	0.913	0.295
Time			
2-Mo F/U (T2)	reference		
1-Yr F/U (T3)	0.22 (0.22)	0.303	0.591
2-Yr F/U (T4)	0.32 (0.20)	0.116	0.533
Group X Time			
T2 x Intervention	reference		
T3 x Intervention	0.03 (0.25)	0.901	0.431
T4 x Intervention	0.08 (0.25)	0.753	0.499
Site			
Allegheny County	reference		
Illinois	-0.62 (0.22)	0.005*	0.368

	Collaborative Practice Behavior		
	B (SE)	*p*	FMI
Massachusetts	-0.49 (0.18)	0.006*	0.316
Random Effects Parameter (ID: Respondent)			
Constant	0.65 (0.08)		0.526
Residual	0.75 (0.06)		0.751

Notes. N = 159 unduplicated respondents; 477 observations over T2 to T4. Sample was imputed using MICE with 100 datasets.

Figure 26. (Self-Survey) Estimate of Collaborative Practice Behaviors from T2 to T4 for Intent-to-Treat Community Partner Sample by Project Sites



Notes. N = 159 unduplicated respondents; 477 observations over T2 to T4. Sample was imputed using MICE with 100 datasets.

In Adult Survivor Field Survey, we observe no significant difference between the intervention and comparison sample in CW-Partner communication and collaboration in case activities. For Adult Survivor Field Survey Results, see Table 62.

In the Coaching Focus Groups, half described there was some increase in collaboration across child welfare and DV, including increased reliance and collaboration on the IPV specialists and DVCLA and other DV staff, however this practice change was clearly attributed to the QIC-DVCW generally, not specifically to the impact of coaching. Still, as it reported in the coaching focus groups, it is included here. In one focus group in IL reported "the biggest change was [that] we used the co-located advocate…which changed the flavor of things a little bit" (FG 8). Another Coaching focus group demonstrated this qualification of the collaboration increasing, stating, "…being more cognizant of the fact that, hey, let's reach out to [IPV specialists] now, because they were already referred. I don't know if it would, if it has changed any, but I'll say the collaboration maybe has increased more" (FG 2).

Collaboration across child welfare and DV seemed be informed by the knowledge that Approach coaching was happening for cohorts of other supervisors/managers. This was illustrated here:

I would say that I felt more empowered and more capable of doing the cross-agency collaboration. Well, obviously, the work with [DV agencies]. Also, even though we didn't do our coaching calls with [CW], knowing that there was this shared language, that's - came back to as being really helpful. I was able to say to supervisees, "Well, why don't you talk to [CW] around this?" We know they've been through the QIC training, so maybe we can talk about it. You can talk about the case in this way. And so, there's value in that. (FG 9)

1.B.3. Enhanced Cross-Organization Communication & Collaboration

1.B.3.1. How did CW-Partner communication at management level change at different time points during the intervention?

The Centering Racial Equity in Collaboration survey was the data source used to answer this question. Within the Centering Racial Equity in Collaboration survey, three domains were used to measure CW-Partner communication: Communication, Conflict Resolution, and Cultural Humility.

In the Communication domain, no statistically significant increase was observed in the three domain items. In the Conflict Resolution domain, we observed statistically significant increase in two of the four items between 2019 and 2021, as reported by Implementation and Management Teams (See Table 65). The Conflict Resolution items with statistically significant increase were:

- People in our collaborative group deal with conflict openly and respectfully.
- People in our collaborative group are willing to compromise, particularly those with more power.

In the Cultural Humility domain, we observed statistically significant increase in one of the four items between 2019 and 2021, as reported by Implementation and Management Teams (See Table 65). The Cultural Humility items with statistically significant increase was:

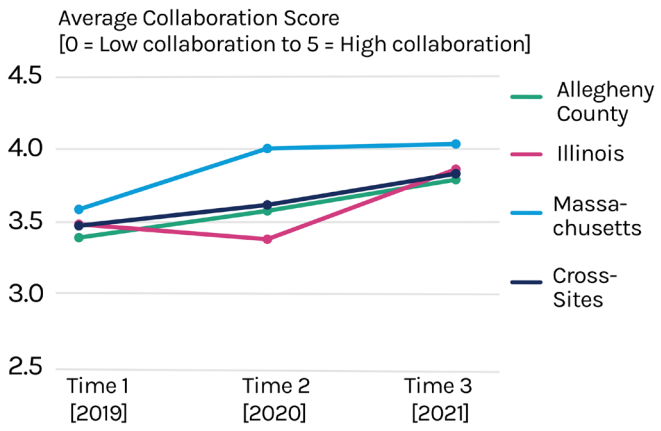
- Members of our collaborative group enhance their awareness of their own cultural assumptions and impositions in ways that enable them to engage and build trust with marginalized groups.

1.B.3.2. How did CW-Partner collaboration at management level change at different time points during the intervention?

Two data sources were used to answer this question, the Centering Racial Equity in Collaboration survey and Key Informant Interviews.

Data from the Centering Racial Equity in Collaboration Survey showed a statistically significant increase in perceived collaboration overall over time, as reported by Implementation and Management Teams. Specifically, the collaboration score increased by 0.42 points on average from 2019 to 2021 [on a scale from 0 – *Low Collaboration* to 5 – *High Collaboration*], controlling for respondent race/ethnicity, type of organization, years in the child welfare/domestic violence field, and site location. See Figure 27. Massachusetts participants reported higher collaboration scores on average compared to Illinois and Allegheny County site participants, all else being equal.

Figure 27. (Collaboration Survey) Change in Average Collaboration Score by Data Collection Time Point



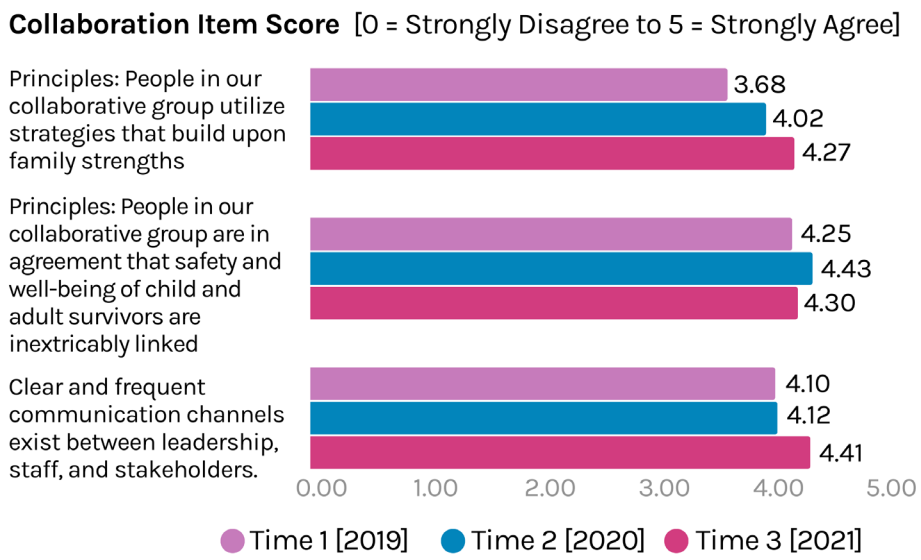
Notes. *N* = 173

Key items, by domains, where we observed statistically significant increases in reported collaboration level between 2019 to 2021:

- Clarity & Structure:
  - People in our collaborative group have systems in place to track goals and progress.
- Sustainability:
  - People in our collaborative group use their existing resources (human, equipment, financial, etc.) fairly and effectively to support project implementation.
  - People in our collaborative group have a plan to sustain the work beyond the life of the federal grant period.
- Decision-Making:
  - Within our collaborative group, decisions are made by an agreed upon democratic or consensus process, not just one or a few leaders.
- Diverse Engagement & Inclusions:
  - People in our collaborative group represent the full range of ethnic/cultural groups involved in the child welfare system.
- Leadership & Development:
  - Seasoned leaders help build and develop the skills of newer leaders in our collaborative group.
- Conflict Resolution:
  - People in our collaborative group deal with conflict openly and respectfully.
  - People in our collaborative group are willing to compromise, particularly those with more power.
- Cultural Humility:
  - Members of our collaborative group enhance their awareness of their own cultural assumptions and impositions in ways that enable them to engage and build trust with marginalized groups.
- Data:
  - The collaboration uses participatory research (e.g., storytelling, practice based evidence) to gather data.
- Principles:
  - People in our collaborative group can describe ways that the project works to identify and alleviate race and gender inequities.
- Frameworks:
  - The organizations in our collaborative group operate from a shared understanding of the relational and systemic accountability framework.
  - The organizations in our collaborative group utilize a continuum of programs and responses to hold persons who use violence accountable.

Additionally, the highest scoring collaboration items in 2021, at the end of the project implementation are shown in Figure 28.

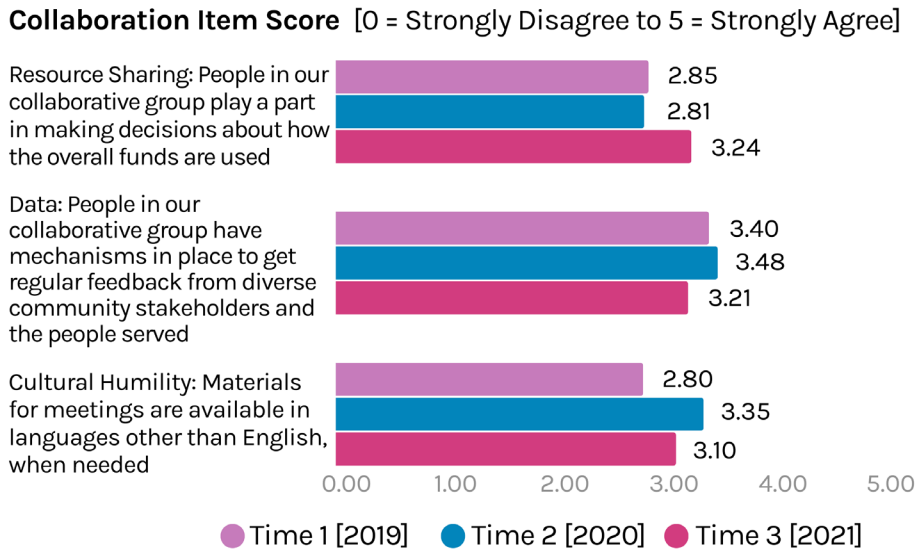
Figure 28. (Collaboration Survey) Highest Scoring Collaboration Items for 2021 (alongside 2019 and 2020 scores)



Notes. *N* = 173

By 2021, key areas for growth in the Collaboration survey included decision-making about use of funds, mechanisms for regular feedback, and having materials in languages other than English. See Figure 29.

Figure 29. (Collaboration Survey) Lowest Scoring Collaboration Items for 2021 (alongside 2019 and 2020 scores)



Notes. *N* = 173

Table 64. (Collaboration Survey) Average Collaboration Score Regressed on Time (N = 165 cases with complete data)*

Independent Variables	B (SE)	95% CI	p
Time (in years)	0.21 (0.05)	[0.11, 0.30]	< 0.001*
Race/Ethnicity			
Latino/a [reference]			
Black and non-Latino/a	0.03 (0.16)	[-0.30, 0.36]	0.854
White and non-Latino/a	-0.13 (0.15)	[-0.42, 0.16]	0.371
Other and non-Latino/a	0.04 (0.29)	[-0.53, 0.61]	0.892
Organization Type			
Child Welfare [reference]			
Domestic Violence	-0.15 (0.11)	[-0.36, 0.06]	0.169
Courts	0.16 (0.13)	[-0.11, 0.42]	0.246
Other	-0.02 (0.12)	[-0.26, 0.23]	0.894
CW/DV Experience			
None to < 1 Year [reference]			
1 to 5 Years	-0.50 (0.33)	[-1.15, 0.15]	0.123
6 to 10 Years	-0.80 (0.33)	[-1.46, -0.15]	0.016*
10 or More Years	-0.63 (0.32)	[-1.25, -0.00]	0.049*
Site			
Allegheny County [reference]			
Illinois	0.00 (0.11)	[-0.22, 0.22]	0.990
Massachusetts	0.25 (0.11)	[0.03, 0.47]	0.026*
Constant	3.93 (0.35)	[0.03, 0.47]	< 0.001*
Model Fit			
F (12, 152)		3.39	< 0.001*
R-squared		0.21	

Notes. The multivariate analysis did not use clustered standard errors due to the model not converging when control variables were added; site was added as a control in lieu of this limitation. The *p*-value reports the probability of observing a false positive (null hypothesis) to be true; statistically significant p-values are denoted by an asterisk (*).

Table 64 shows the results of a multivariate linear regression. The average collaboration score increased by 0.42 points on average from 2019 to 2021, controlling for respondent race/ethnicity, type of organization, years in the child welfare/domestic violence field, and site location. Controlling for all other variables, Massachusetts participants reported higher collaboration scores on average compared to Illinois and Allegheny County site participants (see Figure 2.1). It is also notable that respondents with six or more years of experience reported lower rates of collaboration on average compared to respondents with no to 1 year experience, holding all else equal.

Given that collaboration was one of the QIC-DVCW principles, its emergence as a finding in the Key Informant Interviews may be expected. Seventeen of the 26 participants provided examples of how collaboration that they attributed to be a result of the Approach implementation. Samples of these are described below as key collaboration examples. Additionally, from the participants' descriptions, two collaboration sub-clusters surfaced: (1) IPV Specialist/DV advocate specific collaboration benefits and (2) collaboration support by implementation and management teams and project managers.

Key Collaboration Examples. One important facet of the collaboration Approach principle is that collaboration was conceptualized to happen with professionals and families not only with and among professionals. Some participants described this did indeed take place, as one participant stated it was "definitely happening" (P20). A further illustration of this family and professional form of collaboration was shared:

> *I've been on meetings where survivors have been empowered, especially with having that backup of a IPV specialist to help like in those [case meetings] to help remind [child welfare] that, 'hey, look, let's utilize the Approach. This is part of the Approach or this may be a strength. This is what I'm hearing. This may be a strength.' And vice versa for people using violence as well. I mean, it's that same thing, 'Hey, let's give him his voice so that he can speak, get his point across what it is that he feels that he mainly -- things of that nature.' So I feel like it's definitely empowering to our clients as a whole. (P26)*

At the same time, most participants descriptions of collaboration were between professionals, even if it was for the benefit of families experiencing DV and who are child welfare involved. These collaboration examples of practice change illustrated the mechanisms of the Approach implementation, namely being more knowledgeable about each other, "not just a cold call," (i.e., relationships built during the training, coaching, and implementation and management teams) and each other's work to better make connections for families. One participant described it like this:

> *What I think is really changed is that we're collaborating – [child welfare units] are having a stronger collaboration, because we have a [DV advocate], and [child welfare units] know more about what services [the DV agency] provides, in regards to domestic violence for victims and for people using violence. I think that we are now more connected than we were ever before with our DV agency, working closely. (P5)*

There were many examples of this professional level collaboration increasing.

Another aspect of the benefits of collaboration because of the Approach implementation was the capacity to address more difficult family circumstances and decision making within those circumstances, which the child welfare context have serious consequences for the family. For example, one participant shared the perception that the Approach informed collaboration led to tolerating more risk:

> *I feel like people held risk more, there were situations where I felt like, in a different office with a different group of people, they would have taken custody of these kids. And in [the intervention] offices, I was in conversations where we easily could have made the argument in court that we needed to [remove] kids, but they really wanted to try to do a different approach with the adults before feeling like that was our only course of action. (P8)*

Similarly, another participant described how the foundation of Approach informed collaboration, "It makes me feel like if I'm really having an issue with how an office is responding on a case, I could call an area manager because they know me now. You know, it's not just a cold call. And I'm like I'm a little bit more of a face to those folks now" (P13).

IPV Specialist/DV Advocate Specific Collaboration Benefits. Half of the participants (13/26) identified that Approach implementation resulted collaboration change occurred because of the effectiveness of the IPV Specialist and DV Advocates that were integral to the Approach, although not the only mechanism per the Approach principles and frameworks. One of the main ways described was the Approach informed increased engagement of the IPV Specialists and DV Advocates and the case workers, and how "light bulbs were going off." Described by one participant as:

> *I think that having a [DV advocate] there to model interactions with families and specifically that contributed to the principle of planning with survivors, as opposed to planning for them or about them. I think that that has been something that I've really seen come to life... And more, in particular here in [this state], we have so many veteran child welfare professionals. There's a lot of egos that comes with it, "I've been doing this how long, longer than you, longer than you were born, and so on and so forth, and I have this expertise, I'm doing it my way." (P2)*

Another participant from a DV agency shared:

> *When I think about outcomes on cases, again, I just think there was probably more and deeper collaborative efforts and conversation between service providers, between our [DV] staff, and between – and [child welfare] staff on cases...And I think that as a result of this effort, maybe more people [at DV agencies] were comfortable stepping into that like uninvited consultant role. (P13)*

And further, another participant described the increase in "collaborative thinking on cases":

> *There has been an uptick in group thinking, group consultations, that involve far more people than usually it would, in the past, it might be a social worker and supervisor asking to consult with [DV experts]. There have been a lot of cases in the [deidentified] intervention offices where it was the [deidentified higher level administrators], the supervisor and the social worker, and maybe the response team, there's like nine people in this conversation, problem solving. So, I think that goes, and there were also some community providers that were in some of those meetings. So, the use of sort of a collaborative thinking on cases together, I think increased. (P8)*

Collaboration Support by Implementation and Management Teams and Project Managers. One dominant way collaboration supported the Approach implementation 11 Key Informant Interview participants described was the mechanism of the implementation and management teams, and the role of the project site Project Managers. Time for relationship building during the team meetings was attributed to improving collaboration. For example, one participant said team meetings gave:

> *...opportunities in smaller breakouts for people to build the relationships necessary to actually have the infrastructure work. Because I think you can have a plan and have accountability without people actually making the necessary relationships to really pull it off. (P20)*

Additionally, some Key Informant Interview participants identified it was the cross-sector/multi-field make-up of the teams that provided a unique ingredient to aid the collaboration. One participant from within the child welfare system stated, "we hear ourselves at [CW agency] too much like sometimes, so we need outside people to be like, 'They need to do better. And here is why.' And explain the bigger picture. We're so in our little world" (P21). Another participant described that importance of diversity within the teams stating, the "external internal partnership is critical"

(P12). For some participants identified a deep appreciation for role of the community partners in increasing collaboration. This was illustrated by one participant within the court system who shared:

> *...the collaboration with the treatment providers and the local community that were involved, which I'm sure you'll speak with, was phenomenal. I think that definitely the collaboration was very impressive. [Within the teams] they spoke so much about how they strengthen the partnership between [child welfare] and [community partners]. (P1)*

In addition to the importance of the makeup of the teams facilitating improved collaboration, the team meetings' consistency and duration over time also acted as an incubator for the Approach learning and a crucible for that learning to deepen over time. As one participant illustrated saying:

> *There are particular folks in our implementation and management teams who have been in this process with us for now, like three years, I think, for whom they are considering the challenges of DV and child welfare in a new way, and supporting their supervisees to think about it in different ways. And they talk about those instances, and they talk about the benefit of speaking with collaterals and having space for that in ways that they hadn't previously. (P3)*

1.B.3.3. How did sites' use of shared Approach principles change at different time points during the intervention?

Two data sources were used to answer this question, the Centering Racial Equity in Collaboration survey and the Coaching Focus Groups.

Within the Centering Racial Equity in Collaboration survey, the Principles domain was used to measure the implementation and management teams' assessment of shared Approach principles at different time points during the intervention. In the Principles domain, we observed statistically significant increase in one of the five items between 2019 and 2021, as reported by implementation and management teams (See Table 65). The Principles item with statistically significant increase was:

- People in our collaborative group can describe ways that the project works to identify and alleviate race and gender inequities.

In the Coaching Focus Groups, evidence of shared Approach principles change at different time points during the intervention emerged in the adoption of Approach language, namely, "person that uses violence" and "survivor." This change was identified by half of the coaching focus groups. Prior to the Approach implementation, the terms such as "batterer," "perpetrator," "offender" were more commonly used by the Project sites in place of "person that uses violence." And the term "victim" was more commonly used than "survivor." This adoption of Approach language was described as integral to changing mindsets that then impacted practice. Here, a participant described this change process:

> *...it's changing our language. You know, it's not the batterer, it's not the victim. And I would take that into supervision, because I think it really, those terms are so negative, and it really biases how you look at the survivor and the person who uses violence very differently. (FG 7)*

Another focus group described the adoption of Approach language and the way it has shaped supervision, and in terms of how the Approach is implemented with families.

> *I think just the language – it's not even written, right? But just the language change and the shift in how we even speak about IPV cases, right? No longer using words like the – we still use, we try to use survivor instead of victim. Switching from blaming, the survivor,*

switching the mindset, "This woman shouldn't be in the home with this person who is abusing her because it's affecting. It's not keeping her children safe." So, just thinking about things differently, using different language and helping our staff because I don't directly supervise. Our supervisors and caseworkers directly supervise, the supervisor supervises the caseworkers. So, my input comes in when I'm supervising others and/or during a staffing at time, So, ensuring that I am using the appropriate language, and that I am asking questions to help them look at the situation from a different view. (FG 5)

1.B.3.4. How did sites' use of shared frameworks (PF and RSA) change at different time points during the intervention?

Three data sources were used to answer this question, the Centering Racial Equity in Collaboration survey, Key Informant Interviews, and the Coaching Focus Groups.

In the Centering Racial Equity in Collaboration survey Frameworks domain, we observed statistically significant increases in reported collaboration level between 2019 to 2021 in two of the four items:

- The organizations in our collaborative group operate from a shared understanding of the relational and systemic accountability framework.
- The organizations in our collaborative group utilize a continuum of programs and responses to hold persons who use violence accountable.

Particularly relevant to the assessment of change of sites shared Protective Factors for Survivors framework, the finding from the Coaching Focus Groups that in four out of the ten groups (and not across Project sites) participants experienced an ideological tension with the Approach when it came to the definition and understanding of safety in DV involved child welfare cases. Some of this focused on the concept of child safety (not the adult and child survivor safety) that is prioritized in the child welfare ideological stance, and how this made case work with DV involved families within the child welfare system difficult. Given that these focus groups were conducted at the end of the Project, it is noteworthy that this ideological barrier regarding safety remained after almost two years of coaching. The following quote illustrates the unresolved nature of this barrier, this dilemma about defining safety and the implications for child families and the staff who work with them is highlighted:

And I think that safety -- when you're looking at safety when there is intimate partner violence in a home, it's extremely complex. And the feedback we get from caseworkers is that it's one of the most difficult things to assess, because we hear a lot from families like, 'well, I'm not, that my child isn't being hurt. I'm only being hurt'. But like, how do we talk to the parent about what that means for their family as a whole? So, I think changing the conversation that we have as a team, and then also bringing that back into the families to get better information and plan. (FG 6)

It noteworthy that the implication in the participant using the singular of "parent" here; while it is not completely clear which parent they meant, from the context it appears that they are holding the survivor responsible, in the commonly used "reason for removal term" blame on the adult survivors' "failure to protect" within the child welfare system.

In the Key informant interviews, two main practice and/or policies changes related to the Approach implementation were identified: (1) direct practice with families and (2) collaboration between and among providers, with both changes categorized under the Fidelity and Systems Intervention drivers.

Direct Practice with Families. Almost all participants identified observing direct practice change with families within the intervention sites (23/26). These practice changes clustered into four change areas: most prominently (1) related to protective factors, and (2) practice with people who use violence; and less prominently, but still identified, (3) child welfare case level practice, and (4) how courts/judges work with families. As mentioned above, these both illustrate the Fidelity and System Intervention drivers. Relatedly it is important to note the two most prominently identified change areas parallel exactly the Protective Factors for Survivors framework and the Systemic and Relational Accountability Framework, the two core frameworks that provide guidance for the Approach implementation and are distributed written materials that can be referred to after the training and used in Approach coaching.

Practice Change Related to Protective Factors. Twelve of the 23 participants reported direct practice change related to the Protective Factors for Survivors framework; this is defined as when participants either cited the Protective Factors for Survivors framework or they used the explicit language of the Protective Factors for Survivors framework when describing the practice change with members of the family, this included adult survivors and people who use violence. The protective factors related practice change participants described most often across participants was "promoting safer and more stable conditions with adult and child survivors of DV," and specifically the emphasis in that protective factor to *plan with survivors*, as one participant reported that looking like "planning with survivors, just being able to sit down, and either allow them to do their own plan or assist with them planning" (P25). How this planning with survivors focused practice change rippled through one Project site unit work was illustrated here:

> *I think paying closer attention to the survivor wishes…particularly when we have responses that come in, so if we get the [allegation report], and then we're doing the response, really during our meetings, working with the response worker to make sure that conversations are happening and that integrated in their formulation of the problem, is the survivors wish, so higher focus in intentional questions around that, from the supervisors and from screening team meetings when we have those. (P6)*

Similarly, another participant observed "We're hearing a little bit about what mom has done to try to protect the children" (P15).

Change in Practice with People Who Use Violence. Participants also observed practice change with people who use violence, 11 out of 23 participants. These observed changes included more direct involvement with the person that uses violence, more depth and nuance on how and when to engage people that use violence, more collaboration with father specific staff who would engage men that use violence. For some participants, increased engagement of "fathers" (which is sometimes used interchangeably with people that use violence) was one of the most significant change they saw based on the Approach implementation, as illustrated by this participant who said:

> *…I would say off the top of my head that is definitely one of the things that I know has been spoken a lot about, that's something that is one of the big changes. I can see progress with that so to speak…Before…dads had no voice, dads had nothing, so now we have a lot of different programs and stuff and just father engagement as a whole, like, at least trying to reach out to the father, trying to get those conversations started. (P26)*

Another participant's observations concurred with this assessment that engaging fathers was definitively a change in practice, stating, "And then we have seen more fathers be involved, that's one of the things that I personally didn't expect, but more fathers have been involved, they have been engaged" (P25).

In addition to these more larger scale observations of practice change with people that use violence, some participants shared how the Approach changed their individual perceptions of the importance of engaging people that use violence. For example, one participant shared that, "…now I see the person that uses violence different than just the file that I'm reading, and I tell people that he's no longer that record that I pulled out, and he's more than just that. So that shaped the way I see people that use violence" (P23). While at the same time, some participants described that the Approach, and specifically the Relational and Systemic Accountability framework, complicated and deepened their practice with people that use violence. One participant described the evolution of 'the when and how' of their practice with people that use violence like this: "So, it's not a like, 'Oh, we're going to do this [specific thing] on every case'. It's not always appropriate. And we've – and we're engaging more in like that dialogue around like when and how should this be used" (P13).

How Cases Within the Child Welfare System Were Handled Changed. In the eight participant descriptions of how cases within the child welfare system were handled changed due to the Approach implementation, several examples were reported. One participant stated how they saw practice change particularly at the supervisor and manager level of child welfare:

> *I ended up actually getting pulled into a lot of cases, because they wanted to sort of practice [the Approach], right. And I feel like I saw a lot of growth in that, especially in the supervisors and managers. We've got staff rotate in and out of the social work. Like, the supervisors and managers really sort of landed…I saw it in action in their conversations and how they looked at things. (P8)*

Examples of changes in how cases were handled also included the case status, as reported by a participant who said:

> *I have been in meetings where people have discussed area clinical meetings, where people have discussed their concerns about DV. Serious concerns in terms of whether or not, the person who uses violence poses a risk to the children or not, and that the planning has been very thoughtful. And that I've seen some of those cases closed because people have been able to really stabilize. (P9)*

In addition, several participants described child welfare case level practice change specifically with regards to becoming more adult **and** child survivor centered, which is core tenant of the Approach. This was poignantly described by this participant who shared:

> *I never really looked at it from the [adult] victim's perspective and/or the possible perspective, right, I was just so child focused, and starting with this QIC and working with [DV advocates], it helped me shift the way that I thought about IPV and the children, and what is in their best interests, and thinking about the trauma from removing them from specific circumstances, if the family is willing to do the work as well. So that's really new to me too. And embracing that right and being able to shift the mindsets of my staff as well, sometimes I still have to do it. 'Hold on, wait a second, we have to think about this differently and here's why.' (P25)*

How the Courts Related Work with Families Changed. Although less prominently identified as a practice change observed as a result of the Approach implementation, four participants did describe change in how courts and/or judges specifically worked with family. One participant described the change, stating:

> *So just having one of the judges mentioned once that now when [they] see the person that uses violence, [they are] also looking at more, and what else*

> *can we connect this person, and how can they -- how can we better serve the family, not just this is what I'm here to do, we're thinking about the entire family. So having a judge having people in power, saying this is how this is helping us make a lot of things easier. So now we don't have the distrust, well if you go to the district court, most likely this is what's going to happen, and now you can say actually, if you go to [deidentified] Court, they're trying to make a push to be able to see the entire family. Be able to talk to and hear what the family need, and hear what advocates are the recommendations that the advocates are having. So I think just being with each other, I think made that connection even stronger. (P23)*

In another example of court related practice change as a result of the Approach implementation, a participant shared:

> *...these cases are involved in the court, the decisions that judges are able to make, based upon the quality, the social workers write like court reports for the judge and providing a lot of that detail around the resiliency factors and their engagement in these community based treatment programs. It really helps the court and the judge, you know, with the goal of obviously keeping children, you know, in their homes and in their communities. So it completely impacts you know, all of our practice...the decrease of assumptions and the quick judgment and ultimately making those assessment decisions was really slowed down. (P1)*

1.B.3.5. How did sites' data-driven/ community stakeholder inclusion & feedback change at different time points during the intervention?

Grounded in the Approach principles (e.g., collaboration) and implementation science, particularly the frameworks of teams and improvement cycles, data-driven/community stakeholder inclusion and feedback, was a key implementation outcome. Three data sources were used to answer this question, the Centering Racial Equity in Collaboration survey and Key Informant Interviews.

From the Centering Racial Equity in Collaboration survey, there was mixed evidence of changes in data-driven/community stakeholder inclusion and feedback change. In the Data domain of the Collaboration Survey, significant change over timepoints was observed in one out of the four items, participants' (i.e., implementation and management team members) reports of "*The collaboration uses participatory research (e.g., storytelling, practice-based evidence) to gather data.*" (See Figure 28). In addition, the other Data domain item "*People in our collaborative group have mechanisms in place to get regular feedback from diverse community stakeholders and the people served.*" was one of the three top areas for improvement at Time 3. See Table 65 for descriptive statistics of these items.

In the Key Informant Interviews, the topic of data-driven inclusion and feedback did not surface explicitly. Given the monthly implementation reports produced by the Evaluation team and delivered to the Project managers and TA leads to be shared, discussed, and used for decision making purposes, it is of note that data sharing, data use, or any other kind of "data-driven" strategies used at the implementation and management team to support implementation were not reported by any key informant interview participants, other than description by one participant about their perception that the roll out of the fidelity checklist in the coaching sessions could have been improved.

There was some description, by some Project sites, of concern with the representation of community stakeholders when describing the implementation and management teams' composition. This is reported in full in the section above.

1.B.3.6. How did sites actively work toward racial, ethnic, and gender equity in their collaborative work together change at different time points during the intervention?

Two data sources were used to answer this question, the Centering Racial Equity in Collaboration survey and Coaching Focus Groups.

In the Centering Racial Equity in Collaboration survey, we observed (refer to Table 65) statistically significant increases in reported collaboration level within the domain of Diverse Engagement & Inclusion between 2019 to 2021 in one of the four items:

- People in our collaborative group represent the full range of ethnic/cultural groups involved in the child welfare system.

In the domain of Cultural Humility, we observed statistically significant increases in reported collaboration level between 2019 to 2021 (refer to Table 65) in one of the four items:

- Members of our collaborative group enhance their awareness of their own cultural assumptions and impositions in ways that enable them to engage and build trust with marginalized groups.

In the domain of Principles, we observed statistically significant increases in reported collaboration level between 2019 to *2021 (refer to Table 65) in one* of the five items:

- People in our collaborative group can describe ways that the Project works to identify and alleviate race and gender inequities.

Table 65. (Collaboration Survey) Descriptive Statistics of Items, Organized by Domains

Collaboration Item (Organized by Domain)	T1 M (SD)	T2 M (SD)	T3 M (SD)	b (p)	*a***
Shared Vision, Mission, & Goals					**0.583**
1. Everyone in our collaborative group shares the same vision and agreed upon goals for the project.	3.60 (0.98)	3.65 (0.85)	4.13 (0.66)	0.26 (0.096)	
2. Each level (e.g., board, administrators, supervisors, frontline staff) within my organization is committed to the projects vision and goals.	3.79 (0.99)	3.94 (0.75)	4.00 (0.71)	0.11 (0.292)	
3. Each level (e.g., board, administrators, supervisors, frontline staff) within other organizations in this collaborative group is committed to the projects vision and goals.	3.39 (0.83)	3.80 (0.66)	3.73 (0.77)	0.18 (0.112)	
Clarity & Structure					**0.821**
4. People in our collaborative group have identified tasks, timelines, and person(s) responsible to enable the collective vision to be achieved.	3.61 (1.03)	3.78 (0.86)	4.07 (0.70)	0.23 (0.218)	
5. People in our collaborative group have systems in place to track goals and progress.	3.54 (0.99)	3.54 (0.96)	3.92 (0.78)	0.19 (0.011)*	
Sustainability					**0.631**

Collaboration Item (Organized by Domain)	T1 M (SD)	T2 M (SD)	T3 M (SD)	b (p)	a**
6. People in our collaborative group use their existing resources (human, equipment, financial, etc.) fairly and effectively to support project implementation.	3.80 (0.83)	3.80 (0.79)	4.19 (0.44)	0.19 (0.018)*	
7. People in our collaborative group have a plan to sustain the work beyond the life of the federal grant period.	3.10 (1.00)	3.36 (0.91)	3.64 (0.83)	0.27 (0.010)*	
Decision-Making					**0.734**
8. Within our collaborative group, decisions are made by an agreed upon democratic or consensus process, not just one or a few leaders.	3.49 (0.99)	3.70 (0.84)	4.15 (0.68)	0.33 (0.041)*	
9. People who make decisions in our collaborative group include representation from marginalized groups.	3.41 (0.99)	3.47 (1.01)	3.75 (0.86)	0.17 (0.278)	
10. People in our collaborative group understand the decision-making process within their own organizations as it relates to the project.	3.56 (0.95)	3.76 (0.88)	4.02 (0.58)	0.23 (0.088)	
Resource Sharing					**0.773**
11. People in our collaborative group play a part in making decisions about how the overall funds are used.	2.85 (1.10)	2.81 (0.98)	3.24 (1.00)	0.19 (0.291)	
12. Project resources (human, equipment, financial etc.) are distributed equitably to promote meaningful participation of less resourced project partners in our collaboration.	3.25 (0.89)	3.46 (0.87)	3.59 (0.83)	0.17 (0.112)	
Diverse Engagement & Inclusion					**0.734**
13. People in our collaborative group represent community members and system players that are affected by the work (e.g., families, community leaders, direct service staff).	3.69 (0.93)	3.86 (0.98)	3.86 (0.87)	0.09 (0.295)	
14. People in our collaborative group represent the full range of ethnic/cultural groups involved in the child welfare system.	3.25 (1.03)	3.56 (1.09)	3.52 (1.02)	0.14 (0.044)*	
15. There is an ongoing discussion and process in place to include perspectives of multiple stakeholders who are not formally members of the collaboration.	3.27 (1.06)	3.30 (0.99)	3.61 (0.91)	0.17 (0.171)	

Collaboration Item (Organized by Domain)	T1 M (SD)	T2 M (SD)	T3 M (SD)	b (p)	a**
20. Members of our collaborative group build authentic relationships with … served to foster understanding and center the experiences and needs of the community in decision-making. .	3.47 (0.89)	3.60 (0.96)	3.83 (0.92)	0.18 (0.100)	
Dismantling Structural Oppression					**0.742**
16. People in our collaborative group consistently discuss and promote change to institutional policies, procedures, and barriers that disparately affect survivors, families, and communities who are marginalized.	3.47 (1.00)	3.72 (0.90)	3.93 (0.84)	0.23 (0.179)	
17. People in our collaborative group consistently discuss how white privilege impacts decision-making, communication, evaluation, etc., and take steps to mitigate it.	3.02 (1.12)	3.30 (1.20)	3.66 (1.07)	0.32 (0.142)	
Leadership & Development					
18. Seasoned leaders help build and develop the skills of newer leaders in our collaborative group.	3.29 (0.97)	3.43 (1.00)	3.78 (0.84)	0.24 (0.007)*	--
Mutual Respect					
19. The people in our collaborative group demonstrate respect and appreciation for the work and experience of one another.	4.10 (0.91)	4.12 (0.84)	4.41 (0.57)	0.15 (0.326)	--
Communication					0.765
22. People in our collaborative group regularly communicate with staff of human service agencies and the community to keep them apprised of the project and informed of project activities.	3.41 (0.87)	3.66 (0.89)	3.66 (0.83)	0.13 (0.483)	
23. Project information is conveyed regularly through formal (e.g., meeting minutes) and informal (e.g., chatting over coffee, texts) channels of communication.	3.52 (1.00)	3.90 (0.86)	3.98 (0.81)	0.24 (0.064)	
24. Meetings are used to identify a shared vision, engage in productive discussion, develop action plans to achieve desired goals, and solve problems impeding progress, not merely to give updates.	3.78 (0.87)	3.98 (1.00)	4.08 (0.84)	0.15 (0.114)	
Conflict Resolution					**0.814**

Collaboration Item (Organized by Domain)	T1 M (SD)	T2 M (SD)	T3 M (SD)	b (p)	a**
25. People in our collaborative group deal with conflict openly and respectfully.	3.58 (0.84)	3.81 (0.76)	4.00 (0.53)	0.21 (0.009)*	
26. People in our collaborative group can raise difficult issues without fear of reprisals or judgement of their communication style.	3.60 (0.81)	3.77 (0.86)	3.92 (0.71)	0.16 (0.147)	
27. People in our collaborative group appear to view discomfort as an essential element to learning and growth.	3.28 (0.73)	3.72 (0.71)	3.82 (0.68)	0.28 (0.112)	
28. People in our collaborative group are willing to compromise, particularly those with more power.	3.30 (0.95)	3.42 (0.97)	3.74 (0.67)	0.22 (0.010)*	
Cultural Humility					**0.757**
21. Members of our collaborative group enhance their awareness of their own cultural assumptions and impositions in ways that enable them to engage and build trust with marginalized groups.	3.26 (0.83)	3.65 (0.95)	3.94 (0.81)	0.34 (0.020)*	
29. Materials for meetings are available in languages other than English, when needed.	2.80 (0.98)	3.35 (0.92)	3.10 (0.86)	0.18 (0.303)	
30. People in our collaborative group use knowledge of historical events and oppression that has taken place on the basis of cultural difference.	3.13 (0.88)	3.36 (1.13)	3.55 (1.12)	0.21 (0.204)	
31. People in our collaborative group attend to the impact of their communication, and not just their intent.	3.42 (0.81)	3.59 (1.00)	3.81 (0.74)	0.19 (0.094)	
Data					**0.804**
32. The collaboration uses participatory research (e.g., storytelling, practice based evidence) to gather data.	3.35 (0.99)	3.72 (0.86)	3.77 (0.81)	0.21 (0.044)*	
33. People in our collaborative group use data to establish goals, implement plans, and measure progress.	3.80 (0.92)	3.85 (0.72)	4.04 (0.76)	0.12 (0.186)	
34. People in our collaborative group have mechanisms in place to get regular feedback from diverse community stakeholders and the people served.	3.40 (1.13)	3.48 (0.78)	3.21 (1.12)	-0.09 (0.080)	

Collaboration Item (Organized by Domain)	T1 M (SD)	T2 M (SD)	T3 M (SD)	b (p)	a**
35. People in our collaborative group apply learning and best practices from multiple people and places in our community, region, state, and elsewhere, to the groups work.	3.55 (0.87)	3.96 (0.74)	3.76 (0.96)	0.12 (0.059)	
Principles					**0.814**
36. People in our collaborative group are in agreement that safety and well-being of child and adult survivors are inextricably linked.	4.25 (0.91)	4.43 (0.68)	4.30 (0.86)	0.03 (0.672)	
37. People in our collaborative group engage and listen to survivors when conducting assessments and crafting case plans.	3.45 (1.00)	3.71 (0.97)	4.15 (0.81)	0.35 (0.052)	
38. People in our collaborative group utilize strategies that build upon family strengths.	3.68 (0.92)	4.02 (0.77)	4.27 (0.53)	0.29 (0.062)	
39. People in our collaborative group can describe ways that the project works to identify and alleviate race and gender inequities.	3.25 (0.92)	3.53 (0.99)	3.89 (0.76)	0.32 (0.009) *	
40. The organizations of our collaborative group work together to address the risk and protective factors of domestic violence at the family, community, and institutional levels.	3.62 (0.85)	4.00 (0.80)	4.02 (0.82)	0.20 (0.084)	
Frameworks					**0.865**
41. The organizations in our collaborative group use the domestic violence risk and Protective Factors for Survivors framework.	3.41 (1.07)	3.98 (0.76)	4.10 (0.63)	0.35 (0.073)	
42. The organizations in our collaborative group operate from a shared understanding of the relational and systemic accountability framework.	3.36 (0.97)	3.87 (0.69)	3.98 (0.73)	0.31 (0.043)*	
43. People in our collaborative group establish relationships with people who use violence to support positive change and decrease harm to adult and child survivors.	3.50 (0.99)	3.66 (1.01)	3.93 (0.77)	0.22 (0.050)	
44. The organizations in our collaborative group utilize a continuum of programs and responses to hold persons who use violence accountable.	3.49 (1.00)	3.79 (0.88)	3.87 (0.78)	0.19 (0.024)*	

Collaboration Item (Organized by Domain)	T1 M (SD)	T2 M (SD)	T3 M (SD)	b (p)	a**
The Collaboration Spectrum					**N/A**
Indicate the current level of collaboration you see among the organizations in this collaborative group:	4.33 (1.21)	4.38 (1.29)	4.48 (1.26)	0.07 (0.502)	
Indicate the ideal level of collaboration that you would personally like to see among organizations in this collaborative group:	6.04 (1.19)	5.80 (1.60)	5.89 (1.30)	-0.08 (0.112)	
Average Collaboration Score	**3.48 (0.57)**	**3.66 (0.49)**	**3.89 (0.47)**	**0.20 (0.002)**	**0.938**

Notes. (*N* = 173) Unadjusted MLR with Clustered SEs were run to compare averages over the three time points, accounting for clustering across sites. The *p*-value reports the probability of observing a false positive (null hypothesis) to be true; statistically significant p-values are denoted by an asterisk (*).

** Cronbach's alpha measures the reliability of the items within the identified conceptual domain. A score between 0.70 and 0.95 is considered to be within an acceptable range of reliability.

Coaching Focus on Racial Equity Supported Supervision/Work. Three out of the ten Coaching Focus Groups described that the Approach coaching focus on racial equity as a one of the principles of the Approach, supported the application of the Approach in their supervision and overall work with staff. Coaching focus groups described that it was the concentrated time together focused on racial equity, listening, and learning as a collective in the Approach coaching session that was particularly valuable to sustaining attention on racial equity. This was expressed in this way in FG 5:

> *...the racial equity discussions, really for me, seem to have a strong focus in our coaching sessions. And I think, reinforced that we already knew [was] really important, but we tend to fall away from them when they're not in focus...And recognizing you have to have a network, and you have to have partners, even though we felt like - you're getting the work, you can't do it alone. (FG 5)*

In another Coaching Focus Group, a person who identified as white described what this Approach coaching focus on racial equity with their cohort peers supported their practice "to everyplace" that they are:

> *I needed to hear from other white staff how they were coping and dealing with things, I needed to hear how my coworkers of color were experiencing this and try to be there to support them, but also take as much in as I possibly could. And that has translated to everyplace else that I am. I listen to my staff in a new and, and different way I think. I think about having that lens on all of the work in the cases that I do in a different way, because we spent so much time talking about it, and in, in a forum that I felt like I was with peers. (FG 7)*

RESEARCH QUESTION: HOW DID CHILD OUTCOMES CHANGE?

2.A.1. Were there significant differences between the intervention and comparison sample in measures of child survivor safety?

Data Source

The National Child Abuse and Neglect Data System (NCANDS) was used to track recurrence of maltreatment over time across the three Projects. This is a voluntary data collection system where state child welfare agencies submit standardized information to the Children's Bureau (National Data Archive on Child Abuse and Neglect, 2020). This data was provided directly to the Evaluation Team by Massachusetts and Illinois Project teams. Allegheny County provided the Evaluation Team with an equivalent data set that allowed them to identify recurrence of maltreatment at the regional office level to allow us to accurately identify intervention and comparison sites. We also obtained this data at the county level for the State of Pennsylvania through the National Data Archive on Child Abuse and Neglect (NDACAN) to establish an equivalent baseline for other counties in the State. In addition, each Project team sent the Evaluation team administrative data providing information about DV risk presence upon Project-specific assessment tools.

Sample

To prioritize family-level outcomes and minimize bias that arises from sibling clusters being more alike than different, we focused on *1 index child per initial screened-in report* to follow over time. When only 1 child was identified as the alleged survivor of child maltreatment, this child was selected. When multiple children were identified as alleged survivors of child maltreatment, we prioritized children under the ages of ten years (if present) and then randomly selected an index child from this group when more than one child less than 10 years was identified in the report as an alleged survivor of child maltreatment.

An index child's entry into the system was defined as the first substantiated referral report date between January 1, 2019 to October 1, 2021. From this time point, we were able to track re-maltreatment. Please note that how states defined a child identified as a "victim" in the system varied widely. As a result, we coded "identified maltreatment" when maltreatment was *substantiated* for Massachusetts, *substantiated* for Illinois, *accept for services/active case with a subsequent report* for Allegheny County, and *substantiated* for other counties in Pennsylvania. Cross-site results will be limited in scope, given this variability across state- and county-level documentation and data collection. Project-specific results allowed for more detailed analyses.

Analysis

Survival analyses were used to assess for time to maltreatment recurrence for all identified index children and for the subsample of children when domestic violence was identified as a co-occurring concern. This analytic approach accounts for censored data given outcomes may not have yet occurred for all children (Cleves, Gould, & Marchenko, 2016). As a result, we followed unique children over time with initial time point aligning with first substantiated report after January 1, 2019. The final possible time point that was observed was dated September 30, 2021 for Illinois and Massachusetts and June 30, 2020 for Pennsylvania. We coded all data with recurrence as 1; we calculated time between the first maltreatment report after January 1, 2019 and subsequent report for this group. If data was censored (defined by no recurrence of maltreatment occurring within the observed time period), we calculated time between the

first maltreatment report after January 1, 2019 and the final observation date of September 30, 2021 for Illinois and Massachusetts and June 30, 2020 for Allegheny County/Pennsylvania. There were 9134 index children identified across intervention (n = 5344) and comparison sites (n = 3,790). Approximately 11.4% of cases were missing information on child gender or race. As a result, the sample was further reduced to an **analytic sample of 8,089 index youth with complete information**. We observed cases with missing information had a longer length of stay than cases with complete information ($t(9132) = 8.106$, $p < 0.001$) with a mean difference of 73.76 days (SE = 9.10); however, this pattern was consistently observed across both intervention and comparison groups. There were no other significant differences between cases with missing and complete data by child age, gender, race/ethnicity, or initial allegation.

Any cases flagged as having DV risk were included within a subsample of children who were likely exposed to domestic violence in their home. We then examined maltreatment recurrence for this subpopulation of children with higher likelihood of being exposed to domestic violence. There were 1,594 index children identified across intervention (n = 979) and comparison sites (n = 615). The sample was further reduced to an **analytic sample of 1,235 index youth with complete information**.

Findings report hazard ratios, which can be interpreted as percent increase (above 1.0) or decrease (below 1.0) in the relative risk of a child experiencing a recurrence of maltreatment at any given point in time (Cleves, Gould, & Marchenko, 2016). For example, a hazard ratio of 2.0 can be interpreted as 2 times the number of recurring events or a 100% increase in the number of recurring event seen in the intervention sites relative to the comparison sites at any point in time or. Figures show the estimated proportion of youth that do not experience recurrence over time. We were able to control for child age group at initial report, child gender, child race, and type of maltreatment across sites. We were also able to control from prior maltreatment and child ethnicity for the Illinois and Massachusetts Projects.

2.A.1.1. Decrease maltreatment by person using violence and/or adult survivor

For research question 2.A.1.1, we used administrative data (described above) and focused on one index child within the first substantiated referral and complete date to follow over time. This resulted in a final analytic sample of 73,588 index children with at least one report where child maltreatment was confirmed. There were 4,531 children served by intervention sites; 4,445 children served by comparison sites; and 64,612 served by other within each state where a Project was located. See Table 66 for characteristics of index children in sample. See Table 67 for maltreatment recurrence rates and average length of stay from 2019 to 2021.

Table 66. Cross-Project Baseline Characteristics of Index Children with Substantiated Referrals between 2019-2021 by Intervention Site, Comparison Site, and Other Sites within States

Characteristic	Intervention n (%)	Comparison n (%)	State n (%)	X^2 (df)	*p*
Child gender				6.961 (2)	0.031*
Female	2220 (49.0)	2188 (49.2)	32687 (50.6)		
Male	2311 (51.0)	2257 (50.8)	31925 (49.4)		
Child race				279.116 (6)	< 0.001*
Black/Afr Amer	1505 (33.2)	1578 (35.5)	19434 (30.1)		
White	2676 (59.1)	2381 (53.6)	41158 (63.7)		
Multiracial	265 (5.9)	361 (8.1)	2990 (4.6)		
Other	85 (1.9)	125 (2.8)	1030 (1.6)		
Maltreatment type				880.182 (10)	< 0.001*
Physical abuse	377 (8.3)	297 (6.7)	7267 (11.3)		
Neglect	2928 (64.6)	3019 (67.9)	38509 (59.6)		
Sex abuse/trafficking	256 (5.7)	201 (4.5)	6524 (10.1)		
Other type	199 (4.4)	248 (5.6)	1023 (1.6)		
Multiple types	186 (4.1)	139 (3.1)	3088 (4.8)		
Unknown	585 (12.9)	541 (12.2)	8201 (12.7)		
	M(SD)	**M(SD)**	**M(SD)**	***F* (df1, df2)**	***p***
Child age (years)	6.1 (4.9)	5.9 (4.9)	5.9 (4.9)	1.87 (2,73585)	0.154
Number identified maltreatment events	1.3 (0.7)	1.3 (0.6)	1.2 (0.5)	66.74 (2,73585)	< 0.001*

Notes: *N* = 73,588 unique children with complete cases; *n* = 4,531 for intervention sites, *n* = 4,445 for comparison sites, and *n* = 64,612 for other sites within each state.

- Child gender was limited to binary constructs of male/female within the administrative data systems.
- Child ethnicity was not available across all sites, so only child race can be reported across Projects.
- Median child age for intervention sites was 5 (Min = 0, Max = 17), for comparison sites was 5 (Min = 0, Max = 17), and for other state sites was 5 (Min = 0, Max = 17).
- Median number of identified maltreatment events for intervention sites was 1 (Min = 1, Max = 8), for comparison sites was 1 (Min = 1, Max = 7), and for other state sites was 1 (Min = 1, Max = 8).
- Asterisk (*) denotes significant differences between sites observed.

Table 67. Cross-Project Recurrence of Maltreatment between 2019-2021 by Intervention Sites, Comparison Sites, and Other Sites Within States

Cross-site Child Maltreatment	Intervention M(SD) or *n* (%)	Comparison M(SD) or *n* (%)	State M(SD) or *n* (%)	*X2* (df) / *F* (df1, df2)	*p*
Maltreatment recurrence				114.604 (2)	< 0.001*
No	3642 (80.4)	3533 (79.5)	54501 (84.4)		
Yes	889 (19.6)	912 (20.5)	10111 (15.7)		
Days to recurrence	470.5 (277.6)	451.4 (279.8)	484.2 (286.9)	30.80 (2,73585)	< 0.001*

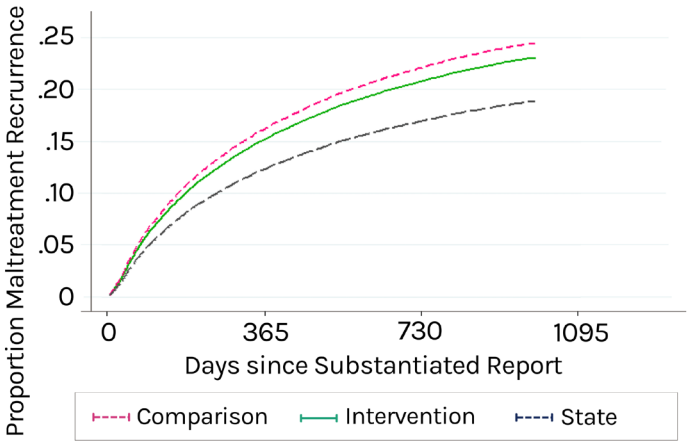
Notes: *N* = 73,588 unique children with complete cases; *n* = 4,531 for intervention sites, *n* = 4,445 for comparison sites, and *n* = 64,612 for other state sites. Median number of days to recurrence for intervention sites was 456 days (Min = 1, Max = 1003), for the comparison sites was 438 days (Min = 1, Max = 1003), and for the other state sites was 475 days (Min = 1, Max = 1003). Asterisk (*) denotes significant differences between sites observed.

Across the three Projects, we observed a no significant differences in maltreatment recurrence between intervention and comparison sites ($HR_{comparison}$ = 1.07, 95% CI (0.98, 1.17), p = 0.147) when controlling for child age, gender, race, and initial maltreatment type. By 1,000 days, comparison sites had an estimated 24.4% of children who re-experienced maltreatment while intervention sites had an estimated 23.0% of children who re-maltreatment (all else being equal). See Figure 30 for visual.

That being said, we observed **significantly lower maltreatment recurrence rates within other state sites compared to intervention sites at any point in time** (HR_{state} = 0.80, 95% CI (0.74, 0.85), p < 0.001). By 1,000 days, other state sites had an estimated 18.8% of children re-experienced maltreatment while intervention sites had an estimated 23.0% of children who re-experienced maltreatment (all else being equal).

In sum, we observed comparable maltreatment recurrence rates within the intervention sites and comparison sites at the cross-Project level; however, both intervention and comparison sites had higher rates of maltreatment recurrence relative to other state sites in the post-intervention time period between 2019-2021.

Figure 30. Cross-Project Maltreatment Recurrence Rate by Group Between 2019 and 2021 by Intervention Sites, Comparison Sites, and Other Sites Within States



Notes. *N* = 73,588. This figure represents the estimated cumulative proportion of maltreatment recurrence by site; a lower proportion of experiencing maltreatment recurrence is identified as a desirable outcome.

2.A.1.2. Decrease exposure to DV

For research question 2.A.1.2, we used two data sources, administrative data and the Adult Survivor Field Survey.

Using the methods described in 2.A.1., we used a complete case analysis that focused only on index children with identified maltreatment who also had co-occurring domestic violence documented within their case file. This resulted in a final sample of 1,763 index children with at least one report where child maltreatment was confirmed (n = 687 for intervention sites and n = 1,763 for comparison sites). See Table 68 for full description of characteristics of index children. See Table 69 for reoccurrence of maltreatment between 2019-2021 for co-occurring maltreatment and DV sample by intervention and comparison groups.

Table 68. Cross-Project Baseline Characteristics of Index Children with Identified Co-occurring Maltreatment & Domestic Violence between 2019-2021 by Intervention and Comparison Groups

Characteristic	Intervention *n* (%)	Comparison *n* (%)	X^2 (df)	*p*
Child gender			0.490 (1)	0.484
Female	338 (49.2)	511 (47.5)		
Male	349 (50.8)	565 (52.5)		
Child race			13.073 (3)	0.004*
Black/African Amer	164 (23.9)	260 (24.2)		
White	456 (66.4)	669 (62.2)		
Multiracial	57 (8.3)	99 (9.2)		
Other	10 (1.5)	48 (4.5)		
Maltreatment type			12.056 (5)	0.034*
Physical abuse	48 (7.0)	45 (4.2)		
Neglect	481 (70.0)	816 (75.8)		
Sex abuse/ trafficking	19 (2.8)	17 (1.6)		
Other type	28 (4.1)	36 (3.3)		
Multiple types	33 (4.8)	50 (4.7)		
Unknown	78 (11.4)	112 (10.4)		
	M(SD)	**M(SD)**	**t (df)**	***p***
Child age (years)	6.1 (5.0)	6.0 (4.8)	0.549 (1761)	0.583
Number identified maltreatment events	1.5 (0.9)	1.4 (0.8)	1.49 (1761)	0.136

Notes. N = 1,763 unique children with complete cases; n = 687 for intervention sites and n = 1076 for comparison sites.

- Child gender was limited to binary constructs of male/female within the administrative data systems.
- Child ethnicity was not available across all sites, so only child race can be reported across Projects.
- Median child age for intervention sites was 5 (Min = 0, Max = 17) and for comparison sites was 6 (Min = 0, Max = 17).
- Median number of identified maltreatment events for intervention sites was 1 (Min = 1, Max = 6) and for comparison sites was 1 (Min = 1, Max = 6).
- Asterisk (*) denotes significant differences between intervention and comparison sites observed.

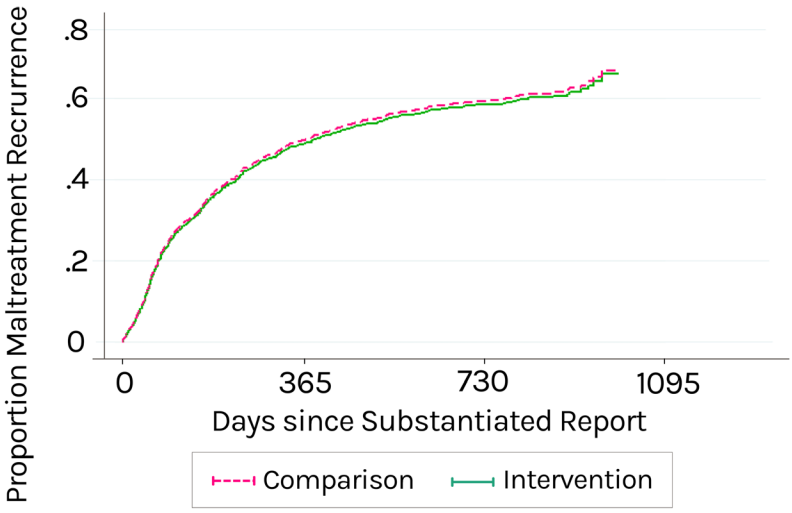
Table 69. Cross-Project Recurrence of Maltreatment & Domestic Violence between 2019-2021 for Co-occurring Sample by Intervention and Comparison Groups

Cross-site Child Maltreatment	Intervention M(SD) or n (%)	Comparison M(SD) or n (%)	X^2 / t (df)	p
Maltreatment recurrence			0.000 (1)	0.997
No	482 (70.2)	755 (70.2)		
Yes	205 (29.8)	321 (29.8)		
Days to recurrence	481.7 (296.4)	496.6 (299.2)	-1.02 (1761)	0.307

Notes. *N* = 1,763 unique children with complete cases; *n* = 687 for intervention sites and *n* = 1076 for comparison sites. Median number of days to recurrence for intervention sites was 468 days (Min = 2, Max = 1002) and for the comparison sites was 519 days (Min = 1, Max = 1003). Asterisk (*) denotes significant differences between intervention and comparison sites observed.

Across Projects, we did not observe a significant difference in the rate of children re-experiencing maltreatment. We observed similar rates of recurrence across intervention and comparison sites ($HR_{comparison}$ = 1.02, 95% CI (0.85, 1.22), *p* = 0.790) when controlling for child age, gender, race, and initial maltreatment type. Refer to Figure 31. for recurrence rate by intervention and comparison groups over time.

Figure 31. Cross-Project Maltreatment Recurrence Rate for Children Exposed to Domestic Violence and Identified by the Child Welfare System Between January 1, 2019 and September 30, 2021



Notes. *N* = 1,763. This figure represents the estimated proportion of maltreatment recurrence for intervention and comparison sites; a lower proportion of re-experiencing maltreatment is identified as a desirable outcome.

In the Adult Survivor Field Survey, we observed no significant difference between the intervention and comparison survivors' perceptions of child safety related to PUV, including when alone with PUV and PUV's parenting. Although, it is noteworthy that the ratings of PUV's parenting were low for both intervention and comparison. See Table 70.

Table 70. Adult Survivors Ratings of Child Safety and PUV Parenting

Child Safety Outcomes	N	Intervention n (%)	Comparison n (%)	X^2 / t (df)	*p*
Adult survivor worries about children's safety when alone with PUV				0.144 (1)	0.664
No	26	19 (44.2)	7 (50.0)		
Yes	31	24 (55.8)	7 (50.0)		
Availability of other childcare options that are safer				5.305 (1)	0.052
No	26	2 (7.7)	3 (42.9)		
Yes	31	24 (92.3)	4 (57.1)		
	N	**Median** (Min, Max)	**Median** (Min, Max)	**Mann-Whitney U test**	*p*
PUV Parenting Average Score [1 = never to 5 = extremely often]	90	2.6 (1.0, 4.6)	2.2 (1.0, 5.0)	702.000	0.525
Frequency of AS & PUV making decisions about children together	90	1.0 (1.0, 5.0)	1.0 (1.0, 5.0)		
Frequency PUV stops abusive behavior when learns it's harmful to the children	82	2.0 (1.0, 5.0)	1.5 (1.0, 5.0)		
Frequency PUV does not tell children they are responsible for abuse**	83	5.0 (1.0, 5.0)	5.0 (1.0, 5.0)		
Frequency PUV supports R's parenting decisions	79	2.0 (1.0, 5.0)	1.5 (1.0, 5.0)		
Frequency PUV makes sure children's needs are met	89	3.0 (1.0, 5.0)	1.0 (1.0, 5.0)		

Notes. ***N*** = 96; intervention ***n*** = 70, comparison ***n*** = 26. Item marked by double asterisk (**) were reverse coded to align with directionality of other questions.

- Average score for "PUV parenting" was composed of 5 items that demonstrated adequate reliability at *a* = 0.763.

2.A.2. Were there significant differences between the intervention and comparison sample in child permanency?

Data Source

The Adoption and Foster Care Analysis and Reporting System (AFCARS) was used to track reoccurrence of maltreatment over time across the three Projects. This is a mandatory data collection system where state child welfare agencies submit standardized information to the Children's Bureau on children place in out-of-home care (National Data Archive on Child Abuse and Neglect, 2022). This data was provided directly to the Evaluation Team by Projects with additional linked information to assist in identifying intervention and comparison sites.

Sample

The data represents unique foster care episodes across children who entered the foster care system between January 1, 2014 to September 30, 2021; the same children may leave and enter foster care multiple times within this time period. We identified a total of 163,269 episodes that met eligibility criteria for inclusion in this analysis; 3,621 (2.2%) of these had some missing information.

Any children entering a foster care episode on or after January 1, 2019 are considered to be a part of the post-intervention time period.

The following findings focused on the analytic sample of 159,648 episodes with complete information:

- For evaluating the relative rate of reunification with parents at any time point, we focused on all foster care episodes between January 1, 2014 to September 30, 2021. We observed the likelihood of experiencing reunification at any point in time.
- For placement stability, we focused on all foster care episodes between January 1, 2014 to September 30, 2021. We observed how the likelihood of experiencing placement stability (defined by 2 or less placements) varied by time period and length of stay in foster care.
- Table 71 provides details on analytic sample characteristics (N = 159,648) for Cross-Project child demographics associated with unique foster care episodes.
- Table 72 provides details on cross-Project foster care episode characteristics by intervention sites, comparison sites, and other sites within each state.

Table 71. Cross-Project Child Demographics Associated with Unique Foster Care Episodes by Intervention Sites, Comparison Sites, and Other sites within Each State

Out-of-Home Care Sample	Intervention	Comparison	State	X^2 (df)	p
Child gender				0.070 (2)	0.965
Female	2864 (48.8)	3528 (48.6)	71178 (48.6)		
Male	3010 (51.2)	3732 (51.4)	75336 (51.4)		
Child race/ethnicity				825.743 (6)	< 0.001*
Black and not Latino/a	1975 (33.6)	2349 (32.4)	43566 (29.7)		
Latino/a, any race	1639 (27.9)	1019 (14.0)	25105 (17.1)		
Latino/a and Black	148 (2.5)	87 (1.2)	3119 (2.1)		
Latino/a and White	872 (14.9)	599 (8.3)	15674 (10.7)		
Latino/a and other race/multiracial	619 (10.5)	333 (4.6)	6312 (4.3)		
White and not Latino/a	1919 (32.7)	3193 (44.0)	68363 (46.7)		
Other race/multiracial and not Latino/a	341 (5.8)	699 (9.6)	9480 (6.5)		
Other race and not Latino/a	23 (0.4)	150 (2.1)	947 (0.7)		

Out-of-Home Care Sample	Intervention	Comparison	State	X^2 (df)	p
Multiracial and not Latino/a	318 (5.4)	549 (7.6)	8533 (5.8)		
Any diagnosed disability?				1,500.000 (4)	< 0.001*
Yes	1195 (20.3)	1572 (21.7)	24411 (16.7)		
No	2983 (50.8)	4219 (58.1)	101394 (69.2)		
Not yet determined	1696 (28.9)	1469 (20.2)	20709 (14.1)		
Reason for FC Involve				991.003 (12)	< 0.001*
Physical abuse	290 (4.9)	353 (4.9)	8025 (5.5)		
Neglect	2111 (35.9)	3314 (45.7)	44292 (30.2)		
Parent alcohol/drug use	580 (9.9)	508 (7.0)	13557 (9.3)		
Parent inability cope	158 (2.7)	117 (1.6)	6511 (4.4)		
Other	328 (5.6)	277 (3.8)	9639 (6.6)		
Multiple reasons	1645 (28.0)	1973 (27.2)	47318 (32.3)		
Unknown	762 (13.0)	718 (9.9)	17172 (11.7)		
	M(SD)	**M(SD)**	**M(SD)**	***F* (df 1, df 2)**	***p***
Child Age @ Entry	7.8 (5.9)	7.0 (5.7)	7.3 (5.9)	26.55 (2, 159645)	< 0.001*

Notes. ***N*** = 159,648 unique foster care episodes; ***n*** = 5,874 for intervention sites, ***n*** = 7,260 for comparison sites, and ***n*** = 146,514 for other state sites.

- Child gender was limited to binary constructs of male/female within the administrative data systems.
- Racial/ethnic groups were collapsed to provide sufficient power for subsequent analyses; composition of groups that compose "Latino/a, any race" and "Other race/multiracial and not Latino/a" are provided in gray for information only.
- Median child age for intervention sites was 7 (Min = 0, Max = 17), for comparison sites was 6 (Min = 0, Max = 17), and for other state sites was 6 (Min = 0, Max = 17).
- Asterisks (*) denotes significant differences across sites.

Table 72. Cross-Project Foster Care Episode Characteristics by Intervention Sites, Comparison Sites, and other sites within Each State

Out-of-Home Care Sample	Intervention	Comparison	State	X^2 (df)	p
Entry Cohort				91.285 (14)	< 0.001*
2014	651 (11.1)	996 (13.7)	20057 (13.7)		
2015	773 (13.2)	1061 (14.6)	20382 (13.9)		
2016	827 (14.1)	991 (13.7)	19328 (13.2)		
2017	790 (13.5)	950 (13.1)	19686 (13.4)		
2018	801 (13.6)	957 (13.2)	19408 (13.3)		
2019	894 (15.2)	1006 (13.9)	19315 (13.2)		
2020	731 (12.4)	793 (10.9)	16302 (11.1)		
2021	407 (6.9)	506 (7.0)	12036 (8.2)		
Most Recent Case Goal				283.383 (8)	< 0.001*
Reunify with Family	4267 (72.6)	4879 (67.2)	94940 (64.8)		
Adoption	775 (13.2)	1387 (19.1)	28602 (19.5)		
Guardianship	312 (5.3)	303 (4.2)	6525 (4.45)		
LTFC/Emancipation	369 (6.3)	463 (6.4)	12856 (8.8)		
Not Established/ Unknown	151 (2.6)	228 (3.1)	3591 (2.5)		
Placement Stability				134.261 (2)	< 0.001*
≤ 2 placements / year	4353 (74.1)	4890 (67.4)	97972 (66.9)		
3+ placement / year	1521 (25.9)	2370 (32.6)	48542 (33.1)		
Prior Episodes				20.690 (2)	< 0.001*
None	4542 (77.3)	5842 (80.5)	116391 (79.4)		
1 or More	1332 (22.7)	1418 (19.5)	30123 (20.6)		
Reason for Discharge				415.548 (10)	< 0.001*
Reunify with Family	2917 (49.7)	3127 (43.1)	66044 (45.1)		
Adoption	470 (8.0)	967 (13.3)	18297 (12.5)		
Guardianship	387 (6.6)	402 (5.5)	6386 (4.4)		
Emancipation	187 (3.2)	186 (2.6)	5868 (4.0)		
Transfer/Runaway/Death	82 (1.4)	51 (0.70)	3862 (2.6)		
Not Applicable/Unknown	1831 (31.2)	2527 (34.8)	46057 (31.4)		
	M(SD)	**M(SD)**	**M(SD)**	***F* (df 1, df 2)**	***p***
Days in Foster Care	548.3 (548.9)	668.0 (598.1)	612.8 (580.2)	69.28 (2, 159645)	< 0.001*

Notes. ***N*** = 159,648 unique foster care episodes; ***n*** = 5,874 for intervention sites, ***n*** = 7,260 for comparison sites, and ***n*** = 146,514 for other state sites.

- ***Not Established/Unknown*** and ***Not Applicable/ Unknown*** indicates when information was not provided for an episode due to this action not yet being determined in the record or having missing information.

- Median days in foster care for intervention sites was 393 days (Min = 1, Max = 2806), for comparison sites was 539 days (Min = 0, Max = 2822), and for other state sites was 451 (Min = 0, Max = 2829).
- Asterisks (*) denotes significant differences across sites.

Analysis

Survival analyses were used to assess for time to reunification for children who were removed from their home between January 1, 2014 and September 30, 2021. This analytic approach accounts for censored data given outcomes may not have yet occurred for all children (Cleves, Gould, & Marchenko, 2016). As a result, we followed unique episodes over time with initial time point aligning with a foster care entry date as early as January 1, 2019. The final possible time point that was observed was dated September 30, 2021. We coded all data with a discharge date and "reunification" as an uncensored event occurring; all other discharge outcomes were coded as an uncensored event not occurring.

We calculated time between foster care entry after January 1, 2019 and foster care discharge date for this group. If data was censored (defined by the child remaining in care occurring within the observed time period), we calculated time between foster care entry after January 1, 2019 and the final observation date of September 30, 2021. Findings report hazard ratios, which can be interpreted as percent increase (above 1.0) or decrease (below 1.0) in the hazard of experiencing a reoccurrence of maltreatment over time; figures report proportion of episodes that resulted in reunification with family by length of stay in number of days, calculated as (1 - estimated survival function; Cleves, Gould, & Marchenko, 2016). In addition to assessing for differences between intervention, comparison, and other state sites, we controlled for foster care entry cohort, child characteristics (i.e., age, gender, race/ethnicity, any clinical disability), and episode characteristics (i.e., prior foster care episodes).

Binary logistic regression were used to assess the likelihood of a child experience 3 or more placements per year by intervention exposure. Any foster care episode that had a start date between January 1, 2014 and September 30, 2021 was included in this sample. Findings report odds ratios, which can be interpreted as percent increase (above 1.0) or decrease (below 1.0) in the odds of experiencing multiple placements within a year. These models controlled for foster care entry cohort, child characteristics (i.e., age, gender, race/ethnicity, any clinical disability), and episode characteristics (i.e., case goals, prior foster care episodes).

2.A.2.1. Decrease Rate of Foster Care Removals

Data Source

The National Child Abuse and Neglect Data System (NCANDS) was used to track recurrence of maltreatment over time across the three Projects. This is a voluntary data collection system where state child welfare agencies submit standardized information to the Children's Bureau (National Data Archive on Child Abuse and Neglect, 2020). This data was provided directly to the Evaluation Team by Massachusetts and Illinois Project teams. Allegheny County provided the Evaluation Team with an equivalent data set that allowed them to identify recurrence of maltreatment at the regional office level to allow us to accurately identify intervention and comparison sites. We also obtained this data at the county level for the State of Pennsylvania through the National Data Archive on Child Abuse and Neglect (NDACAN) to establish an equivalent baseline for other counties in the State. In addition, each Project team sent the Evaluation team administrative data providing information about DV risk presence upon Project-specific assessment tools.

The Adoption and Foster Care Analysis and Reporting System (AFCARS) was used to track reoccurrence of maltreatment over time across the three Projects. This is a mandatory data collection system where state child welfare agencies submit standardized information to the Children's Bureau on children place in out-of-home care

(National Data Archive on Child Abuse and Neglect, 2022). This data was provided directly to the Evaluation Team by Projects with additional linked information to assist in identifying intervention and comparison sites.

Sample

The data represents substantiated reports across children who were investigated by the child welfare system between January 1, 2014 to September 30, 2021. Any children with a report date on or after January 1, 2019 are considered to be a part of the post-intervention time period; however, implementation (defined by training initiation) varied by Project:

- Massachusetts: January 2019 (2019 Q1)
- Illinois: March 2019 (2019 Q2)
- Allegheny County: June 2019 (2019 Q3)

For Massachusetts and Illinois, we aggregated counts for the substantiated reports (NCANDS) observed within Intervention and Comparison sites by report date in 3-month intervals (quarter); any children with more than 1 report within a 3-month time period were deduplicated. We calculated quarterly child removal rate using the following formula for each quarter-year: (Number with Foster Care Removals Reported in NCANDS / Total Number of Substantiated Reports Reported in NCANDS).

For Allegheny County, we aggregated counts for the substantiated reports (NCANDS) and foster care entries (AFCARS) observed within Intervention and Comparison sites by report date/foster care entry date in 3-month intervals (quarter); any children with more than 1 report/entry within a 3-month time period were deduplicated. We calculated quarterly child removal rate using the following formula for each quarter-year: (Number with Foster Care Entries Reported in AFCARS / Total Number of Substantiated Reports reported in NCANDS).

Analysis

Interrupted Time Series Analysis (ITSA) with a 3-month time lag was used to assess variation in foster care removal rates between 2014 to 2021. We assessed for differences between intervention and comparison sites during pre-intervention, post-intervention, and post-covid time periods (when available).

Because of the Project level variability, Project level analysis was justified, not cross-Project. See Project specific results in Sections 7-9.

2.A.2.2. Increased Reunification Rate

For this sample, we followed all Cross-Project episodes involving youth entering foster care between January 1, 2014 and September 30, 2021. Reunification was defined as a child being reunited with a parent/original caregiver and/or living with family. If a child was not reunited with family upon discharge from foster care or remained in care at the end of the observation period, they were coded as "not reunified." All models assessed for a site by time interaction and controlled for child characteristics and episode characteristics.

We then assessed relative rate of a child being reunified with family between intervention, comparison, and other state sites. Holding all else equal, we observed likelihood of being reunified with family post-intervention significantly differed for child survivors who entered foster care after January 1, 2019 and served by comparison sites relative their counterparts served by intervention (reference) sites ($HR_{Comparison}$ = 0.89, 95% CI (0.80, 0.99), p = 0.033), with the intervention sites having a significantly higher reunification rate than comparison or other state sites. We observe significant differences in trends when comparing other state sites to the intervention (reference) sites (HR_{State}= 0.88, 95% CI (0.82, 0.96), p = 0.002).

Table 73. Cross-Project Estimated Proportion of Foster Care Episodes that Resulted with Children being Reunified with Families by Site and Time Period

Time Period	Intervention % Reunified with Family by 1,000 Days	Comparison % Reunified with Family by 1,000 Days	State % Reunified with Family by 1,000 Days
2014-2018	49.7%	49.1%	48.0%
2019-2021	38.7%	36.9%	36.9%

Notes. ***N*** = 159,648.

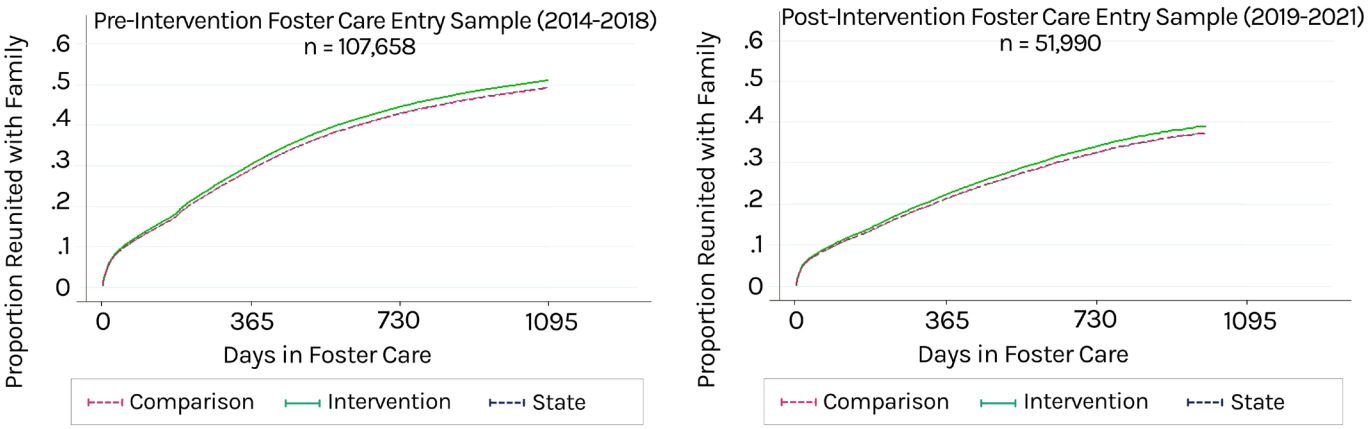
Between 2019 to 2021 within the intervention sites, we observed 22.1% of foster care episodes within the first 12 months of care were associated with children being reunified with family. The proportion of episodes resulting in reunification with family rose another 11.6% for youth who stayed in care from 12 to 24 months and additional 4.8% for youth who stayed in care over 24 months. By 1,000 days, or the 2.7 years that we collected data post-intervention, the adjusted models estimated 38.6% of foster care episodes ended with youth being returned to the care of their family.

Between 2019 to 2021 within the comparison sites, we observed 21.0% of foster care episodes within the first 12 months of care were associated with children being reunified with family. The proportion of episodes resulting in reunification with family rose another 11.2% for youth who stayed in care from 12 to 24 months and additional 4.7% for youth who stayed in care over 24 months. By 1,000 days, or 2.7 years, the adjusted models estimated 36.9% of foster care episodes ended with youth being returned to the care of their family.

Using a difference-in-difference model, we observed the relative difference in rates of children being reunified with families before and after the intervention was implemented did not significantly differ. In other words, we observed no significant differences in the relative rates of experiencing reunification for youth entering foster care when comparing pre- and post-intervention time periods across sites ($HR_{Comparison \times Post\text{-}Intervention}$ = 0.94, 95% CI (0.83, 1.06), p = 0.308; $HR_{State \times Post\text{-}Intervention}$ = 0.96, 95% CI (0.88, 1.05), p = 0.395).

Therefore, while we see intervention sites have slightly higher reunification rates than other sites, this difference appears to be consistent across pre-intervention and post-intervention levels. Figure 32 provides a visualization of relative difference in reunification rates by site for pre-intervention and post-intervention time periods.

Figure 32. Cross-Project Reunification Rates by Intervention, Comparison Sites and Other Sites within the State comparing FC Entry Cohorts 2014-2018 and 2019-2021



Notes. *N* = 159,648. This figure reports the estimated proportion of foster care episodes that result in reunification with family over days in foster care, holding all else equal.

- Every time a child is estimated to reunify with a family, the cumulative proportion of youth increases. A good outcome is associated with a higher proportion of foster care episodes resulting in reunification with family.
- Differences in relative risk for reunification across pre- and post-intervention foster care entry did not significantly differ. In other words, while we see some relative improvement in reunification rates for the intervention sites compared to the comparison sites, these differences were considered comparable when accounting for variability in outcomes across child and episode characteristics.

Given significant differences in composition of sample populations across sites, we are only reporting stratified analyses at the Project site level.

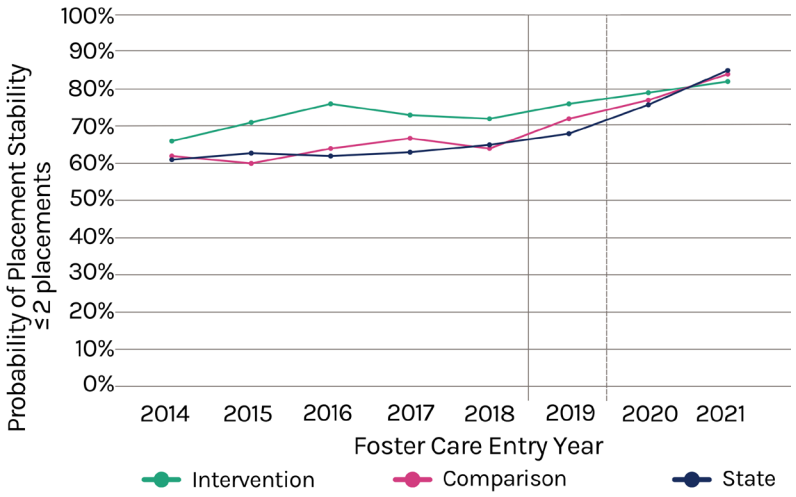
2.A.2.3. Increased Stability

Two data sources are used to answer this question, the primary data source Adult Survivor Field Survey and administrative data. In the Adult Survivor Field Survey (AS report), there were no significant differences between the intervention and comparison groups in measures of child stability, which was measured by "School Absences." See Table 76.

Using the administrative data (See above under 2.A.2. for description of data source, sample, and analysis), we examined stability between intervention and comparison sites as evidenced by **a higher likelihood of experiencing 2 or less placements within a unique foster care episode**.

We used the full sample of *N* = 159,648 as reported in the methods to answer this research question. In the models that assessed for differences between sites by foster care entry cohort and controlled for child and episode characteristics, we observed no significant main effect for the differences in the odds of a child survivor experiencing placement stability between the comparison and intervention (reference) sites ($OR_{comparison}$ = 1.06, 95% CI (0.85, 1.34), p = 0.599) or between other state and intervention (reference) sites (OR_{state} = 0.87, 95% CI (0.73, 1.05), p = 0.146). When placement stability was compared across sites by foster care entry year, we did observe proportions between comparison and other state sites converging with intervention sites between 2018 to 2021. Figure 33 compares site-level differences in the probability of youth experiencing two or less placements for youth entering foster care between 2014 to 2021.

Figure 33. Cross-Project Probability of Placement Stability by Entry Cohort by Intervention Site, Comparison Site, and Other Sites within States



Notes. *N* = 159,648 unique foster care episodes; *n* = 5,874 for intervention sites, *n* = 7,260 for comparison sites, and *n* = 146,514 for other state sites. Intervention start date was January 1, 2019 indicated by the vertical solid line. The onset of Covid-19 is indicated by the vertical dash line.

We ran additional models stratified by duration of the foster care episode to assess for differences in rates by children's length of time in care. Table 74 shows the results of these multivariate models and Table 75 reports the estimated probability by site and time across these three models.

Table 74. Cross-Project Likelihood of Experiencing Placement Stability by Duration in Foster Care by Intervention Site, Comparison Site, and Other Sites within States

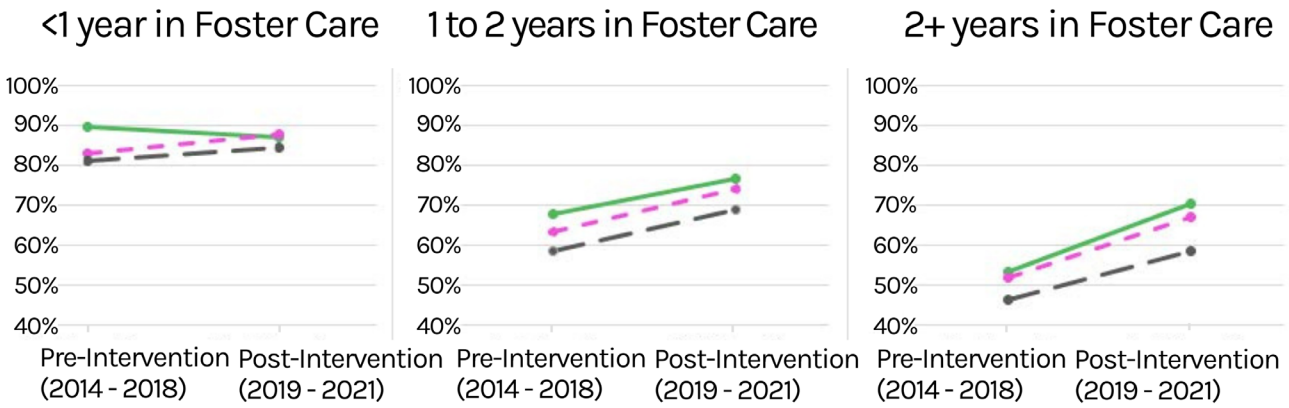
Characteristics	Episode < 1 year OR (95% CI)	Episode 1 to 2 years OR (95% CI)	Episode 2+ years OR (95% CI)
Site			
Intervention	ref	ref	ref
Comparison	0.61 (0.50, 0.75)***	0.84 (0.68, 1.04)	0.93 (0.81, 1.07)
State	0.49 (0.42, 0.57)***	0.64 (0.54, 0.76)***	0.75 (0.67, 0.84)***
Time			
2014-2018	ref	ref	ref
2019-2021	0.78 (0.62, 0.97)*	1.61 (1.27, 2.05)***	2.17 (1.63, 2.88)***
Site * Time			
Comparison*2019-2021	1.87 (1.38, 2.55)***	1.01 (0.74, 1.39)	0.94 (0.66, 1.35)
State*2019-2021	1.61 (1.28, 2.02)***	1.02 (0.80, 1.30)	0.77 (0.58, 1.03)
Child age (in yrs)	0.97 (0.97, 0.98)***	0.93 (0.93, 0.93)***	0.93 (0.93, 0.93)***

Characteristics	Episode < 1 year OR (95% CI)	Episode 1 to 2 years OR (95% CI)	Episode 2+ years OR (95% CI)
Child gender			
Female	ref	ref	ref
Male	1.02 (0.98, 1.07)	0.97 (0.93, 1.02)	0.95 (0.91, 0.98)**
Child race/ethnicity			
Black and not Latino/a	ref	ref	ref
Latino/a, any race	1.18 (1.11, 1.25)***	1.16 (1.08, 1.24)***	1.03 (0.98, 1.09)
White and not Latino/a	1.45 (1.38, 1.52)***	1.50 (1.42, 1.58)***	1.30 (1.25, 1.36)***
Other race/multiracial and not Latino/a	1.25 (1.14, 1.37)***	1.33 (1.21, 1.47)***	1.13 (1.05, 1.22)**
Child any disability			
Yes	ref	ref	ref
No/Not Yet Determined	1.56 (1.48, 1.65)***	1.24 (1.17, 1.32)***	1.33 (1.26, 1.39)***
Prior Episode			
None	ref	ref	ref
At least 1 prior episode	0.88 (0.84, 0.92)***	0.91 (0.86, 0.97)**	0.82 (0.78, 0.86)***
Case Goal			
Reunify with Family	ref	ref	ref
Adoption	1.17 (1.03, 1.32)*	1.40 (1.31, 1.50)***	0.98 (0.93, 1.02)
Guardianship	0.98 (0.83, 1.16)	2.02 (1.81, 2.27)***	1.36 (1.26, 1.46)***
LTFC/Emancipation	0.76 (0.70, 0.83)***	0.94 (0.86, 1.02)	1.25 (1.18, 1.33)***
Unknown	1.76 (1.58, 1.96)***	1.28 (1.02, 1.60)*	3.11 (2.58, 3.74)***
Project Site			
Massachusetts	ref	ref	ref
Illinois	0.76 (0.71, 0.81)***	0.91 (0.85, 0.97)**	0.66 (0.63, 0.70)***
Pennsylvania	2.21 (2.11, 2.32)***	1.83 (1.72, 1.93)***	1.34 (1.28, 1.41)***
Model Fit			
LR Chi2 (df)	2662.56 (18)***	3455.48(18)***	3504.23 (18)***
Pseudo R2	0.0421	0.0704	0.0478

Notes. * > .05, ** > .01, ** > .001. Less than one year in foster care *n* = 69,242; 1 to 2 years in foster care *n* =37,454; and 2+ years in foster care *n* = 52,952.

To better understand the treatment effects reported in the prior table (site * time interaction), Figure 34 depicts the probability of a child experiencing placement stability across sites by a child's duration in foster care and when a child entered foster care (i.e., pre-intervention time period between 2014-2018 or post-intervention time period between 2019-2021).

Figure 34. Cross-Project Estimated Probability of a Child Experiencing Placement Stability by Duration in Foster Care and Entry Cohort by Intervention Site, Comparison Site, and Other Sites within States



Notes. *N* = 159,648. Less than one year in foster care *n* = 69,242; 1 to 2 years in foster care *n* =37,454; and 2+ years in foster care *n* = 52,952.

Table 75. Cross-Project Estimated Probability of a Child Experiencing Placement Stability by Duration in Foster Care and Entry Cohort by Intervention Site, Comparison Site, and Other Sites within States

Episode Length by & Foster Care Entry Year	Intervention % (95% CI) of Placement Stability	Comparison % (95% CI) of Placement Stability	State % (95% CI) of Placement Stability
Less than 1 year in foster care:			
2014-2018	89.6 (88.2, 91.0)	84.3 (82.6, 85.9)	81.2 (80.8, 81.6)
2019-2021	87.1 (85.3, 88.9)	88.5 (86.8, 90.1)	84.2 (83.8, 84.7)
1 to 2 years:			
2014-2018	68.0 (64.7, 71.3)	64.5 (61.7, 67.3)	58.6 (57.9, 59.2)
2019-2021	76.8 (73.9, 79.7)	74.1 (71.2, 77.0)	69.0 (68.3, 69.8)
2+ years in foster care:			
2014-2018	53.4 (50.8, 55.9)	51.6 (49.6, 53.6)	46.6 (46.1, 47.1)
2019-2021	70.4 (65.2, 75.6)	67.7 (63.6, 71.8)	58.5 (57.4, 59.7)

Notes. *N* = 159,648. Less than one year in foster care *n* = 69,242; 1 to 2 years in foster care *n* =37,454; and 2+ years in foster care *n* = 52,952.

For children whose foster care episode has a duration of less than a year:

- We observed significant pre-intervention differences between intervention sites and both comparison sites (z = -4.78, Bonferroni p < 0.001) and state sites (z = -8.97, Bonferroni p < 0.001).
- We do not observe significant post-intervention differences between intervention sites and both comparison sites (z = 1.16, Bonferroni p = 1.000) and state sites (z = -2.77, Bonferroni p = 0.084).
- Holding all else equal, we observed a significant treatment by time interaction. Intervention sites reported relatively consistent proportions of pre- and post-intervention episodes that experienced

placement stability (z = -2.21, Bonferroni p = 0.404).

- In contrast, we observed significant increases in stability within comparison (z = 3.48, Bonferroni p = 0.007) and other state sites (z = 9.44, Bonferroni p < 0.001) when comparing the pre- and post-intervention time periods.

For children whose foster care episode has a duration of 1 to 2 years:

- Holding all else equal, we did not observe a significant treatment by time interaction. Any observed differences between sites remained relatively consistent during pre- and post-intervention time periods.
- In other words, we observed a significant increase in likelihood of children experiencing placement stability across all sites when comparing children who entered foster care between 2019-2021 (post-intervention) compared to those who entered foster care between 2014-2018 (pre-intervention; Bonferonni p < 0.001).

For children whose foster care episode has a duration of 2+ years:

- We observed a significant increase in likelihood of children experiencing placement stability across all sites for those children who entered foster care between 2019-2021 compared to those who entered foster care between 2014-2018 (Bonferonni p < 0.001).
- There was no significant treatment effect between intervention and comparison sites. For example, we observed no difference in likelihood of placement stability between intervention and comparison sites prior to the intervention (z = -1.06, Bonferonni p = 1.000) and after the implementation of the intervention (z = -0.79, Bonferonni p = 1.000).

In sum, we did not observe any significant increases in stability associated with the implementation of the Approach at a cross-Project level.

2.A.3. Were there significant differences between the intervention and comparison sample in child well-being?

2.A.3.1. Increase in emotional and social development and physical health

Two data sources are used to answer this question, the Adult Survivor Field Survey and the Family Survey. In the Adult Survivor Field Survey (AS report), there were no significant differences between the intervention and comparison groups in measures of emotional and social development and physical health; see Table 76.

In the Family Survey (caseworker report) included items measuring "child social and emotional abilities," the terms used in the Protective Factors for Survivors framework. The scale, as collected using planned missingness, demonstrated low internal reliability with items typically correlating at a |0.200| correlation or less. As a result, items are individually reported. See Table 77 and Table 78. We observed statistically significant differences between intervention and comparison ratings at Time 2, controlling for Project site and baseline ratings in one of the 10 items:

- Caseworkers rated "Child understands that it is wrong to intentionally hurt people physically or hurt their feelings" as lower on average for the intervention group compared to the comparison group (b = -10.9, se = 4.1, p = 0.008). The effect size was small (partial eta2 = 0.028).

Table 76. (ASFS) Adult Survivor Ratings of Child Outcomes

Child Outcomes	N	Intervention n (%)	Comparison n (%)	X^2	df	*p*
Learning Ability				2.393	1	0.146
No delays	56	39 (56%)	17 (65%)			
Some to significant delays	37	31 (44%)	6 (23%)			
Missing	3	0 (0%)	3 (12%)			
Emotional Development				.562	1	0.481
No problems	40	28 (40%)	12 (46%)			
Some to significant problems	52	40 (57%)	12 (46%)			
Missing	4	2 (3%)	2 (8%)			
Physical Health				1.482	1	0.264
No problems	74	53 (76%)	21 (81%)			
Some to significant problems	20	17 (24%)	3 (12%)			
Missing	2	0 (0%)	2 (8%)			
Social Development				0.210	1	0.807
No delays	59	43 (61%)	16 (62%)			
Some to significant delays	35	27 (39%)	8 (31%)			
Missing	2	0 (0%)	2 (8%)			
Attend School or Daycare?				1.555	1	0.224
No	34	23 (33%)	11 (42%)			
Yes	58	44 (66%)	12 (46%)			
Missing	4	1 (1%)	3 (12%)			
School Absences				0.955	1	0.431
0 to 5 days	36	31 (44%)	5 (19%)			
5 or more days	16	12 (17%)	4 (15%)			
Not Applicable/Missing	44	27 (39%)	17 (65%)			
PUV-Child Relationship (1 = Never to 5 = Extremely Often)	N	Intervention Median (Min,Max)	Comparison Median (Min,Max)	Mann-Whitney U		p-value

Notes. *N* = 96: Intervention n=70, Comparison n=26. The *p*-value reports the probability of observing a false positive (null hypothesis) to be true; statistically significant p-values are denoted by an asterisk (*).

Table 77. (Family Survey) Part 1. Child Social and Emotional Abilities

Item	Intervention Group			Comparison Group			estimated *r* between pre-test & post-test
	n	Pre-test M (SD)	Post-test M (SD)	n	Pre-test M (SD)	Post-test M (SD)	
Expresses negative emotions in ways that do not cause harm to themselves and others							
Pre-test observed	28	70.7 (29.3)		21	69.7 (30.7)		
Post-test observed (9 Mo F/U)	11		80.5 (26.9)	6		51.7 (30.7)	
Analytic sample	174	58.5	58.1	139	52.5	67.8	(0.089, 0.157)
Understands that it is wrong to intentionally hurt people physically or hurt their feelings							
Pre-test observed	24	53.2 (28.9)		28	70.5 (34.6)		
Post-test observed (9 Mo F/U)	15		75.8 (25.5)	8		67.8 (24.7)	
Analytic sample	174	59.7	65.7	139	67.3	76.8	(0.008, 0.119)
Seems to be in a good mood most of the time							
Pre-test observed	34	75.6 (20.1)		20	73.4 (20.5)		
Post-test observed (9 Mo F/U)	13		80.4 (19.5)	10		82.5 (16.1)	
Analytic sample	174	69.3	81.6	139	65.9	78.7	(-0.217, -0.136)
Gets along with children their age							
Pre-test observed	34	75.1 (25.0)		25	77.9 (19.8)		
Post-test observed (9 Mo F/U)	15		88.1 (18.0)	6		83.7 (18.3)	
Analytic sample	174	65.0	89.1	139	66.0	89.9	(-0.081, 0.028)

Item	Intervention Group			Comparison Group			estimated *r* between pre-test & post-test
	n	Pre-test M (SD)	Post-test M (SD)	n	Pre-test M (SD)	Post-test M (SD)	
Will turn to a trusted adult when they need to feel safe, alleviate stress, or feel							
Pre-test observed	33	80.2 (21.9)		25	69.0 (24.9)		
Post-test observed (9 Mo F/U)	13		78.8 (20.5)	13		83.3 (16.1)	
Analytic sample	174	77.3	74.6	139	69.7	70.3	(- 0.062, -0.004)

Notes. ***N*** = 313 unduplicated cases. Caseworkers reported their observations of child social and emotional abilities on a slider scale from **0 (Strongly Disagree) to 100 (Strongly Agree)**. Due to planned missingness design, not all items were answered across cases resulting in variation in complete cases observed by item. Analytic sample used Multiple Imputation for Chained Equations (MICE) using the PCAux package in R; pooled means and range of correlations observed across 100 imputed data sets are reported for the analytic sample.

Table 78. (Family Survey) Part 2. Child Social and Emotional Abilities

Item	Intervention Group			Comparison Group			estimated *r* between pre-test & post-test
	n	Pre-test M (SD)	Post-test M (SD)	n	Pre-test M (SD)	Post-test M (SD)	
Tries again when first attempts to achieve a goal are not successful							
Pre-test observed	23	75.5 (25.4)		22	65.6 (21.9)		
Post-test observed (9 Mo F/U)	13		64.3 (27.1)	11		69.6 (18.3)	
Analytic sample	174	63.9	71.8	139	65.3	70.1	(0.023, 0.071)
Listens and follows directions							
Pre-test observed	28	65.2 (25.2)		25	60.5 (28.3)		
Post-test observed (T2 9 Mo F/U)	11		69.0 (28.7)	7		65.7 (27.8)	
Analytic sample	174	58.9	58.3	139	51.2	57.4	(-0.153, -0.075)
Recognized and manages their own emotions							
Pre-test observed	26	46.7 (27.6)		27	56.6 (29.7)		

Item	Intervention Group			Comparison Group			estimated *r* between pre-test & post-test
	n	Pre-test M (SD)	Post-test M (SD)	n	Pre-test M (SD)	Post-test M (SD)	
Post-test observed (9 Mo F/U)	15		68.5 (25.2)	8		66.0 (22.9)	
Analytic sample	174	61.0	70.3	139	58.0	77.5	(-0.146, -0.084)
Understands others' emotions and shows empathy toward others							
Pre-test observed	29	68.1 (22.9)		19	62.4 (24.0)		
Post-test observed (9 Mo F/U)	12		75.6 (17.4)	9		65.7 (23.6)	
Analytic sample	174	68.9	74.0	139	63.8	66.2	(-0.125, -0.049)
Aware that they can do some things well							
Pre-test observed	33	78.4 (22.5)		25	72.0 (21.5)		
Post-test observed (9 Mo F/U)	15		81.0 (20.4)	6		74.8 (23.3)	
Analytic sample	174	68.9	78.1	139	63.8	84.2	(-0.005, 0.076)

Notes. **N** = 313 unduplicated cases. Caseworkers reported their observations of child social and emotional abilities on a slider scale from **0 (Strongly Disagree) to 100 (Strongly Agree)**. Due to planned missingness design, not all items were answered across cases resulting in variation in complete cases observed by item. Analytic sample used Multiple Imputation for Chained Equations (MICE) using the PCAux package in R; pooled means and range of correlations observed across 100 imputed data sets are reported for the analytic sample.

In the Family Survey, there were no significant differences between intervention and comparison sample in the four items measuring child emotional and social development and physical health outcomes at Time 2, controlling for Project site and baseline functioning. See Table 79.

Table 79. (Family Survey) Child Emotional and Social Development, and Physical Health

Item	Intervention Group			Comparison Group			estimated *r* between pre-test & post-test
	n	Pre-test M (SD)	Outcome M (SD)	n	Pre-test M (SD)	Outcome M (SD)	
Learning Abilities							
Pre-test Observed (T1 Baseline)	52	24.9 (27.6)		44	23.2 (22.8)		
Post-test Observed (T2 9 Mo F/U)	24		27.7 (25.8)	20		25.9 (24.6)	
Analytic Sample	174	28.7	35.1	139	34.1	38.1	(0.121, 0.175)
Emotional Development							
Pre-test Observed (T1 Baseline)	49	31.2 (29.3)		47	27.6 (25.4)		
Post-test Observed (T2 9 Mo F/U)	22		35.4 (28.3)	19		51.2 (19.9)	
Analytic Sample	174	30.8	37.6	139	27.6	44.3	(-0.004, 0.071)
Physical Health							
Pre-test Observed (T1 Baseline)	43	12.9 (19.2)		43	15.8 (23.3)		
Post-test Observed (T2 9 Mo F/U)	33		21.2 (31.5)	17		12.4 (20.3)	
Analytic Sample	174	26.5	35.4	139	25.2	35.9	(-0.002, 0.084)
Social Development							
Pre-test Observed (T1 Baseline)	60	22.4 (26.2)		37	21.9 (22.3)		
Post-test Observed (T2 9 Mo F/U)	24		26.5 (28.2)	22		26.0 (23.8)	
Analytic Sample	174	33.2	36.5	139	31.1	35.8	(0.051, 0.115)

Notes. **N** = 313 unduplicated cases. Caseworkers reported their observations of child development on a slider scale from **0 (No Delays/Concerns) to 100 (Significant Delays/Concerns)**. Due to planned missingness design, not all items were answered across cases resulting in variation in complete cases observed by item. Analytic sample used Multiple Imputation for Chained Equations (MICE) using the PCAux package in R; pooled means and range of correlations observed across 100 imputed data sets are reported for the analytic sample.

2.A.3.2. Increase supportive relationships with specific individuals (grandparents, parents/parent figure, siblings)

The Family Survey was the data source used to answer this question. In the Family Survey, no significant differences were observed between intervention and treatment groups at Time 2, controlling for baseline number of supportive adults in a child's life ($p = 0.638$); see Table 80. Please note that this item only conveys *the number* of relationships rather than quality of relationships.

Table 80. (Family Survey – Caseworker Report) Focal Child Number of Meaningful Adult Relationships

Number of Meaningful Adult Relationships	Intervention Group			Comparison Group			*r (p)* between pre-test & post-test
	n	Pre-test M (SD)	Post-test M (SD)	n	Pre-test M (SD)	Post-test M (SD)	
Pre-test observed	88	4.3 (2.3)		67	4.6 (2.5)		
Post-test observed (9 Mo F/U)	37		3.7 (1.8)	30		4.2 (2.3)	
Both pre-test & post-test observed	19	4.6 (1.9)	4.1 (1.8)	17	3.4 (1.4)	4.4 (2.5)	0.342 (0.041)

Notes. ***N*** = 313 unduplicated family cases. Only cases with complete information are reported within this table.

RESEARCH QUESTION: HOW DID ADULT SURVIVOR OUTCOMES CHANGE?

2.B.1. Were there significant differences between the intervention and comparison sample in adult survivor safety and stability?

Within the adult survivor outcome of significant differences in measure of adult survivor safety and stability, there are two major variables, safety and stability. There are three sub-outcomes nested within this research question:

- 2.B.1.1: Decreased DV-related Risk Level between Adult Survivor and Person Using Violence (PUV)
- 2.B.1.2: Decreased Abuse of Adult Survivor, including Use of Children & Systems
- 2.B.1.3: Increased Stability

2.B.1.1: Decreased DV-related Risk Level between Adult Survivor & Person Using Violence (PUV)

The Family Survey was used to observe whether there were significant differences among the intervention and comparison groups in DV-related risk level between the adult survivor and PUV. In the Family Survey, we observed from caseworker reports that both the intervention and comparison group average scores for DV-related risk level increased. Statistical testing indicated that there were not statistically significant differences between the intervention and comparison groups (See Table 81).

Table 81. (Family Survey – Caseworker Reports) Level of Risk PUV Poses to AS

Level of Risk PUV Poses to AS	Intervention Group			Comparison Group			r (p) between pre-test & post-test
	n	Pre-test M (SD)	Post-test M (SD)	n	Pre-test M (SD)	Post-test M (SD)	
Pre-test observed	71	31.9 (28.9)		66	42.3 (27.5)		
Post-test observed	10		52.5 (36.6)	9		39.3 (25.5)	
Both pre-test & post-test observed	6	30.4 (28.0)	62.0 (40.7)	5	38.1 (23.3)	49.2 (23.2)	-0.110 (0.890)
Analytic sample	174	40.03	57.6	139	46.3	54.4	

Notes. **N** = 313 unduplicated cases. Caseworkers reported the level of risk PUV poses to adult survivors on a slider scale from **0 (Low Risk) to 100 (High Risk)**. Due to planned missingness design, not all items were answered across cases resulting in variation in complete cases observed by item. Analytic sample used Multiple Imputation for Chained Equations (MICE) using the PCAux package in R; pooled means observed across 100 imputed data sets are reported for the analytic sample.

2.B.1.2: Decreased Abuse of AS, including use of children & systems

Two data sources were used, the Family Survey and the Adult Survivor Field Survey. In the Family Survey, no statistically significant differences between intervention and comparison groups were observed in how the caseworker reported adult survivor description of PUV behavior change, controlling for baseline ratings and Project site (See Table 82). However, both intervention and comparison groups decreased, which in this case is better, as it means that case worker reported the adult survivor observed change in PUV behaviors.

Table 82. (Family Survey) AS Observations of PUV Behavior Change

Extent to which AS observed a change in PUV behaviors	Intervention Group			Comparison Group			r (p) between pre-test & post-test
	n	Pre-test M (SD)	Post-test M (SD)	n	Pre-test M (SD)	Post-test M (SD)	
Pre-test observed	69	48.7 (28.0)		66	46.3 (32.5)		
Post-test observed (9 Mo F/U)	15		51.3 (30.5)	11		51.1 (25.0)	
Both pre-test & post-test observed	10	52.9 (31.6)	48.7 (29.5)	6	39.8 (31.0)	56.5 (25.5)	0.848 (0.355)
Analytic sample	174	47.5	22.0	139	45.5	20.2	

Notes**. N** = 313 unduplicated cases. Caseworkers reported the extent to which AS observed a change in PUV behaviors on a slider scale from **0 (No Change) to 100 (Significant Change)**. Due to planned missingness design, not all items were answered across cases resulting in variation in complete cases observed by item. Analytic sample used Multiple Imputation for Chained Equations (MICE) using the PCAux package in R; pooled means observed across 100 imputed data sets are reported for the analytic sample.

In the Adult Survivor Field Survey, we observed no statistically significant difference between the intervention and comparison sample in economic, emotional, violence, stalking, threats of violence, physical abuse, physical abuse – bodily injury, and sexual violence (See Table 83). We also observed no significant difference in use of children and systems by the person using violence as a form of coercion both in type and frequency between intervention and comparison groups (See Table 84 and Table 85).

Table 83. (ASFS) Adult Survivor Experiences of Violence by Intervention & Comparison Groups

In the last 6 months, have you experienced by the PUV	N	Intervention *n* (%)	Comparison *n* (%)	*X2*	*df*	*p*
Economic Abuse				2.985	2	0.234
Yes	31	26 (39%)	5 (21%)			
No	16	12 (18%)	4 (17%)			
Previously	44	29 (43%)	15 (63%)			
Emotional Abuse				3.712	2	0.125
Yes	49	39 (58%)	10 (42%)			
No	3	1 (2%)	2 (8%)			
Previously	39	27 (40%)	12 (50%)			
Stalking				1.849	2	0.406
Yes	40	29 (43%)	11 (46%)			
No	24	20 (30%)	4 (17%)			
Previously	27	18 (27%)	9 (38%)			
Threats of Violence				1.573	2	0.437
Yes	36	29 (43%)	7 (29%)			
No	10	7 (10%)	3 (13%)			
Previously	45	31 (46%)	14 (58%)			
Physical Abuse				1.276	2	0.608
Yes	27	22 (33%)	5 (21%)			
No	10	7 (10%)	3 (13%)			
Previously	54	38 (57%)	16 (67%)			
Physical Abuse – Bodily Injury				3.030	2	0.228
Yes	21	18 (30%)	3 (14%)			
No	12	7 (12%)	5 (24%)			
Previously	48	35 (58%)	13 (62%)			
Not Applicable	10	--	--			
Sexual Violence				2.786	2	0.262
Yes	11	10 (15%)	1 (4%)			
No	52	39 (58%)	13 (54%)			

In the last 6 months, have you experienced by the PUV	N	Intervention *n* (%)	Comparison *n* (%)	*X2*	*df*	*p*
Previously	28	18 (27%)	10 (42%)			

Notes. *N* = 96: Intervention n=70, Comparison n=26; however, 91 respondents opted into this section of questions when asked if they were willing to answer potentially triggering questions about prior domestic violence experiences. Fisher's Exact Test was used to correct for expected cell count less than 5; missing values were not included in the calculation of inferential statistics.

Table 84. (ASFS) Adult Survivor Experiences of PUV Use of Systems Coercion by Intervention & Comparison Groups

Systems Coercion	N	Intervention *n* (%)	Comparison *n* (%)	*X2*	*df*	*p*
Harm to AS Reason CW Inv				0.681	1	0.411
Yes	70	53 (79%)	17 (71%)			
No	21	14 (21%)	7 (29%)			
Harm to Child Reason CW Inv				0.083	1	0.813
Yes	51	38 (57%)	13 (54%)			
No	39	28 (42%)	11 (46%)			
Missing	1	1 (1%)	0 (0%)			
How often PUV use systems in last 6 months?				11.026	6	0.089
Every day/almost every day	9	5 (7%)	4 (17%)			
Every week	4	6 (6%)	0 (0%)			
Every month	7	7 (10%)	0 (0%)			
A few times	14	12 (18%)	2 (8%)			
One time	5	3 (5%)	2 (8%)			
Not at all in last 6 months	29	17 (25%)	12 (50%)			
Never	22	18 (27%)	4 (17%)			
Missing	1	1 (1%)	0 (0%)			
PUV attempt to get DVPO				1.491	1	0.269
Yes	22	14 (21%)	8 (33%)			
No	69	53 (79%)	16 (67%)			
PUV succeed in getting DVPO				2.121	1	0.204
Yes	10	8 (57%)	2 (25%)			
No	12	6 (43%)	6 (75%)			
Not Applicable	69	--	--			

Notes. *N* = 96: Intervention n=70, Comparison n=26; however, 91 respondents opted into this section of questions when asked if they were willing to answer potentially triggering questions about prior domestic violence experiences. Fisher's Exact Test was used to correct for expected cell count less than 5; missing values were not included in the calculation of inferential statistics. CW = child welfare. DVPO = domestic violence protection order.

Table 85. (ASFS) Adult Survivor Frequency of PUV Use of Other Coercive Behavior by Intervention & Comparison Groups

Frequency of Coercive Behavior (1 Every Day to 7 Never)	N	Intervention Median (Min, Max)	Comparison Median (Min, Max)	Mann-Whitney U	p
Average Coercion Frequency	91	6.0 (2.0, 7.0)	6.0 (1.1, 7.0)	780.000	0.828
PUV use CW against AS	90	6.5 (1.0, 7.0)	6.0 (1.0, 7.0)		
PUV Interfere CW Require	82	7.0 (1.0, 7.0)	6.0 (2.0, 7.0)		
PUV Use Children	90	5.0 (1.0, 7.0)	6.0 (1.0, 7.0)		
PUV Make AS Use Drugs	91	7.0 (1.0, 7.0)	7.0 (1.0, 7.0)		
Interfere Sobriety	40	6.0 (1.0, 7.0)	6.0 (1.0, 7.0)		
PUV Keep AS from Self Care	91	6.0 (1.0, 7.0)	6.0 (1.0, 7.0)		
PUV Use Religious Beliefs/ Family Loyalty	91	6.0 (1.0, 7.0)	6.0 (1.0, 7.0)		

Notes. N = 96: Intervention n=70, Comparison n=26; however, 91 respondents opted into this section of questions when asked if they were willing to answer potentially triggering questions about prior domestic violence experiences.

2.B.1.3: Increased Stability

Two data sources were used, the Adult Survivor Field Survey and the Family Survey.

In the Adult Survivor Field Survey, we observed no significant differences in enrollment in school or employment status in the last six months by intervention and comparison groups (See Table 86). We observed significant differences in current living situation in the last six months by intervention and comparison groups (See Table 87). Specifically, adult survivor participants in the intervention offices were less likely to rent or own in their current living situation. We observed no significant difference in number of moves in the last six months, in school enrollment or paid employment, in essential expenses not being met (pre-Covid-19 and post-Covid-19), and in relationship with PUV by intervention and comparison groups.

Table 86. (ASFS) Adult Survivor Socio-economic Factors by Intervention & Comparison Groups

Variable	N	Intervention *n* (%)	Comparison *n* (%)	X2	df	p
Highest Grade Completed				6.552	4	0.162
High School or Less	50	38 (54%)	12 (46%)			
Some College	21	11 (16%)	10 (39%)			
Associate's, Trade, or Technical School	16	13 (19%)	3 (12%)			
Bachelor's Degree or More	9	8 (11%)	1 (4%)			
Enrolled in School or Work?				1.329	2	0.541
Yes	50	38 (54%)	12 (46%)			
No, but employed in last 6 mo	14	11 (16%)	3 (12%)			
No, not in last 6 mo	32	21 (30%)	11 (42%)			
Variable	**N**	**Intervention Median (Min, Max)**	**Comparison Median (Min, Max)**	**Mann-Whitney U**		***p***
Essential expenses not met (1 to 5 scale)	95	2.0 (1.0, 4.0)	2.0 (1.0, 5.0)	1060.500		0.156
Essential expenses not met (pre-Covid; 1 to 5 scale)	95	2.0 (1.0, 5.0)	1.0 (1.0, 4.0)	1023.000		0.256

Notes. *N* = 96: Intervention n=70, Comparison n=26. Fisher's Exact Test was used to correct for expected cell count less than 5; missing values were not included in the calculation of inferential statistics.

Table 87. (ASFS) Adult Survivor Current Living Situation & Relationship Status by Intervention & Comparison Groups

Variable	N	Intervention *n* (%)	Comparison *n* (%)	X2	df	p
Current Living Situation						
Rent/Own	64	40 (57%)	24 (92%)	8.854	1	0.002*
Other living situation	28	26 (37%)	2 (8%)			
Missing	4	4 (6%)	0 (0%)			
# Move in last 6 months				2.390	1	0.094
None	58	39 (57%)	19 (73%)			
One	17	11 (16%)	6 (23%)			
Two or more	19	18 (27%)	1 (4%)			
AS Relationship to PUV				1.582	2	0.453
Current Partner	14	12 (17%)	2 (8%)			

Variable	N	Intervention *n* (%)	Comparison *n* (%)	X2	df	p
Partner within last 2 years	56	39 (56%)	17 (65%)			
Ex-partner	21	16 (23%)	5 (19%)			
Missing	5	3 (4%)	2 (8%)			

Notes. *N* = 96: Intervention n=70, Comparison n=26. Fisher's Exact Test was used to correct for expected cell count less than 5; missing values were not included in the calculation of inferential statistics. Asterisks (*) denotes significant finding.

The Family Survey protective factor scale developed by QIC-DVCW partners in partnership with the Evaluation team, was collected using planned missingness, demonstrated low internal reliability with items, typically correlating at a |0.200| correlation or less. In other words, the scale items did not relate to each other or "hang together" as intended to represent a single construct for the protective factors. As a result, items are individually reported by domains.

In the Family Survey, we observed statistically significant differences between intervention and comparison on the *Safer & More Stable Conditions* ratings at Time 2, controlling for Project site and baseline ratings (See Table 88). Caseworkers rated "AS identifies strategies to counter the negative impact of domestic violence on their children" as higher on average for the intervention group compared to the comparison group (b = 19.0, se = 8.5, *p* = 0.026). In addition, there was a significant interaction between group assignment and baseline rating, indicating that difference between groups was largest among cases where the baseline rating of this item was lower. The effect size for this treatment effect was small (partial eta2 = 0.019).

At the same time, for the following *Safer & More Stable Conditions* items, we observed no significant differences between intervention and comparison ratings at Time 2, controlling for Project site and baseline ratings for:

- AS talks with their children about ways they can stay safe if domestic violence occurs or gets worse.
- AS knows what to do when their safety is threatened.
- AS is willing to ask for help (from people or organizations in their community) to stay safe.

Table 88. (Family Survey – Caseworker Report) Caseworkers' Perceptions of Adult Survivor Protective Factors

Protective Factors: Safer & More Stable Conditions	Intervention Group			Comparison Group			estimated *r* between pre-test & post-test
	n	Pre-test M (SD)	Post-test M (SD)	n	Pre-test M (SD)	Post-test M (SD)	
AS identifies strategies to counter the negative impact of domestic violence on their children.							
Pre-test observed	54	57.8 (31.1)		36	65.9 (23.8)		
Post-test observed (9 Mo F/U)	23		61.9 (29.2)	18		49.6 (22.2)	

Protective Factors: Safer & More Stable Conditions	Intervention Group			Comparison Group			estimated *r* between pre-test & post-test
	n	Pre-test M (SD)	Post-test M (SD)	n	Pre-test M (SD)	Post-test M (SD)	
Analytic sample	174	57.6	46.2	139	57.9	44.0	(0.004, 0.044)
AS talks with their children about ways they can stay safe if domestic violence occurs or gets worse.							
Pre-test observed	43	42.0 (29.1)		32	43.0 (26.3)		
Post-test observed (9 Mo F/U)	23		44.4 (31.0)	18		50.2 (21.8)	
Analytic sample	174	54.4	33.1	139	50.9	34.6	(-0.063, -0.033)
AS knows what to do when their safety is threatened.							
Pre-test observed	47	65.7 (31.6)		42	58.2 (28.8)		
Post-test observed (9 Mo F/U)	21		62.4 (24.7)	17		67.9 (21.0)	
Analytic sample	174	56.9	68.6	139	56.6	68.8	(-0.016, 0.039)
AS is willing to ask for help (from people or organizations in their community) to stay safe.							
Pre-test observed	44	71.5 (29.2)		38	61.2 (29.2)		
Post-test observed (9 Mo F/U)	22		65.4 (30.3)	11		70.0 (23.3)	
Analytic sample	174	54.3	53.9	139	51.3	47.9	(-0.117, -0.098)

Notes. **N** = 313 unduplicated cases. Caseworkers reported their observations of adult survivor protective factors on a slider scale from **0 (Strong Disagree) to 100 (Strongly Agree)**. Due to planned missingness design, not all items were answered across cases resulting in variation in complete cases observed by item. Analytic sample used Multiple Imputation for Chained Equations (MICE) using the PCAux package in R; pooled means and range of correlations observed across 100 imputed data sets are reported for the analytic sample.

2.B.1.4. Increase empowerment related to safety

In the Adult Survivor Field Survey, the data source used, we observed significant differences in adult survivor overall empowerment (p = 0.045), with the adult survivors served by the intervention sites reported lower overall empowerment (See Table 89). For example, we observed that adult survivors served by the intervention sites reported a stronger agreement that their *actions towards safety would cause new problems in other domains* than compared to the adult survivors served by the comparison sites.

Table 89. (ASFS) Adult Survivor Empowerment by Intervention & Comparison Groups

Empowerment Related to Safety	N	Intervention Median (Min,Max)	Comparison Median (Min,Max)	Mann-Whitney U	*p*
Safety-related goals & belief in one's ability to accomplish them	**96**	**6.4 (2.3, 7.0)**	**6.5 (4.7, 7.0)**	**820.500**	**0.456**
Adult survivor can cope with challenges	95	7.0 (1.0, 7.0)	7.0 (1.0, 7.0)		
Adult survivor knows what to do when safety is threatened	96	7.0 (1.0, 7.0)	7.0 (1.0, 7.0)		
Adult survivor knows their next steps on the path to safety	96	7.0 (1.0, 7.0)	7.0 (5.0, 7.0)		
When something doesn't work, adult survivor can try something else	96	7.0 (2.0, 7.0)	7.0 (2.0, 7.0)		
Adult survivor has a clear sense of their goals for the next few years	96	7.0 (1.0, 7.0)	7.0 (4.0, 7.0)		
Adult survivor feels confident in their decisions	96	7.0 (1.0, 7.0)	7.0 (5.0, 7.0)		
Sense one's actions towards safety will not cause new problems in other domains	**96**	**4.7 (1.0, 7.0)**	**5.7 (2.3, 7.0)**	**613.500**	**0.014***
Adult survivor ***does not*** have to give up too much**	95	5.0 (1.0, 7.0)	6.5 (1.0, 7.0)		
Adult survivor working to keep safe ***does not*** create new problems for them**	96	4.0 (1.0, 7.0)	7.0 (1.0, 7.0)		
Adult survivor working to keep safe ***does not*** create problems for the people they care about**	96	5.0 (1.0, 7.0)	7.0 (1.0, 7.0)		
Perceived support one needs to move toward safety	**96**	**6.5 (1.3, 7.0)**	**6.6 (5.0, 7.0)**	**842.500**	**0.567**

Empowerment Related to Safety	N	Intervention Median (Min,Max)	Comparison Median (Min,Max)	Mann-Whitney U	p
Adult survivor has ideas about support for safety from friends, family, community	94	7.0 (1.0, 7.0)	7.0 (5.0, 7.0)		
Adult survivor feels comfortable asking for help	96	7.0 (1.0, 7.0)	7.0 (1.0, 7.0)		
Adult survivors have an idea about supports for safety from community programs	96	7.0 (1.0, 7.0)	7.0 (5.0, 7.0)		
Community programs provide support that adult survivor needs to keep safe	95	7.0 (1.0, 7.0)	7.0 (1.0, 7.0)		
Average empowerment score	**96**	**5.8 (1.9, 7.0)**	**6.4 (4.9, 7.0)**	**666.500**	**0.045***

Notes. ***N*** = 96; intervention ***n*** = 70, comparison ***n*** = 26. Asterisks (*) denotes significant finding.

Average empowerment score is rated on a scale from 1 = ***low empowerment*** to 7 = ***high empowerment***; reliability of this scale was good at *a* = 0.817.

- Individual items were coded to where higher ratings are associated with a higher rating of empowering beliefs about oneself. Double asterisks (**) denote items that were asked in the negative and reverse coded to align with direction of other responses; labels are rewritten to align with the direction of the scale.
- Adult survivors served by the intervention sites reported lower overall empowerment (***p*** = 0.045). We observed that adult survivors served by the intervention sites reported a stronger agreement that their ***actions towards safety would cause new problems in other domains*** than compared to the adult survivors served by the comparison sites.

2.B.2. Were there significant differences between the intervention and comparison sample in adult survivor well-being?

Research question 2.B.2. aims to understand three of the adult survivors' protective factors ratings. The sub-outcomes nested under this question reflect key factors in the Approach Protective Factors for Survivors framework: (1) social, cultural, & spiritual connections; (2) resilience & growth mindset; and (3) nurturing parent & child interactions.

In the Family Survey, caseworkers provided ratings of adult survivor protective factors. As described above, the Family Survey protective factor scale developed QIC-DVCW partners in partnership with the Evaluation team, as collected using planned missingness, demonstrated low internal reliability with items, typically correlating at a |0.200| correlation or less. In other words, the scale items did not relate to each other or "hang together." As a result, items are individually reported by domains.

2.B.2.1: Increased social, cultural, & spiritual connections

Two data sources, the Family Survey and Adult Survivor Field Survey were used to observe whether there were differences among the intervention and comparison groups in social, cultural, and spiritual connections for adult survivors. In the Family Survey, we observed no statistically significant differences between intervention and comparison groups in *social, cultural, & spiritual connections* ratings at Time 2, controlling for Project site and baseline ratings (See Table 90). In the ASFS, we observed no significant difference between intervention and comparison groups *social, emotional, & cultural connections* ratings (See Table 91).

Table 90. (Family Survey – Caseworker report) Caseworkers' Perceptions of AS Social, Cultural & Spiritual Connections by Intervention and Comparison Groups

Protective Factors: Connections	Intervention Group			Comparison Group			estimated r between pre-test & post-test
	n	Pre-test M (SD)	Post-test M (SD)	n	Pre-test M (SD)	Post-test M (SD)	
AS has someone (besides caseworker) who helps with things like transportation, financial assistance, food, and childcare when needed.							
Pre-test observed	45	70.6 (29.6)		39	71.5 (24.8)		
Post-test observed (9 Mo F/U)	22		80.7 (25.5)	11		68.4 (23.2)	
Analytic sample	174	51.4	74.8	139	56.0	80.6	(-0.066, -0.001)
AS has someone (besides caseworker) from whom they get advice and encouragement.							
Pre-test observed	46	75.5 (27.1)		42	74.5 (24.1)		
Post-test observed (9 Mo F/U)	21		58.0 (28.6)	17		71.4 (20.0)	
Analytic sample	174	56.8	64.4	139	58.0	70.8	(-0.082, -0.028)
AS has someone (besides caseworker) who helps them feel good about the things they do as a parent.							
Pre-test observed	44	72.5 (24.6)		43	71.4 (22.7)		
Post-test observed (9 Mo F/U)	19		57.2 (33.2)	16		51.1 (30.8)	
Analytic sample	174	71.0	64.4	139	75.3	58.4	(-0.111, -0.080)
AS draws strength from belief in a higher power.							

Protective Factors: Connections	Intervention Group			Comparison Group			estimated r between pre-test & post-test
	n	Pre-test M (SD)	Post-test M (SD)	n	Pre-test M (SD)	Post-test M (SD)	
Pre-test observed	27	55.8 (25.4)		30	58.8 (33.4)		
Post-test observed (9 Mo F/U)	29		52.0 (25.6)	14		62.6 (28.1)	
Analytic sample	174	59.7	57.2	139	61.1	56.0	(-0.005, 0.042)

Notes. **N** = 313 unduplicated cases. Caseworkers reported their observations of adult survivor protective factors on a slider scale from **0 (Strong Disagree) to 100 (Strongly Agree)**. Due to planned missingness design, not all items were answered across cases resulting in variation in complete cases observed by item. Analytic sample used Multiple Imputation for Chained Equations (MICE) using the PCAux package in R; pooled means and range of correlations observed across 100 imputed data sets are reported for the analytic sample.

Table 91. (ASFS) Adult Survivor Well-being Outcomes by Intervention & Comparison Groups

Well-being Outcomes	N	Intervention Median (Min,Max)	Comparison Median (Min,Max)	Mann-Whitney U	*p*-value
Average Social Connection Score	96	6.5 (1.0, 7.0)	6.3 (2.3, 7.0)	1002.500	0.428
Someone helps when need	96	7.0 (1.0, 7.0)	6.0 (1.0, 7.0)		
Someone to ask advice from	96	7.0 (1.0, 7.0)	7.0 (1.0, 7.0)		
Someone helps me feel like a good parent	95	7.0 (1.0, 7.0)	7.0 (2.0, 7.0)		
Resilience & Growth Mindset	9	7.0 (2.0, 7.0)	7.0 (5.0, 7.0)	895.500	0.866
Nurturing Parent-Child Relationship	95	5.0 (1.0, 5.0)	5.0 (1.0, 5.0)	883.000	0.940
Average Trauma Symptom Score	96	2.7 (1.0, 4.3)	2.3 (1.0, 5.0)	1151.500	0.046*
Depression Symptoms	96	3.0 (1.0, 5.0)	2.0 (1.0, 4.0)	1128.500	0.063

Notes. *N* = 96; intervention *n* = 70, comparison *n* = 26. The *p*-value reports the probability of observing a false positive (null hypothesis) to be true; statistically significant p-values are denoted by an asterisk (*).

- Average social connection (*a* = 0.741) is rated on a scale from 1 = *low connections to others* to 7 = *high connections to others.* Individual social connection items were recoded to be on a scale from 1 = *definitely false* to 7 = *definitely true.*
- Resilience & Growth Mindset is captured by the item "*I am confident that I can achieve goals.*" This item was recoded to be on a scale from 1 = *definitely false* to 7 = *definitely true*; higher scores indicate a higher level of agreement with the statement.
- Nurturing Parent-Child Relationship is rated on a scale from 1 = *never able to comfort child* to 5 = *always able to comfort child*;

higher ability to comfort one's child aligns with higher ratings.

- Trauma symptoms are rated on a scale from 1 = *little to no trauma symptoms* to 5 = *extremely high levels of trauma symptoms*; more severe trauma symptoms in number and frequency are associated with higher ratings. The average trauma score was composed of 6 items with adequate reliability (X = 0.792).
- Depression symptoms are rated on a scale from 1 = *never feeling depressed in last two weeks* to 5 = *all the time feeling depressed in last two weeks*; higher ratings are associated with higher frequency of recently feeling depressed.

2.B.2.2: Increased resilience & growth mindset

Two data sources, the Family Survey and Adult Survivor Field Survey were used to observe whether there were differences among the intervention and comparison groups in resilience and growth mindset. In the Family Survey, we observed statistically significant differences between intervention and comparison *Resilience & Growth Mindset* ratings of three of the five items at Time 2, controlling for Project site and baseline ratings (See Table 92).

Caseworkers rated **"AS expresses confidence that they can achieve positive goals."** as higher on average for the intervention group compared to the comparison group (b = 39.6, se = 13.6, p = 0.004). In addition, there was a significant interaction between group assignment and baseline rating, indicating that difference between groups was largest among cases where the baseline rating of this item was lower. The effect size for this treatment effect was small (partial eta2 = 0.023).

Caseworkers rated **"AS recognizes tough or bad situations as temporary."** as higher on average for the intervention group compared to the comparison group (b = 15.0, se = 4.8, p = 0.002). The effect size for this treatment effect was medium (partial eta2 = 0.057).

Caseworkers rated **"AS perseveres even when they encounter challenges."** as similar on average between the intervention group compared to the comparison group (b = -9.8, se = 8.4, p = 0.248). However, the greatest change between pretest and posttest scores occurred for cases with lower baseline scores (p = 0.009). In addition, we observed a significantly greater increase in posttest scores for the intervention group compared to the comparison group with differences increasing as baseline scores increased (p = 0.03). The effect size for this treatment effect was small (partial eta2 = 0.016).

Table 92. (Family Survey) Caseworkers Perceptions of AS Resilience & Growth Mindset by Intervention and Comparison Groups

Protective Factors: Resilience & Growth Mindset	Intervention Group			Comparison Group			estimated r between pre-test & post-test
	n	Pre-test M (SD)	Post-test M (SD)	n	Pre-test M (SD)	Post-test M (SD)	
AS perseveres even when they encounter challenges.							
Pre-test observed	39	69.1 (21.6)		41	67.4 (29.0)		
Post-test observed (9 Mo F/U)	29		64.5 (31.8)	14		65.6 (25.1)	
Analytic sample	174	54.8	56.9	139	50.3	52.2	(-0.114, -0.059)

Protective Factors: Resilience & Growth Mindset	Intervention Group			Comparison Group			estimated r between pre-test & post-test
	n	Pre-test M (SD)	Post-test M (SD)	n	Pre-test M (SD)	Post-test M (SD)	
AS believes they are making responsible decisions.							
Pre-test observed	53	67.5 (26.6)		34	71.0 (24.2)		
Post-test observed (9 Mo F/U)	23		71.2 (25.5)	18		69.0 (17.9)	
Analytic sample	174	64.3	64.0	139	61.6	60.6	(-0.063, 0.035)
AS recognizes tough or bad situations as temporary.							
Pre-test observed	42	57.4 (28.9)		38	58.6 (23.5)		
Post-test observed (9 Mo F/U)	22		72.3 (20.0)	11		61.4 (19.2)	
Analytic sample	174	56.6	64.0	139	64.3	52.0	(-0.075, -0.039)
AS believes that their life will get better even when bad things happen.							
Pre-test observed	46	69.2 (26.8)		34	69.5 (21.7)		
Post-test observed (9 Mo F/U)	21		60.6 (31.0)	17		61.4 (18.4)	
Analytic sample	174	56.6	64.8	139	64.3	70.2	(-0.043, 0.028)
AS expresses confidence that they can achieve positive goals.							
Pre-test observed	15	66.2 (22.7)		14	71.8 (15.8)		
Post-test observed (9 Mo F/U)	19		64.5 (20.7)	16		57.7 (26.6)	
Analytic sample	174	74.5	69.3	139	63.1	60.7	(0.036, 0.126)

Notes. **N** = 313 unduplicated cases. Caseworkers reported their observations of adult survivor protective factors on a slider scale from 0 (Strong Disagree) to 100 (Strongly Agree). Due to planned missingness design, not all items were answered across cases resulting in variation in complete cases observed by item. Analytic sample used Multiple Imputation for Chained Equations (MICE) using the PCAux package in R; pooled means and range of correlations observed across 100 imputed data sets are reported for the analytic sample.

In the Adult Survivor Field Survey, we did not observe significant difference in the average *resilience & growth mindset* score by intervention and comparison groups. This was assessed with one item. See Table 91.

2.B.2.3: Increased social & emotional abilities

In the Family Survey, the data source used, we observed significant differences between intervention and comparison *Social & Emotional Abilities* ratings of one of the three items at Time 2, controlling for Project site and baseline ratings (See Table 93).

- Caseworkers rated **"AS has told their children that the PUV is responsible for the violence – it is nobody else's fault"** as lower on average for the intervention group compared to the comparison group (b = -8.7, se = 4.3, *p* = 0.041). The effect size for this treatment effect was small (partial eta2 = 0.016).

Table 93. (Family Survey) Caseworkers Perceptions of AS Social & Emotional Abilities by Intervention and Comparison Groups

Protective Factors: Resilience & Growth Mindset	Intervention Group			Comparison Group			estimated r between pre-test & post-test
	n	Pre-test M (SD)	Post-test M (SD)	n	Pre-test M (SD)	Post-test M (SD)	
AS has told their children that the PUV is responsible for the violence– it is nobody else's fault.							
Pre-test observed	33	32.5 (33.8)		33	48.7 (33.2)		
Post-test observed (9 Mo F/U)	22		54.0 (24.7)	11		41.8 (27.5)	
Analytic sample	174	47.2	53.8	139	52.0	63.1	(0.020, 0.091)
AS reassures their children that their feelings about violence are okay.							
Pre-test observed	38	56.4 (34.4)		37	47.5 (29.0)		
Post-test observed (9 Mo F/U)	21		53.3 (25.4)	17		57.1 (21.9)	

Protective Factors: Resilience & Growth Mindset	Intervention Group			Comparison Group			estimated r between pre-test & post-test
	n	Pre-test M (SD)	Post-test M (SD)	n	Pre-test M (SD)	Post-test M (SD)	
Analytic sample	174	62.3	41.9	139	60.2	48.0	(0.066, 0.136)
AS expresses negative emotions in ways that do not cause harm to themselves or others.							
Pre-test observed	49	56.2 (30.0)		40	55.8 (26.6)		
Post-test observed (9 Mo F/U)	19		47.3 (32.8)	16		55.6 (26.2)	
Analytic sample	174	59.4	66.6	139	56.2	65.5	(0.039, 0.063)

Notes. **N** = 313 unduplicated cases. Caseworkers reported their observations of adult survivor protective factors on a slider scale from **0 (Strong Disagree) to 100 (Strongly Agree)**. Due to planned missingness design, not all items were answered across cases resulting in variation in complete cases observed by item. Analytic sample used Multiple Imputation for Chained Equations (MICE) using the PCAux package in R; pooled means and range of correlations observed across 100 imputed data sets are reported for the analytic sample.

2.B.2.4: Increased nurturing parent & child interactions

In the Adult Survivor Field Survey, we observed no statistically significant differences between intervention and comparison *nurturing parent & child interactions*' ratings at Time 2, controlling for Project site and baseline ratings (See Table 91).

2.B.2.5: Decrease trauma symptoms and depression

In the Adult Survivor Field Survey, we observed statistically significant difference in average trauma symptom score by intervention and comparison groups (See Table 91). Specifically, adult survivor participants in the intervention offices were more likely to rate trauma symptoms as more severe in number and frequency than comparison offices. We observed no significant difference by intervention and comparison groups in depression symptoms.

RESEARCH QUESTION: HOW DID PERSON WHO USES VIOLENCE OUTCOMES CHANGE?

As described in the Methods section above, the evaluation activities used to collect data to measure person who uses violence outcomes was thwarted. Specifically, no participants completed the planned Partners & Parents Survey (for people who use violence). Therefore, for the person who uses violence outcomes data is limited to the following. First, primary data (i.e., original data collected for the purpose of the QIC-DVCW evaluation) examining differences over time between intervention and comparison groups was limited to report by caseworker (Family Survey). Second, two additional data sources provided one time (i.e., cross-sectional) data because although they do not provide change over time, they do provide additional insight into person who use violence experiences within the QIC-DVCW Project sites. Namely, we include observations by adult survivors on an identified person who used violence in their history (see Methods and

Appendices on Adult Survivor Field Survey for more information about selection process), and data from the Strong Fathers focus groups, conducted in only one site (Massachusetts) with only a sample of intervention fathers (See Methods for more information about Strong Fathers).

2.C.1. Were there significant differences in PUV blaming adult survivor and justification for violence between the intervention and comparison sample?

Given that the data collection strategy to obtain this data source (i.e., the PUV survey) for this outcome was not successful (See PUV Survey in Methods Section), we are unable to compare differences between intervention and comparison groups. However, providing some description of the construct of PUV blaming adult survivor justification for violence is still possible. This outcome included two sub-outcomes, which for one - 2.C.1.1: Increase understanding of the impact of DV on adult and child survivors - the Strong Fathers focus group provides descriptive narrative of the participants' understanding of the impact of DV on adult and child survivors. For the other 2.C.1.2: Decrease blaming adult survivor and justification for violence, there was no relevant data available.

2.C.1.1: Increase understanding of the impact of DV on adult and child survivors.

In the Strong Fathers focus groups, participants shared their feelings when facing harm that they had done to child/ren. The main area of "harm" the fathers identified in the focus groups was their tone of voice. As one participant described:

> *Before, I used to be very, very loud when things didn't go my way, so I always yelled, threatened, I was never really physical, but I always did -- I'm bigger than you type thing and every time I try to look at my son now and to go forward, it still always in my head, I always want to, I feel like I'm going to start yelling, when is no need for it, I mean, I have a lot of fear with that coming back around. But I try to pay attention to that not just say something to think about what I actually want to say, get to the core problem, and voice it that way. (FG2, P4)*

Of note was that participants often described that they were perceived as yelling or arguing, even when they thought they weren't.

> *I know even when I'm not yelling, like if we're talking right now, if I were to talk to my kids like this, they'd be like, why are you yelling at us, like, what did we do, like no, I'm not yelling, I'm sorry. And then I'm like, oh, man, I did just yell, I'm sorry, just silly things like that. I'm kind of a loud guy (FG1, P1)*

Another participant shared:

> *I don't know if because it's me with my wife, she's not too much, she takes it a little better, [but I wanted it to me 0:24:37] if I say, I just say no or I suggest well why don't you take this one instead of that one, and she's very sensitive, I like that, so I got to learn a little. Interviewer: Yeah, so you're feeling like she's maybe reacts a little differently to you than she does to your wife? Interviewee 2: A little more with me, yes, she's a little better with my wife, I don't know if she just thinks that I'm yelling at her (FG1, P2)*

Strong Fathers focus group participants also named new awareness of the harm they caused and creating a dangerous environment for kids. For one participant, he explained that he has older children and very young children, and he recognizes the limits to repairing the harm with the older ones:

> *And it hurts that I can't repair, or I want to put my best foot forward, and I've tried to communicate and everything, apologize, but I just can't repair that relationship that was damaged, so long ago. And I just move forward, I don't*

> *allow myself to dwell on that, I don't allow the toxic or the hurtful feelings, to keep me from giving the love that this one needs now. My oldest daughter told me dad the love that you didn't give us make sure that you give it to our little sister. And I was happy with that. (FG2, P5)*

One participant described becoming aware of the environment they were responsible for, saying he learned to notice:

> *...what kind of environment I'm creating for my kids that point of time, that comes to first, any kind of argument, right, any kind, which can go bad is creating an environment, a very dangerous environment for the kids, whether it's physical or mental, so that's the first thing which comes up. No, we cannot do that, right. (FG2, P2)*

In dialogue between two participants (FG2, P1 and P2), they named that they learned about "anger cues" and a "safety plan" at the Strong Fathers group:

> *...from attending the strong father group as well, I mean, we got, especially we all got some very good tips from [de-identified] and [de-identified] we have to always sense that, okay, what might be causing an anger into us, like if we practice to sense it pretty early in any conversation, or we can probably stop that, we can work on from there or whatever, we can take many action. We have to first sense that that that's getting angered or I'm not feeling good about this thing, this conversation, but that's fine to stop it. So I guess that's the best thing and it's a side note that if you ever feel such kind of the conversation is going into that path, better stop going to that path, there's no point talking there. Either listen, stay calm, go to your hobbies, go out, take a walk, change the conversation.*
>
> *Interviewee 1: Safety plan.*
>
> *Interviewee 2: Yes, safety plan.*
>
> *Interviewee 1: Anger cues and safety plan.*

Participants described recognition of when they harm their children, naming not communicating with them, not really listening to them, not allowing them "the freedom to figure out who they are." This participant illustrates the harm and impact on the parent-child relationship that comes from not listening:

> *If you're not really in-depth of what you're actually listening to what they're saying, then you're not going to be able to give them good answers. And then eventually, they're just going to feel they're not going to be able to come to you, that and talk to them, not at them. (FG2, P3)*

For some participants this awareness was put in conversation with the recognition that they were harmed as children. One participant shared, "...I know for me when I was a kid learning, learning how many lies I was told growing up, how much things were hidden from me, that really hurt. So I try not to do the same with my kids" (FG1, P1).

Other participants identified the harm they had done, and how they were committed to changing. One father described this change interacting with his son saying:

> *I'm actually able to see what he's capable of doing. By controlling and having too much involvement in their lives in certain situations and stuff like that can be damaging...So, I told him, I said it is what it is, we'll see, I didn't stress it, I didn't put any pressure on him, I just said what time will you come over, he told me a time, I said I'd be there by then. And I just kind of let it go from there, I didn't hound him like I used to. (FG2, P4)*

Another participant shared his commitment to change: "I wasn't able to raise my older daughters. Because of problems with the law, I was imprisoned for a long time, and I wasn't able to raise them and not be in their life totally. And now I'm committed to this one" (FG2, P5).

In addition, Strong Father focus group participants described their feelings when facing the harm they have done to partners/ex-partners (i.e., adult survivors). However, it should be noted that although the focus group questions included one about this, it was asked as a part 2 of the harm to children question and therefore wasn't replied to by most participants. What was shared during the focus group is described here. First, there was ownership of the harm of partner, not blaming the other person, as exemplified here:

> *Yeah, I mean, to say to another person, I've been abusive to my wife, or my children, who I love with all my heart, but partially fueled by alcohol, partially fueled by stress, partially fueled by wanting to numb all these things. And that's not an excuse, that's not an out. But to say that to another human is really hard. And really, I think, takes a lot to say, hey, I want to let you know that these are the things that I've done, and I want to be better. (FG2, P1)*

Still, there was at least one participant who vocalized that while he recognized the role he played, he also pointed out things she had done (i.e., cheated on him), saying:

> *Regret, guilt, obviously…I still look at the fact that I could have changed how I reacted…I realized how I could have approached the situation differently or either not approached it at all and just packed my stuff and left…Whenever I realize I do screw up I try to I try to apologize and make amends. (FG1, P1)*

This participant parsed his experience of difference between harm to partner and preventing harm to children:

> *I think when it comes to your kids versus like, past relationships, like past relationships, like I feel bad about that, it sucks, I can't change it. But my kids, this is something that I can change in the moment, right now I can address it (FG1, P1)*

2.C.2. Were there significant differences in PUV positive beliefs, attitudinal, & behavioral change between the intervention and comparison sample?

Outcome 2.C.2. included three sub-outcomes: (1) 2.C.2.1: Increase demonstration of motivation to change, (2) 2.C.2.2: Increase understanding of healthy relationships, and (3) 2.C.2.3: Increase nurturing parent and child interactions.

2.C.2.1: Increase demonstration of motivation to change

Using the Family Survey analytic sample (N = 313 using MICE), no statistically significant differences were observed in CW report of PUV readiness to change between intervention and comparison groups, controlling for baseline ratings and Project site. See Table 94.

For the intervention group, the top reasons caseworkers identified as motivations for PUVs changing behaviors at Time 2 included: (1) Their role as a parent, and (2) Don't want to lose their family. For the comparison group, the top reasons identified as motivations for changing behaviors at Time 2 included: (1) Don't want their kids to go into foster care, and (2) Accountability from the legal system.

Table 94. (Family Survey-Caseworker Report) CW Observed a Change in PUV Behaviors by Intervention & Comparison Groups

Extent has CW observed a change in PUV behaviors	Intervention Group			Comparison Group			r (p) between pre-test & post-test
	n	Pre-test M (SD)	Post-test M (SD)	n	Pre-test M (SD)	Post-test M (SD)	
Pre-test observed	67	29.7 (29.9)		61	35.3 (32.9)		
Post-test observed (9 Mo F/U)	11		61.3 (31.8)	11		39.0 (35.6)	
Both pre-test & post-test observed	7	26.5 (33.3)	55.3 (33.7)	6	23.0 (28.6)	45.0 (32.9)	0.848 (0.355)
Analytic sample	174	45.3	66.7	139	39.9	63.5	

Notes. **N** = 313 unduplicated cases. Caseworkers reported on the extent of PUV behaviors changed on a slider scale from **0 (Not at all ready) to 100 (Extremely ready)**. Due to planned missingness design, not all items were answered across cases resulting in variation in complete cases observed by item. Analytic sample used Multiple Imputation for Chained Equations (MICE) using the PCAux package in R; pooled means observed across 100 imputed data sets are reported for the analytic sample.

In addition, in the Family Survey, no statistically significant differences between intervention and comparison groups were observed caseworker report of adult survivor description of PUV behavior change, controlling for baseline ratings and Project site. See Table 95.

Table 95. (Family Survey) AS Described PUV behavior Change

Extent has AS observed a change in PUV behaviors	Intervention Group			Comparison Group			r (p) between pre-test & post-test
	n	Pre-test M (SD)	Post-test M (SD)	n	Pre-test M (SD)	Post-test M (SD)	
Pre-test observed	69	48.7 (28.0)		66	46.3 (32.5)		
Post-test observed (9 Mo F/U)	15		51.3 (30.5)	11		51.1 (25.0)	
Both pre-test & post-test observed	10	52.9 (31.6)	48.7 (29.5)	6	39.8 (31.0)	56.5 (25.5)	0.848 (0.355)
Analytic sample	174	47.5	22.0	139	45.5	20.2	

Notes. **N** = 313 unduplicated cases. Caseworkers reported adult survivor reports of PUV behavior changes on a slider scale from **0 (Negative significant Change) to 100 (Positive significant change)**. Due to planned missingness design, not all items were answered across cases resulting in variation in complete cases observed by item. Analytic sample used Multiple Imputation for Chained Equations (MICE) using the PCAux package in R; pooled means observed across 100 imputed data sets are reported for the analytic sample.

2.C.2.2: Increase understanding of healthy relationships

Strong Father focus group participants described their understanding of a positive relationship with an intimate partner, clustered on three components: (1) communication, (2) respect/cherishing, and (3) someone you can be your whole self. However, it is noteworthy that alongside descriptions of what makes up a positive relationship with an intimate partner, participants conceptualized the interconnectedness of a partner-children positive relationship.

Communication, the dominant component of a positive relationship with an intimate partner expressed, included verbal communication, reducing arguments, and listening. Listening, for participants, was particularly important to good relationships with intimate partners. This was illustrated by FG2:P2, "be a good listener, that's the biggest thing. So, a big part of communication is listening." Participants also conceptualized that good communication with their intimate partners as a part of a positive relationship was also connected to their relationship with their children. One participant described that he wanted to make sure he could teach his children specific messages about arguing, saying:

> *I think I really pass on to my kids is it takes two to argue, so if I'm an upset mood, or if she's in an upset mood, and there's a particular situation where we're not be seeing it together, we need to both take some space, calm down, before we talk, because if we don't, and I start yelling and she got shouting back at me. Well, there's a two, there's an argument, then it goes from this to all the way up to here. And then what's the end result of that, the end result is a bigger fight, things can be said that people will not mean. (FG2, P3)*

Another participant expressed this partner-and-children approach to the importance of communication and healthy relationships. He shared "I would say be a productive relationship where we can communicate being all together as a family. I would say having meals together, have play time together and things like that…I have to be present, involved" (FG1, P2).

The second component of a positive relationship with an intimate partner expressed was respect/cherishing. This was described both as the importance of respecting what a partner says and who they are and the reality that demonstrating that respect and "cherishing" of them is crucial:

> *…you can say anything under the sun. But when your kids see that you are cherishing your wife, or significant other, whatever, that you are cherishing them, you are respecting them, there's not abuse…and obviously we all have disagreements, we all have conversations, but the fact that you're respectful, cherishing, setting those examples for our kids. (FG2, P1)*

This respecting/cherishing stance toward the partner as the second component of a positive relationship toward intimate partner, like the communication component, included that recognition of that the health of partner relationship impacted the children.

The third and last component was expressed as having a partner who you can be your whole self. Participants described this in uniquely vulnerable terms.

> *I realized that someone you can cry with, someone you can be upset with, someone you can use to vent, someone who's seen you at your worst, and still feels like they want to continue being part of your life, possibly the most important person because you basically feed off each other's energy. And if you guys are both miserable constantly, it's just not going to happen. (FG1, P1)*

Again, in this component, there was the recognition of the children's relationships being integral to the health of the partner relationship, illustrated here, "That was the biggest thing is trying to have somebody that accepts not just only me, but accept your family" (FG2, P3).

2.C.2.3: Increase nurturing parent and child interactions.

In the Adult Survivor Field Survey, we observed no statistically significant difference in PUV in the PUV-Child Relationship between intervention and comparison groups (See Table 96). We also observed no statistically significant difference in PUV use of children and systems as a form of coercion both in type and frequency between intervention and comparison groups (See Table 84 and Table 85). It should be noted as it is the Methods, that we purposefully asked the adult survivor about their perception of the PUV outcomes, informed both by the literature about trusting survivors' descriptions and to triangulate data with other study sources.

Table 96. (ASFS) Person Using Violence-Child Relationship

PUV-Child Relationship (1 = Never to 5 = Extremely Often)	N	Intervention Median (Min,Max)	Comparison Median (Min,Max)	Mann-Whitney U	p
Average Child PUV Care	90	2.6 (1.0, 4.6)	2.2 (1.00, 5.00)	839.000	0.525
AS & PUV make decisions about children together	90	1.0 (1.0, 5.0)	1.0 (1.00, 5.00)		
PUV stop abusive behavior when learn it's harmful	82	2.0 (1.0, 5.0)	1.5 (1.0, 5.0)		
PUV does not tell child they are responsible for abuse	83	5.0 (1.0, 5.0)	5.0 (1.0, 5.0)		
PUV support AS parenting	79	2.0 (1.0, 5.0)	1.5 (1.0, 5.0)		
PUV meets children's needs	89	3.0 (1.0, 5.0)	1.0 (1.0, 5.0)		

Notes. *N* = 96: Intervention n=70, Comparison n=26. Scaling (1=Never to 5=Extremely often)

Strong Father focus group participants descriptions of a good father included being emotionally supportive, willing to teach them more than we were taught ourselves, be active with the kid, pay attention to them, being a good provider emotionally and being a good financial provider (e.g., support the household, provide basic needs, health, nutrition, education), and creating a safe environment. However, the listening was far beyond the most identified aspect of being a good father.

When describing listening, participants expressed how important listening was in their experience. They relayed that listening to their children included "hearing what they have to say," "listening without judging and getting angry at them for what they are saying," "being receptive to what they have to say – not writing them off – you are just a kid." For some fathers, listening to their children was significantly important, because they were not listened to when they were children. One participant pointed out that he learned in the Strong Fathers group to counter some of the gender norms about men being fixers when problems emerge, and instead focus on "listening to understand."

> *And I think that's one of the big takeaways that I took that, that I've applied to, more than just being a father in my life over the past year, but I think that not always trying to jump in and fix things...I've learned is that in the past,*

> *as a father, I feel like I've always been loving, caring, but I've definitely walked over my family as trying to be the head of the household, the breadwinner, all that." (FG 2, P1)*

Lastly, there was acknowledgement that understanding how to have nurturing parent child interactions was a learning edge, as illustrated here: "I don't know how to be a good father, I'm learning right now, I was very glad [about the] reference to the programs that I was offered" (FG2, P5). Another father questioned what "authority" he had left, with DCF's involvement, to "disciple" his child saying:

> *...you were still the parent, you can still discipline, you can still enforce rules. And I don't feel the DCF gives the parents enough leeway, it's do this or don't do that, and they say -- there are certain things like yes, you don't want to endanger a child, you don't want to -- but you can still discipline, when I was raised discipline was a belt or stick, nowadays, you can't do that. Well, take away the iPhones, take away the video game. And even I've come across with a few people that saying that that's still too much. (FG2, P4)*

2.C.3.Were there significant differences in person using violence well–being & supports between the intervention and comparison sample?

Given that the data collection strategy to obtain this data source (i.e., the PUV survey) for this outcome was not successful (See PUV Survey in Methods Section), we were unable to compare differences between intervention and comparison groups. However, providing some description of the construct of PUV increased well-being and support is still possible. The following narrative from the Strong Fathers focus group (only intervention, only one site) describes participants' experience of supports.

Experiences of Support

Strong Father focus group participants identified a variety of sources of support to talk about issues related to their children being CW involved and their families' domestic violence experience. These people included friends, therapists, and "older" people who had similar experiences. Also, a few participants identified other programs (other than Strong Fathers) that were supportive of these issues, parenting specifically. Most often, participants identified friends (4 out of 7); some identified that they were other fathers, but not all. For example,

> *I like to confide in like my other friends who are also fathers, like one of my best friends, he's actually a single father, and he's raising two boys. And they're incredible little kids, he's an awesome dad. So, like, I like to text him or message him or call him (FG1, P1)*

Other fathers confirmed, talking to other dads helped them talk about the challenges of parenting.

In addition to identifying friends, some participants shared that they needed and valued a support system, which included many individuals. One described his support system related to being a father saying:

> *I've been very, very lucky to have a great support system, my sister is very close to me, I have my brother, my sister, my mother, my wife. And I bounce all these things off of them, and kind of get their role, because I'm still learning. I mean, there's no rulebook for being a parent. (FG 2, P3)*

This participant also included a community organization in his support system, saying "they were really helpful there."

One participant agreed a support system was needed and related what happened for him when his support circle became too small.

> *...because of my work, because of my background, I became very isolated in life, outside of my family, my wife and a couple of close friends leading up to what culminated last [time frame removed] all of this happening, where I mean, it's too much information to go into but up into culminating with DCF getting involved... [I started] to really say, hey, I can't get through life as an island, I need to surround myself with support with people who I can reach out to 24/7. (FG2, P1)*

In addition, the participants identified they talked to their supportive people included the role of people/neighborhoods influencing their ideas about gender (e.g., masculinity, how men treat women), intimate relationships, raising children. One participant shared how in a therapy session he got clarity about generational trauma was causing harm in the way he was parenting, saying "...actually got me really thinking and got me really understanding that what I was doing was harming, it's sort of like generational trauma, it's like, all right, this is what you're taught, this is what happens, you're taught this, you are growing up this way" (FG2, P3). Another participant linked the influence of community level violence and domestic violence, along with gender norms and parenting norms:

> *Yeah, I like to interject this is extremely important. I mean, I grew up in Lawrence, and Lawrence is an extremely violent area, and a lot of the individuals who are involved with DCF are young kids like when I used to be, I mean, I didn't join a gang when I was young, I was born into a gang family. So, I grew up knowing what violence was and experiencing violence as it was natural. So when things occurred, like an uncle would slap my aunt, or my grandfather would tell my grandmother shut up...I didn't have any support people in my life to teach me how to be a good boyfriend, a good husband, a good father, I didn't have those individually, because I mimicked how those individuals in my family did, and everybody that surrounded me, I know now, when I look back, we're all toxic individuals, but they themselves didn't know that they were in that type of cycle in their lives. (FG, P5)*

With these complexities at hand, some participants identified that when they thought about sources of support to talk to about these issues, they looked for people who helped them examine themselves more deeply. One participant shared who he looked to when he faced the harm he had caused his children:

> *I took it hard, I took it really hard I was like, wow! Am I really a bad father? How could I not have known this? And so I could reach out to my wife, I could reach out to my friend, I could really talk to the therapy sessions, and have really good revelations during those epiphanies as my counselor would say it, and really helped me grow, and it's helped me with my kids now...my demeanor in how I talked with the kids, how I talked to -- how I approach the situation (FG 2, P3)*

Another participant shared the need for people who they could bring their challenges to and find support:

> *Just having people that have your back, and we'll encourage you, but we'll also like, give you a kick in the butt if you needed, you know what I mean? Like, hey, man, like are you being completely honest with yourself? We all need that. I mean, and I think it's so scary sometimes to open up, but I think it's important to find those people in your life, so that you can be work on being the best that you can be. (FG 2, P1)*

Experiences with Strong Fathers Program

The main description of what they gained from their Strong Fathers participation was tools. Participants described that the facilitators

"definitely to give us some tools to be more aware of," as well as "teaching." Participants recognized that while they were given these tools from Strong Fathers, they needed to use them. This was illustrated by this participant who said "Strong Fathers definitely gave me other tools…Like [de-identified/Strong Fathers facilitator] was saying, you can't preach it, if you don't do it yourself. So, like I said, I'm always trying to catch myself, I try to use some of the tools that they've given me to go further with it." (FG2, P4).

When describing what they learned or what was reinforced in Strong Fathers, participants included listening to understand, tools to be more aware of, and learning about kids. One participant said the skills about parenting he learned in Strong Fathers has been "100%" helpful (FG1, P1). Another participant echoed how important Strong Fathers has been in his learning about his kids, "And I had a really hard time with that I have six kids, six girls, and their ranges from like, from 12, all the way up to 20 now…I had any kind of questions… Strong Fathers was there" (FG2, P3).

Strong Fathers was also identified as being helpful in participant understanding and addressing their use of domestic violence. For one participant shared that Strong Fathers helped him dig back into his history, "for me, it was a little different for most guys, because I had been divorced for eight years. So, to go back to my roots of how it was with my ex-wife showed me a lot" (FG2, P3). This participant was particularly able to identify the DV part of the Strong Fathers intervention work:

> *…obviously, at some point somewhere we kind of lost our way, if we didn't, we wouldn't be in this -- we wouldn't be where we are right now, but it's where we are right now, that's defining are we going to take what information that we're given and actually embrace it and work with it, are we just going to be like, okay. (FG2, P3)*

Although all the participants were participants of the Strong Fathers program and the focus group questions did not probe into why they were program participants, there was an absence of consistent acknowledgement of why they were going to Strong Fathers.

Focus group members were affirmative of their experience of the support they received at Strong Fathers, both from peers and the facilitators. One participant shared and reflected this with other members of the focus group:

> *We all have different stories. But I think that's one of the biggest keys is that [de-identified] at least for our group… at least for our group, I think [de-identified] and [de-identified], they did such an amazing job of, they always had a plan for group, but we'd have some groups where we'd have one or two or three guys check in with some serious problems or concerns or just wanting to reach out for help, and the group came in. And I know, [de-identified Focus Group member] I've been in group with you, I can't remember if I was in with you, [de-identified Focus Group member] and I know, I was in with [de-identified Focus Group member] for a little while. But it's like, we all have different backgrounds, and different stories, but there's still some common threads where we can say, hey, no, I've been there, and this is what helped me, this is what helped me. And [de-identified] and [de-identified] would just -- I mean, not completely step back, but it's almost like they would let us help ourselves, and then interject as needed and direct and I think that's what made the group so helpful. And just something that you want that you look forward to, and coming back and saying, what else can I learned this week, or what can I bring to help someone else, or maybe this week, I had a hard week, and I need some help…So I definitely felt like it was a huge give and take both from the members and then [de-identified] and [de-identified] did an amazing job as leaders. (FG2, P1)*

Another participant similarly identified fellow focus group member who they had been Strong Fathers group with and had supported him "made me grow as a man and as a father, and as a new husband" (FG2, P3).

2.C.3.1: Decrease trauma symptoms, depression, anxiety, and stress.

No data was obtained that measured this PUV outcome (see Methods and Limitations sections for details).

SECTION 6. RESULTS: COST STUDY CROSS SITE

The evaluation team analyzed BAT data for intervention and comparison sites at each locale. Intervention sites at each of the three locales had been implementing the Approach for two years, beginning in 2019. Due to implementation challenges and difficulties in obtaining quality cost data for IL, only cost study findings are reported for MA and Allegheny County, PA below. Findings from the cost study should be reviewed in conjunction with other evaluation findings related to service delivery and outcomes to understand the full context of services, outputs, and outcomes. Together, this information can be used to inform the Children's Bureau and other child welfare jurisdictions seeking to implement the Approach of the resources needed to support decision making regarding the allocation of resources.

SUMMARY OF COSTS ACROSS LOCALES

Overview of QIC–DVCW Resources and Supports

Between July 1, 2020 – June 30, 2021, the QIC-DVCW provided financial support to intervention and comparison sites to facilitate their implementation of the Approach. QIC-DVCW funds supported the following activities:

- QIC-DVCW training (virtual) and monthly coaching calls (MA and Allegheny County, PA)
  Project manager/consultant salaries (MA and Allegheny County, PA)
- Subcontract with a women's shelter to provide services of domestic violence specialist and consultants (Allegheny County, PA)
- Racial equity trainer/consultant (Allegheny County, PA)
- Research participation incentives (Allegheny County, PA)
- Funding for three domestic violence community programs for staff to participate in the Project on implementation and management teams (MA)

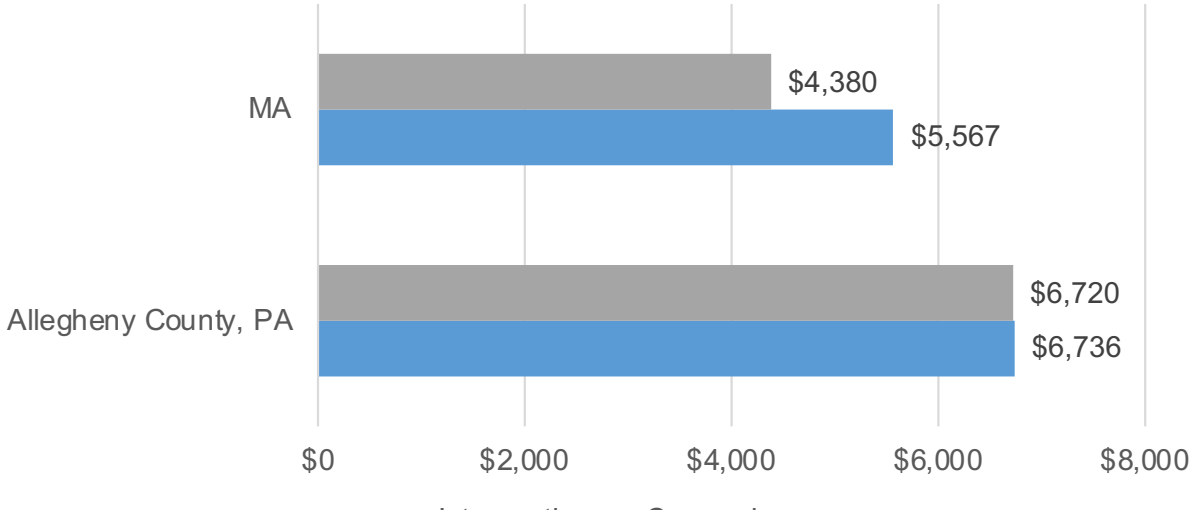
Funding for these areas were distributed across the BAT and are included as part of labor, consultant services, and training in the MA and Allegheny County, PA cost study findings.

Overview of total costs and costs per household for intervention and comparison sites by locale

The average cost per houshold for the intervention sites was lower than the comparison sites.

While the total operational costs between July 1, 2020 – June 30, 2021 were higher for both MA and Allegheny County, PA intervention sites during the cost study timeframe, when factoring in the number of households served the average cost to serve each household was lower for the intervention sites for both locales. Figure 35 shows that it cost more to serve families in the comparison sites implementing practice as usual than it did to serve families in sites where child welfare staff were implementing the Approach. In MA, the cost per household was $1,187 higher for the comparison sites than for the intervention sites. In Allegheny County, PA the per household cost difference in cost between intervention and comparison sites was $16. Additional observations are needed in order to directly attribute the lower cost per household to the Approach.

Figure 35. Comparison of Cost per Household Served by Locale, July 1, 2020 – June 30, 2021



Costs by cost category for intervention and comparison sites by locale.

Labor (both in-house and contracted) was the greatest driver of costs in MA and Allegheny County, PA.

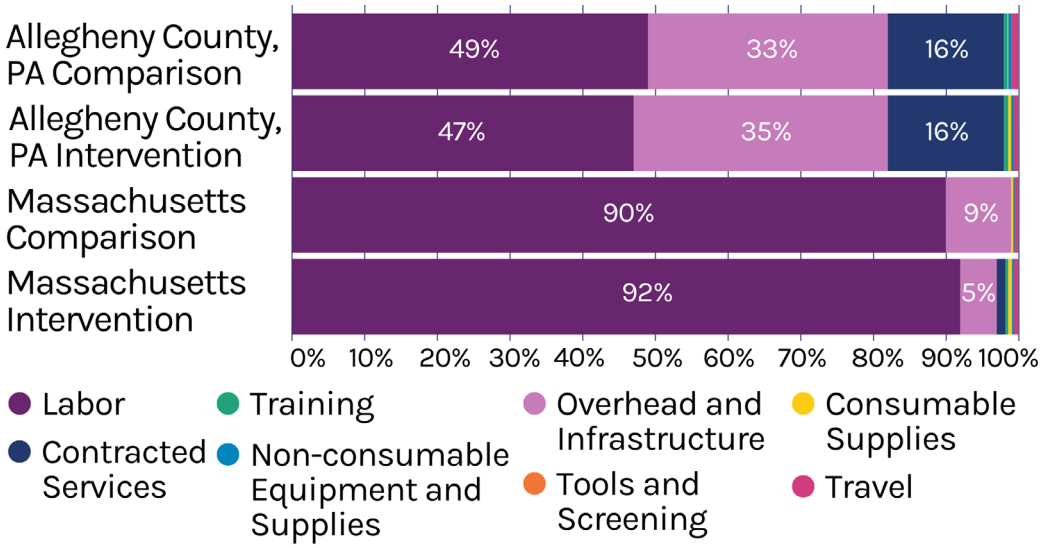
There were 2 to 3 primary drivers of costs for the intervention and comparison sites depending on the locale. In MA, labor and overhead comprised 98% to 99% of total costs, whereas in Allegheny County, PA labor, overhead and infrastructure, and contracted services together accounted for 98% of total costs. The percentage of total costs for all other categories was negligible.

Labor was the greatest driver of costs for the intervention and comparison sites in both locales. While Allegheny County, PA's labor costs were a smaller percentage of total costs than MA, it is also important to consider the differences in contracted services between the two locales.

Many child welfare agencies contract out labor for service delivery, while other agencies keep these services in-house. If the percentages of labor and contracted services are combined for Allegheny County, PA then the percentage for in-house and contracted labor increases to 63% and 65% for the intervention and comparison sites, respectively, which is closer to the percentage of total costs for labor found in MA (94% and 89%).

Looking across locales, the percentage of costs for overhead and infrastructure is between 24% to 30% greater for Allegheny, PA than for MA. Based on BAT data, both Allegheny County, PA and MA reported costs associated with office rent, utilities, and maintenance, but Allegheny County, PA was the only locale to report institutional indirect costs (i.e., general overhead costs) in their BAT. Inclusion of overhead costs reflects more comprehensive reporting, which can increase precision of cost estimates. Factoring in overhead costs in reporting also changes the picture of how costs are allocated across the other cost categories.

Figure 36. Distribution of Costs by Cost Category for Intervention and Comparison Sites, July 1, 2020 – June 30, 2021



Labor allocation by service activity across locales.

Looking across the 12 key service activities tracked in the BAT, three activities accounted for 15% to 32% of all staff's activities in the intervention and comparison sites for both locales. In MA, ongoing case management consumed most staff time, and represented nearly one-third of staff time. This was followed by administrative/ data entry activities and collaboration. The three main activities slightly differed for Allegheny County, PA staff. While ongoing case management and collaboration also accounted for the largest portions of staff time, investigation also accounted for a sizeable portion of staff time. In both MA and Allegheny County, PA, the percent of staff time that staff participated in collaboration with other agency partners was greater for the intervention sites than in the comparison sites. Collaboration activities included receiving case consultations (with IPV specialists, father engagement specialists, case practice specialists, etc.), participating in child and family team meetings, and multidisciplinary team meetings.

SECTION 7. MASSACHUSETTS PROJECT REPORT

As described previously in the report, the Massachusetts Project-specific recruitment of volunteers among DCF staff meant that although there were intervention and comparison offices designated in Massachusetts, not all staff agreed to participate in the study. Therefore, the results presented examining differences between intervention and comparison are limited by this factor.

Implementation Study

The implementation study was oriented around an overarching research question that asked:

What factors are associated with successful implementation and sustainability of an adult and child survivor-centered approach?

This component of the evaluation was informed by implementation science and the frameworks discussed above. The concept of "successful implementation" was operationalized to include Implementation Outcomes of adoption, acceptability, feasibility, fidelity, penetration, and sustainability. (Cost is also included in the Proctor framework from which we draw implementation outcomes; however, costs are covered in the Cost Study section of this report).

RESEARCH QUESTION: TO WHAT EXTENT DID THE APPROACH SPREAD TO SITES?

This research question relates to the implementation outcome of **penetration** (see page 10), which may also be referred to as intervention reach or spread. Ideally, measurement of spread would estimate the percentage of providers who used the Approach in their practice with children, adult survivors, and persons who use violence. Given our limits in observing the Approach in practice, we used several proxies to operationalize spread of the Approach. We considered three metrics to describe each sites' participation in training, coaching, and fidelity as follows:

- Percent of eligible caseworkers, supervisors, and community partners who participated in training
- Percent of eligible supervisors who participated in **coaching**
- Percent of eligible caseworkers for whom a **fidelity checklist** *was completed*
- Table 97 provides percentages for each of the spread indicators. It shows the following:
- **Training**: In Massachusetts intervention sites, 79% of eligible participants participated in training.
- **Coaching**: In Massachusetts intervention sites, 71% of eligible participants participated in coaching.
- **Fidelity Checklists**: In Massachusetts intervention sites, Fidelity Checklist completion spread 40% of eligible participants.

Taken together, these indicators of spread would suggest that the Approach penetrated the practice of those in direct service work with families at mainly moderate levels.

Table 97. Massachusetts Spread: Percent of Eligible People Who Participated in Training, Coaching, and Fidelity Checklist by Site

Key Implementation Activity	Massachusetts
Training (Number of eligible participants)	(N = 373)
No training	15%
Partial (1 day or some of online)	6%
Full (2 days or all online)	79%
Coaching (Number of eligible participants)	(N = 46)
Possible coaching sessions attended*	71%
Fidelity Assessment (Number of eligible participants)	(N = 136)
At least 1 Fidelity Checklist Completed**	40%

Notes.

N is the number of people eligible for the implementation activity. Percent is the percent of those eligible who participated in the implementation activity.

* This sample includes attendees who were a part of the self-survey target sample, identified and tracked through monthly rosters sent from sites. The denominator adjusted for excused absences, defined by leave of absence, emergency conflict, or illness. This demonstrates individual engagement level for the sessions when they were able to attend.

** Only includes participants who consented to participate in Fidelity Checklist data collection.

RESEARCH QUESTION: HOW DID IMPLEMENTATION DRIVERS CHANGE?

This research question was concerned with the extent to which implementation drivers were in place across sites and within each site, aiming to describe the Implementation Outcomes of **adoption** *and* **sustainability.** *Implementation drivers were assessed to demonstrate that the infrastructure needed to support the Approach was put in place. This infrastructure was conceptualized as comprising three main domains as measured by a Drivers Assessment survey:*

- Leadership drivers (3 items)
- Competency drivers (6 items)
- Organization drivers (6 items)

As described in the Method section, participants rated items on a scale from 0 to 2 where 0 = not in place; 1 = partially in place; and 2 = in place. For the purpose of our analysis, an average score of 1.5 was considered high and represented "nearly in place" or "in place."

Table 98 presents the item level average scores for Massachusetts Project in a table format, providing average scores, standard deviations, and statistical test results

Table 98. Massachusetts Drivers Assessment Domain Average Scores

Driver Domain & Time Period	Average (SD) Drivers Assessment Scores
	Massachusetts (N = 39)
Leadership Driver	
Time 1	1.7 (0.7, 2.0)
Time 2	1.7 (1.3, 2.0)
Time 3	1.7 (1.0, 2.0)
Test Statistic (p-value)	0.010 (0.995)
Competency Driver	
Time 1	1.3 (0.6, 2.0)
Time 2	1.6 (1.0, 2.0)
Time 3	1.8 (1.0, 2.0)
Test Statistic p-value)	7.408 (0.025)*
Organization Driver	
Time 1	1.2 (0.2, 2.0)
Time 2	1.2 (0.3, 1.6)
Time 3	1.7 (0.0, 2.0)
Test Statistic (p-value)	0.666 (0.717)

Notes. N = 39 completed surveys.
Scores could range from 0 to 2 with 0 = not in place; 1 = partially in place; 2 = in place.
Median and (Minimum Value, Maximum Value) are reported for each time point.

Nonparametric analyses were used to test differences between groups for small samples. Independent Samples Kruskal-Wallis tests were used for Massachusetts. The *p*-value reports the probability of observing a false positive (null hypothesis) to be true; statistically significant p-values are denoted by an asterisk (*).

RESEARCH QUESTION: HOW DID FIDELITY TO THE APPROACH CHANGE?

This research question focused on fidelity to the Approach and how fidelity varied across sites and changed over time. Fidelity Checklists were completed by Supervisors (including CW and community partners who were trained and coached) associated with the Intervention sites. Fidelity was rated using a 9-point Likert scale where ratings of 1 to 3 indicated "needs work," ratings of 4 to 6 indicated "acceptable work," and ratings of 7 to 9 indicated "good work." Supervisors rated their supervisees' practice behaviors along five dimensions, including (1) Approach knowledge, (2) work with adult and child survivors, (3) work with person using violence and coercion, (4) principles practice, and (5) overall fidelity.

Fidelity Completion and Consent Status

Table 99 presents data on the number of Fidelity Checklists that were completed, showing them by consent status and completion status. Among Massachusetts caseworkers that could have had Fidelity Checklist completed, 54 (40%) had at least one Fidelity Checklist completed and consented to participate in the study.

Table 99. Massachusetts Fidelity Checklist Completion and Consent Status

Consent and Completion Status of Fidelity Checklist	Caseworkers: N (%)
	Massachusetts
Consent Received	
At Least 1 Checklist Complete	54 (40%)
No Checklist Received	13 (10%)
No Consent Received	
At Least 1 Checklist Complete	38 (28%)
No Checklist Received	31 (23%)
Total	**136 (100%)**

Table 100 presents information on average number of Fidelity Checklists per caseworker, grouping this information by consent status and site. The average number of completed Checklists for caseworkers who consented to be in the study was about 5 per supervisee. Massachusetts' average for consented caseworkers was 5.65 (SD = 4.54).

Table 100. Massachusetts Fidelity Checklist Average Number Completed per Caseworker by Consent Status

Consent Status	Caseworkers: Average (SD) Fidelity Checklists Completed
	Massachusetts (N = 92)
Consent Received	5.65 (4.54)
No Consent Received	3.29 (3.39)

Notes. SD = Standard deviation.

Fidelity Average Scores

Table 101 displays Fidelity Checklist data for Massachusetts, using data from participants who consented to the study and showing the average scores in each domain and each year (2019 to 2021) for which the site had fidelity data available.

Table 101. Massachusetts Fidelity Checklist Average Scores by Domain and Year

Checklist Domain & Time Period	Caseworkers: Average (SD) Fidelity Score
	Massachusetts (N = 54)
Approach Knowledge	
2019	6.54 (1.32)
2020	6.89 (1.37)
2021	7.45 (0.78)
Work with Adult and Child Survivors	
2019	6.77 (1.42)
2020	7.02 (1.32)
2021	7.48 (0.79)
Work with Person Using Violence & Coercion	
2019	6.37 (1.73)
2020	6.59 (1.64)
2021	7.42 (1.02)
Principles Practices	
2019	6.89 (1.16)
2020	7.00 (1.14)
2021	7.50 (0.59)
Overall	
2019	6.97 (1.15)
2020	7.07 (1.19)
2021	7.42 (0.72)

Notes. N = 54 fidelity checklists completed by supervisors on caseworkers.

Counts were redacted for 2019 because 5 or less caseworkers had fidelity checklists completed; their scores would likely be unreliable and represent consenting workers and their supervisors, who were early adopters of the intervention.

Fidelity scores can range from 1 to 9 where 1-3 is *needs work*; 4-6 is *acceptable work*; and 7-9 is *good work*. SD = standard deviation.

OUTCOME STUDY

CHILD OUTCOMES

2.A.1 Child Safety

See Section 5. for full description of data source, sample, and analysis.

2.A.1.1 Decrease maltreatment by person using violence and/or adult survivor

In Massachusetts, within the sample of index children with identified maltreatment between January 2, 2019 and September 30, 2021, we identified a total of 16,717 children across sites. There were 731 children served by intervention sites, 1,137 served by comparison sites, and 14,849

served by other state sites. See Table 102 for full description of characteristics of index children with identified maltreatment between 2019-21 by intervention, comparison, and other state sites.

Table 102. Massachusetts Baseline Characteristics of Index Children with Identified Maltreatment between 2019-2021 by Intervention Site, Comparison Site, and Other Sites within State

Characteristic	Intervention n (%)	Comparison n (%)	State n (%)	X2 (df)	*p*
Child gender				0.476 (2)	0.788
Female	354 (48.4)	556 (48.9)	7354 (49.5)		
Male	377 (51.6)	581 (51.1)	7495 (50.5)		
Child race/ethnicity				238.012 (6)	< 0.001*
Black/Afr Amer	37 (5.0)	123 (10.8)	2640 (17.8)		
Latin0/a	283 (38.7)	271 (23.8)	3222 (21.7)		
White	382 (52.3)	586 (51.5)	7739 (52.1)		
Multiracial/Other	29 (4.0)	157 (13.8)	1248 (8.4)		
Maltreatment type				46.212 (10)	< 0.001*
Physical abuse	40 (5.5)	22(1.9)	367 (2.4)		
Neglect	517 (70.7)	885 (77.8)	11684 (78.7)		
Sexual abuse/traffick	17 (2.3)	21 (1.9)	274 (1.9)		
Multiple types	35 (4.8)	36 (3.2)	590 (4.0)		
Unknown	122 (16.7)	173 (15.2)	1934 (13.0)		
Prior maltreatment				7.330 (2)	0.026*
No	449 (61.4)	627 (55.2)	8479 (57.1)		
Yes	282 (38.6)	510 (44.9)	6370 (42.9)		
	M(SD)	**M(SD)**	**M(SD)**	**F (df1, df2)**	***p***
Child age (years)	6.3 (5.1)	6.5 (5.1)	6.2 (5.0)	1.72 (2, 16714)	0.179
Number identified maltreatment events	1.2 (0.5)	1.2 (0.5)	1.2 (0.5)	1.11 (2, 16714)	0.329

Notes. *N* = 16,717 unique children with complete cases; *n* = 731 for intervention sites, *n* = 1137 for comparison sites, and *n* = 14,849 for other state sites.

Child gender was limited to binary constructs of male/female within the administrative data systems.

- Median child age for intervention sites was 6 (Min = 0, Max = 17), for comparison sites was 7 (Min = 0, Max = 17), and for other state sites was 6 (Min = 0, Max = 17).
- Median number of identified maltreatment events for intervention sites was 1 (Min = 1, Max = 5), for comparison sites was 1 (Min = 1, Max = 4), and for other state sites was 1 (Min = 1, Max = 8).
- Asterisk (*) denot es significant differences between sites observed.

Table 103. Massachusetts Recurrence of Maltreatment between 2019-2021 by Intervention Site, Comparison Site, and Other Sites within State

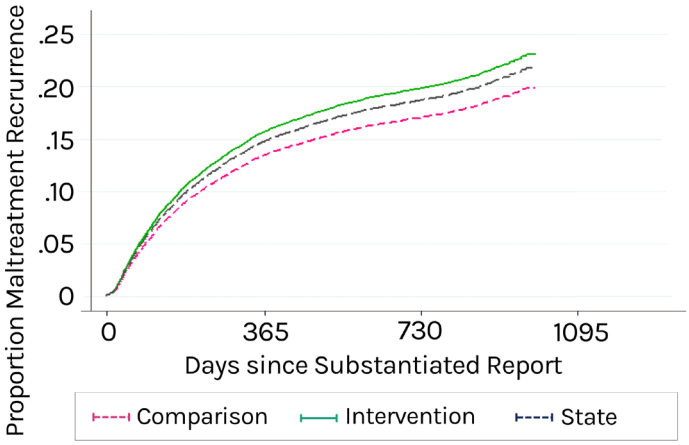
Cross-site Child Maltreatment	Intervention M(SD) or n (%)	Comparison M(SD) or n (%)	State M(SD) or n (%)	*X2* (df)	*p*
Maltreatment recurrence				2.503 (2)	0.286
No	596 (81.5)	956 (84.1)	12239 (82.4)		
Yes	135 (18.5)	181 (15.9)	2610 (17.6)		
Days to recurrence	574.0 (306.8)	577.3 (291.6)	570.0 (300.0)	0.36 (2,16714)	0.697

Notes. *N* = 16,717 unique children with complete cases; *n* = 731 for intervention sites, *n* = 1137 for comparison sites, and *n* = 14,849 for other state sites.

- Median number of days to recurrence for intervention sites was 638 days (Min = 3, Max = 1002), for the comparison sites was 628 days (Min = 21, Max = 1001), and for other state sites 630 days (Min = 1, Max = 1003).
- Asterisk (*) denotes significant differences between sites observed.

We observed no significant difference in rate of maltreatment recurrence between intervention, comparison, and state sites for the Massachusetts Project. When controlling for child and case characteristics, we did not observe a significant difference between comparison and intervention ($HR_{comparison}$ = 0.84, 95% CI (0.68, 1.05), *p* = 0.139) or for other state sites compared to the intervention site (HR_{state} = 0.94, 95% CI (0.79, 1.11), *p* = 0.452). By 1,000 days, intervention sites had an estimated 23.1% of children who re-maltreatment, comparison sites had an estimated 19.9% of children who re-experienced maltreatment, other state sites had an estimated 21.7% of children who re-experienced maltreatment. See Figure 37.

Figure 37. Massachusetts Maltreatment Recurrence Rate for Children Served between 2019-2021 by Intervention Site, Comparison Site, and Other Sites within State



Notes. *N* = 16,717. This figure represents the estimated maltreatment recurrence rate by site; a lower proportion, or lower rate of experiencing maltreatment recurrence, is identified as a desirable outcome.

We observed no differences in outcomes when the sample was stratified by:

- substantiated maltreatment type
- child age category
- child race/ethnicity

When the sample was stratified by prior maltreatment history, we observed significant differences between comparison and intervention sites for children with a prior history of substantiated/indicated maltreatment. Specifically, children with a prior maltreatment history and served by the comparison group faced a hazard of maltreatment recurrence that was 28% lower than children with a prior maltreatment history and served by the intervention site (HR = 0.72, 95% CI (0.28, 0.91), *p* = 0.046).

2.A.1.2. Decrease exposure to DV

For research question 2.A.1.2, we used a complete case analysis that focused only on index children with identified maltreatment and co-occurring domestic violence documented within their case file. Massachusetts provided information on all domestic violence risk assessments by year, allowing us to identify a total of 7,696 unique families (defined by case identification number). DV risk was identified in 62% of investigated and/or open cases between FY2019 to FY2021 for both intervention (n = 1976 indicated some level of DV risk out of 3,186 cases) and comparison (n = 2,789 indicated some level of DV risk out of 4,510 cases) offices; there were no differences in the proportion of cases with dv risks flagged (X2(1) = 0.026, p = 0.872). DV consultation services were indicated by a date flagged within the database; there were no differences between intervention and comparison sites (4% and 5% respectively, p = 0.282).

Within the sample of index children with identified maltreatment between January 2, 2019 and September 30, 2021, we identified a total of 1,035 (55.4%) children who were exposed to domestic violence out of 1,868 index child survivors identified across intervention and comparison sites. See Table 104.

Table 104. Massachusetts Baseline Characteristics of Index Children with Identified Co-occurring Maltreatment & Domestic Violence between 2019-2021 by Intervention and Comparison Groups

Characteristic	Intervention *n* (%)	Comparison *n* (%)	*X2* (df)	*p*
Child gender			0.008 (1)	0.929
Female	182 (47.6)	313 (47.9)		
Male	200 (52.4)	340 (52.1)		
Child race/ethnicity			53.972 (3)	<0.001*
Black and not Latino/a	14 (3.7)	71 (10.9)		
Latino/a and any race	156 (40.8)	153 (23.4)		
Latino/a and Black	15 (3.9)	12 (1.8)		
Latino/a and White	131 (34.3)	121 (18.5)		
Latino/a and other race	10 (2.6)	20 (3.1)		
White and not Latino/a	192 (50.3)	345 (52.8)		
Other race/multiracial and not Latino/a	20 (5.2)	84 (12.9)		
Other race and not Latino/a	3 (0.8)	43 (6.6)		
Multiracial and not Latino/a	17 (4.5)	41 (6.3)		

Characteristic	Intervention *n* (%)	Comparison *n* (%)	*X2* (df)	*p*
Maltreatment type			10.089 (4)	0.039*
Physical abuse	17 (4.5)	14 (2.1)		
Neglect	284 (74.4)	528 (80.9)		
Sex Abuse/Trafficking	4 (1.1)	4 (0.6)		
Multiple Types	21 (5.5)	20 (3.1)		
Unknown	56 (14.7)	87 (13.3)		
Prior maltreatment			3.466 (1)	0.063
No	186 (48.7)	279 (42.7)		
Yes	196 (51.3)	374 (57.3)		
	M(SD)	**M(SD)**	***t* (df)**	***p***
Child age (years)	6.2 (5.1)	6.5 (4.9)	-0.879 (1033)	0.380
Number identified maltreatment events	1.3 (0.6)	1.3 (0.6)	0.248 (1033)	0.805

Notes. *N* = 1,035 unique children with complete cases; *n* = 382 for intervention sites and *n* = 653 for comparison sites.

- Child gender was limited to binary constructs of male/female within the administrative data systems.
- Median child age for intervention sites was 6 (Min = 0, Max = 17) and for comparison sites was 7 (Min = 0, Max = 17).
- Median number of identified maltreatment events for intervention sites was 1 (Min = 1, Max = 5) and for comparison sites was 1 (Min = 1, Max = 4).
- Asterisk (*) denotes significant differences between intervention and comparison sites observed.

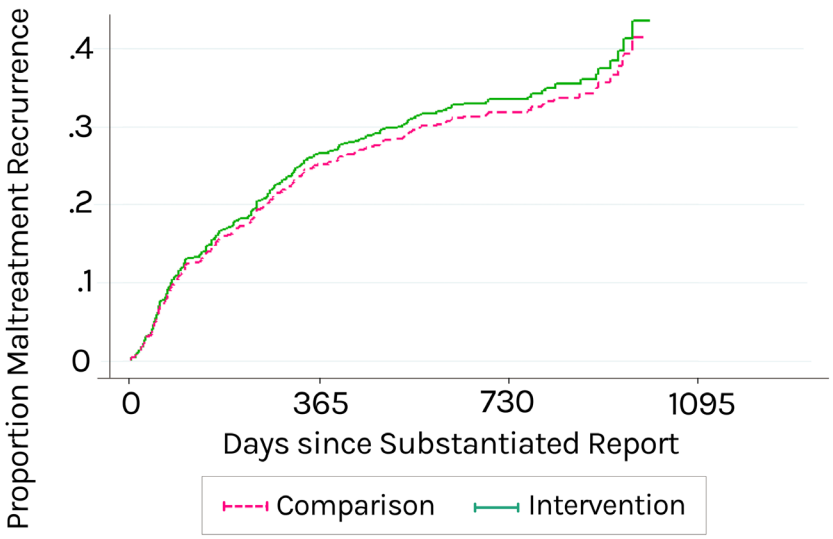
Table 105. Massachusetts Recurrence of Maltreatment between 2019-2021 for Co-occurring Sample by Intervention and Comparison Groups

Cross-site Child Maltreatment	Intervention M(SD) or *n* (%)	Comparison M(SD) or *n* (%)	*X2* / *t* (df)	*p*
Maltreatment recurrence			0.230 (1)	0.631
No	300 (78.5)	521 (79.8)		
Yes	82 (21.5)	132 (20.2)		
Days to recurrence	587.6 (289.4)	598.56 (276.3)	-0.602 (1033)	0.547

Notes. *N* = 1,035 unique children with complete cases; *n* = 382 for intervention sites and *n* = 653 for comparison sites. Median number of days to recurrence for intervention sites was 645 days (Min = 3, Max = 1002) and for the comparison sites was 639 days (Min = 1, Max = 1003). Asterisk (*) denotes significant differences between intervention and comparison sites observed.

We observed no significant differences in maltreatment recurrence for children with co-occurring maltreatment and domestic violence by intervention or comparisons sites ($HR_{comparison}$ = 0.94, 95% CI (0.71, 1.25), *p* = 0.659), controlling for child age, child gender, child race/ethnicity, prior maltreatment history, and maltreatment type. See Table 105. **This relationship remained true when the sample was stratified by child and case characteristics.** Please note that further stratification resulted in small sample sizes that can limit statistical power. Figure 38 depicts the estimated probability of maltreatment recurrence.

Figure 38. Massachusetts Maltreatment Recurrence Rate for Children Exposed to Domestic Violence and Identified by the Child Welfare System Between January 1, 2019 and September 30, 2021



Notes. N = 1,035. This figure represents the estimated maltreatment recurrence rate by site; a lower proportion, or lower rate of experiencing maltreatment recurrence, is identified as a desirable outcome.

2.A.2. Were there significant differences between the intervention and comparison sample in child permanency?

Table 106 provides details of the Massachusetts Project specific child demographics associated with unique foster care episodes used in the analysis. Table 107 provides details of Massachusetts foster care episode characteristics used in the analysis.

Table 106. Massachusetts Child Demographics Associated with Unique Foster Care Episodes by Intervention Site, Comparison Site, and Other Sites within State

Out-of-Home Care Sample	Intervention	Comparison	State	X2 (df)	p
Child gender				2.702 (2)	0.259
Female	1053 (48.9)	1171 (47.8)	17704 (49.5)		
Male	1100 (51.1)	1278 (52.2)	18079 (50.5)		
Child race/ethnicity				878.002 (6)	< 0.001*
Black and not Latino/a	74 (3.4)	250 (10.2)	5832 (16.3)		
Latino/a, any race	1251 (58.1)	766 (31.3)	11078 (31.0)		
Latino/a and Black	103 (4.8)	57 (2.3)	1128 (3.1)		
Latino/a and White	568 (26.4)	402 (16.4)	4979 (13.9)		
Latino/a and other race/multiracial	580 (26.9)	307 (12.5)	4971 (13.9)		

Out-of-Home Care Sample	Intervention	Comparison	State	*X2* (df)	*p*
White and not Latino/a	775 (36.0)	1160 (47.4)	15848 (44.3)		
Other race/multiracial and not Latino/a	53 (2.5)	273 (11.1)	3025 (8.5)		
Other race and not Latino/a	7 (0.3)	127 (5.2)	400 (1.1)		
Multiracial and not Latino/a	46 (2.2)	146 (6.0)	2625 (7.3)		
Any diagnosed disability?				124.802 (4)	< 0.001*
Yes	338 (15.7)	567 (23.1)	5297 (14.8)		
No	1328 (61.7)	1399 (57.1)	2223 (62.1)		
Not yet determined	487 (22.6)	483 (19.7)	8256 (23.1)		
Reason for FC Involve				57.061 (12)	< 0.001*
Physical abuse	89 (4.1)	58 (2.4)	1087 (3.0)		
Neglect	637 (29.6)	766 (31.3)	11879 (33.2)		
Parent alcohol/drug use	204 (9.5)	223 (9.1)	3045 (8.5)		
Parent inability cope	30 (1.4)	30 (1.2)	681 (1.9)		
Other	67 (3.1)	39 (1.6)	710 (2.0)		
Multiple reasons	791 (36.7)	888 (36.3)	12419 (34.7)		
Unknown	335 (15.6)	445 (18.2)	5962 (16.7)		
	M(SD)	**M(SD)**	**M(SD)**	***F* (df 1, df 2)**	***p***
Child Age @ Entry	8.7 (5.9)	8.2 (5.9)	7.6 (5.9)	51.11 (2, 40382)	< 0.001*

Notes. ***N*** = 40,385 unique foster care episodes; ***n*** = 2,153 for intervention sites, ***n*** = 2,449 for comparison sites, and ***n*** = 35,783 for other state sites.

- Child gender was limited to binary constructs of male/female within the administrative data systems.
- Racial/ethnic groups were collapsed to provide sufficient power for subsequent analyses; composition of groups that compose "Latino/a, any race" and "Other race/multiracial and not Latino/a" are provided in gray for information only.
- Median child age for intervention sites was 9 (Min = 0, Max = 17), for comparison sites was 8 (Min = 0, Max = 17), and for other state sites was 7 (Min = 0, Max = 17).
- Asterisks (*) denote significant differences across sites.

Table 107. Massachusetts Foster Care Episode Characteristics by Intervention Site, Comparison Site, and Other Sites within State

Out-of-Home Care Sample	Intervention	Comparison	State	X2 (df)	p
Entry Cohort				54.513 (14)	< 0.001*
2014	258 (12.0)	389 (15.9)	5026 (14.1)		
2015	280 (13.0)	360 (14.7)	5370 (15.0)		
2016	342 (15.9)	334 (13.6)	5215 (14.6)		
2017	307 (14.3)	332 (13.6)	5006 (14.0)		
2018	262 (12.2)	270 (11.0)	4846 (13.5)		
2019	312 (14.5)	312 (12.7)	4549 (12.7)		
2020	222 (10.3)	246 (10.0)	3312 (9.3)		
2021	170 (7.9)	206 (8.4)	2459 (6.9)		
Most Recent Case Goal				103.560 (8)	< 0.001*
Reunify with Family	1680 (78.0)	1911 (78.0)	26380 (73.7)		
Adoption	231 (10.7)	295 (12.1)	5870 (16.4)		
Guardianship	26 (1.2)	38 (1.5)	591 (1.7)		
LTFC/Emancipation	137 (6.4)	129 (5.3)	2139 (6.0)		
Not Established/ Unknown	79 (3.7)	76 (3.1)	803 (2.2)		
Placement Stability				148.713 (2)	< 0.001*
< 2 placements / year	1588 (73.8)	1709 (69.8)	22438 (62.7)		
3+ placement / year	565 (26.2)	740 (30.2)	13345 (37.3)		
Prior Episodes				0.018 (2)	0.991
None	1652 (76.7)	1876 (76.6)	27412 (76.6)		
1 or More	501 (23.3)	573 (23.4)	8371 (23.4)		
Reason for Discharge				69.399 (10)	< 0.001*
Reunify with Family	1204 (55.9)	1282 (52.3)	17707 (49.5)		
Adoption	80 (3.7)	142 (5.8)	2410 (6.7)		
Guardianship	81 (3.8)	125 (5.1)	1829 (5.1)		
Emancipation	87 (4.0)	91 (3.7)	1392 (3.9)		
Transfer/Runaway/ Death	10 (0.5)	6 (0.2)	74 (0.2)		
Not Applicable/ Unknown	691 (32.1)	803 (32.8)	12371 (34.6)		
	M(SD)	**M(SD)**	**M(SD)**	***F* (df 1, df 2)**	***p***
Days in Foster Care	516.6 (601.6)	595.23 (643.8)	649.6 (628.5)	51.93 (2, 40382)	< 0.001*

Notes. N = 40,385 unique foster care episodes; n = 2,153 for intervention sites, , ***n*** = 2,449 for comparison sites, and ***n*** = 35,783 for other state sites.

- ***Not Established/Unknown*** and ***Not Applicable/ Unknown*** indicates when information was not provided for an episode due to this action not yet being determined in the record or having missing information.
- Median days in foster care for intervention sites was 282 days (Min = 1, Max = 2806), for comparison sites was 373 days (Min = 3, Max = 2820), and for other state sites was 443 (Min = 3, Max = 2826).
- Asterisks (*) denote significant differences across sites.

2.A.2.1. Increase of Intact Family vs. Family Removal

In Massachusetts, the system has the choice of providing intact family services or child removals into out-of-home care when child maltreatment has been substantiated or indicated. We observed different trends over time in the proportion of children removed from their homes.

Pre-intervention, between 2014 and 2018, we observed no significant differences between intervention and comparison site removal rates. Post-intervention we see no significant differences in child removal rates between intervention and comparison sites across all time periods. In fact, both sites demonstrated lower child removal rates on average during the post-Covid time period. See Table 108 and Figure 39 for documentation of interrupted time series analysis. Please note that there is significant variability in removal rates over time, particularly during the time period after the onset of Covid-19.

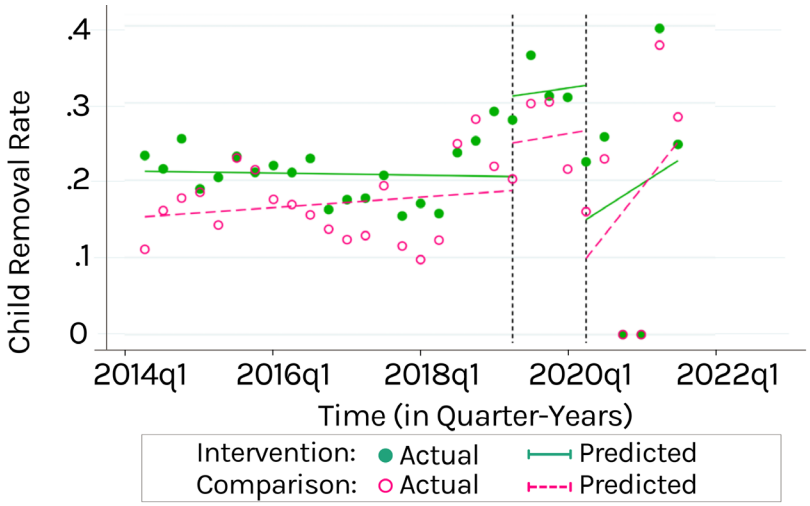
As a result, we cannot conclude that there were significant changes in foster care removal rates as a result of the Approach being implemented.

Table 108. Massachusetts Interrupted Time Series Analysis of Child Removal Rates per 100 Children by Project Sites comparing Trends during Pre-intervention, Post-intervention, and Post-Covid Time Periods

Interrupted Time Series	b (se)	p
Time	0.00 (0.00)	0.277
Intervention	0.06 (0.03)	0.035
Time * Intervention	-0.00 (0.00)	0.558
Post-2019	0.06 (0.06)	0.271
Time * Post-2019	0.00 (0.02)	0.899
Intervention * Post-2019	0.04 (0.07)	0.549
Time * Intv * Post-2019	0.00 (0.02)	0.945
Post-Covid	-0.17 (0.10)	0.114
Time * Post-Covid	0.03 (0.03)	0.327
Intervention * Post-Covid	-0.01 (0.14)	0.953
Time * Intv * Post-Covid	-0.01 (0.04)	0.698
Constant	0.15 (0.02)	< 0.001*
F (11, 48)	9.95	< 0.001*

Notes. *N* = 60. Significant partial slopes are indicated by an asterisk (*).

Figure 39. Massachusetts Interrupted Time Series Analysis of Child Removal Rates per 100 Children by Project Sites Comparing Trends during Pre-intervention, Post-intervention, and Post-Covid Time Periods



Regression with Newey-West standard errors – lag(1)

Notes. *N* = 60 quarter-years. Quarter years are formatted as year and quarter; for example, 2014q1 represents children with reports during quarter 1 of the year 2014. Actual quarterly rates are visualized as data points while estimated trends are visualized by lines.

- Training was implemented during January 2019 at the intervention sites; the dotted line for 2019q1 is visualized within the graph.
- Covid-19 Pandemic started in March 2020; the dotted line for 2020q2 is visualized within the graph.
- Lower child removal rate is a more desirable outcome. We observed no significant differences between intervention and comparison sites over time.

2.A.2.2. Increased Reunification Rate

For this sample, we followed all episodes involving Massachusetts youth entering foster care between January 1, 2014 and September 30, 2021. Reunification was defined as a child being reunited with a parent/original caregiver and/or living with family. If a child was not reunited with family upon discharge from foster care or remained in care at the end of the observation period, they were coded as "not reunified." All models assessed a site by time interaction and controlled for child characteristics and episode characteristics.

We then assessed the relative risk of a child being reunified with family between intervention, comparison, and other state sites. Holding all else equal, we observed no significant differences in the likelihood of being reunified with parents post-intervention for child survivors who entered foster care after January 1, 2019 and served by comparison sites relative their counterparts served by intervention (reference) sites ($HR_{Comparison}$ = 0.97, 95% CI (0.82, 1.16), p = 0.747). We observed other state sites had lower reunification rates relative to the intervention (reference) sites (HR_{State} = 0.72, 95% CI (0.63, 0.81), p < 0.001) during this post-intervention time period, holding all else equal.

Table 109. Massachusetts Estimated Proportion of Foster Care Episodes that Resulted with Children being Reunified with Families by Time Period and by Intervention Site, Comparison Site, and Other Sites within State

Time Period	Intervention % Reunified with Family by 1,000 Days	Comparison % Reunified with Family by 1,000 Days	State % Reunified with Family by 1,000 Days
2014-2018	43.2%	38.2%	34.0%
2019-2021	29.1%	28.4%	21.8%

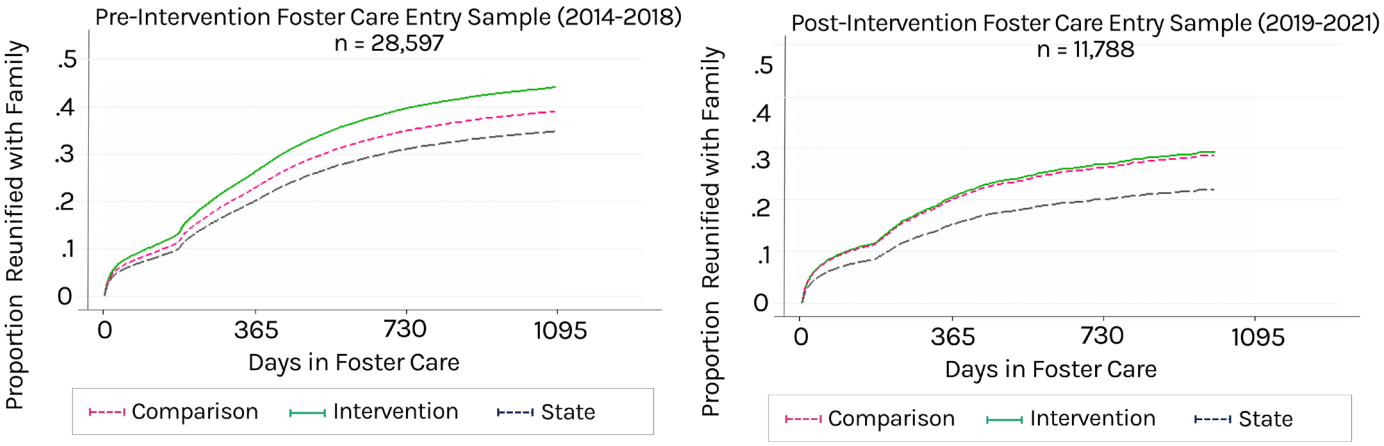
Notes. *N* = 40,385.

Between 2019 to 2021 within the intervention sites, we observed 20.4% of foster care episodes within the first 12 months of care were associated with children being reunified with family. The proportion of episodes resulting in reunification with family rose another 6.3% for youth who stayed in care from 12 to 24 months and additional 2.4% for youth who stayed in care over 24 months. By 1,000 days, or the 2.7 years that we collected data post-intervention, the adjusted models estimated 29.1% of foster care episodes ended with youth being returned to the care of their family.

Between 2019 to 2021 within the comparison sites, we observed 19.8% of foster care episodes within the first 12 months of care were associated with children being reunified with family. The proportion of episodes resulting in reunification with family rose another 6.2% for youth who stayed in care from 12 to 24 months and additional 2.3% for youth who stayed in care over 24 months. By 1,000 days, or 2.7 years, the adjusted models estimated 28.4% of foster care episodes ended with youth being returned to the care of their family.

Using a difference-in-difference model, we observed no significant treatment effect when comparing differences in reunification rates across sites for youth entering foster care between 2014-2018 and for youth entering foster care between 2019-2021. In other words, comparison sites faced a similar likelihood of experiencing reunification for youth entering foster care during the post-intervention time period compared to their counterparts at the intervention (reference) sites ($HR_{Comparison \times Post\text{-}Intervention}$ = 1.16, 95% CI (0.96, 1.41), p = 0.132). Similar results were observed when other state sites were compared to intervention (reference) sites ($HR_{State \times Post\text{-}Intervention}$ = 0.92, 95% CI (0.80, 1.06), p = 0.262).

Figure 40. Massachusetts Reunification Rates comparing FC Entry Cohorts 2014-2018 and 2019-2021 by Intervention Site, Comparison Site, and Other Sites within State



Notes. *N* = 40,385. This figure reports the estimated proportion of foster care episodes that result in reunification with family over days in foster care, holding all else equal.

- Every time a child is estimated to reunify with a family, the cumulative proportion of youth increases. A good outcome is associated with a higher proportion of foster care episodes resulting in reunification with family.
- Differences in relative risk for reunification across pre- and post-intervention foster care entry did not significantly differ. In other words, while we see some relative improvement in reunification rates for the intervention sites compared to the comparison sites, these differences were considered comparable when accounting for variability in outcomes across child and episode characteristics

It is important to note that we see a lower proportion of youth reunifying across all sites during the post-intervention time period that was defined by several historical events, including the onset of the Covid-19 pandemic.

When the sample was stratified by maltreatment type, we observed a no significant treatment effect for child survivors by reasons for entry into foster care. In other words, we see results similar to those presented for the full sample by youth entering foster care for physical abuse only, neglect only, other types of maltreatment only, and multiple types of maltreatment.

When the sample of children entering foster care was further stratified by race/ethnicity, we observed a no significant treatment effect for child survivors by racial/ethnic identification. In other words, we observed reentry rates to not significantly differ across sites during pre-intervention and post-intervention time periods for youth entering foster care who identified as White and not Latino/a, Black and not Latino/a, Latino/a and any other race, and Other Race or Multiracial and not Latino/a.

In sum, significant treatment effects were not observed for reunification rates across intervention, comparison, and other state sites. It's important to note that we see a lower proportion of youth reunifying across all sites during the post-intervention time period that was defined by several historical events, including the onset of the Covid-19 pandemic.

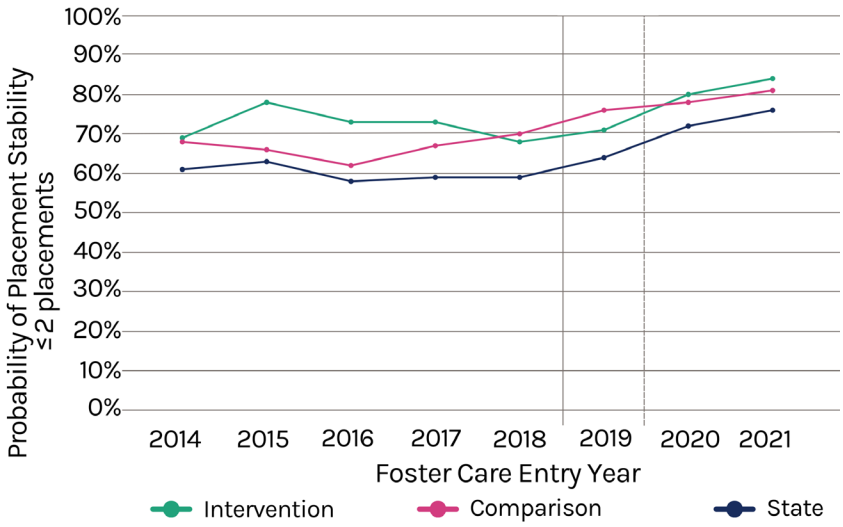
2.A.2.3. Increased Stability

We used Massachusetts foster care sample of *N* = 40,385 reported in the methods to answer this research question.

In the models that assessed for differences between sites by foster care entry cohort and controlled for child and episode characteristics, we observed no significant main effect for the differences in the odds of a child survivor experiencing placement stability between the comparison and intervention (reference) sites ($OR_{comparison}$ = 0.94, 95% CI (0.67, 1.32), p = 0.708).

Similarly, we observed other state sites did not differ in their placement stability across foster care entry cohorts compared to intervention (reference) sites (OR_{state} = 0.79, 95% CI (0.60, 1.03), p = 0.082). Figure 41 compares site-level differences in the probability of youth experiencing 2 or less placements for youth entering foster care between 2014 to 2021.

Figure 41. Massachusetts Probability of Experiencing Placement Stability by Entry Cohort by Intervention Site, Comparison Site, and Other Sites within State



Notes. *N* = 40,385 unique foster care episodes; *n* = 2,153 for intervention sites, *n* = 2,449 for comparison sites, and *n* = 35,783 for other state sites. The intervention start date was January 1, 2019 indicated by the vertical solid line. The onset of Covid-19 is indicated by the vertical dash line.

We ran additional models stratified by duration of the foster care episode to assess for differences in rates by children's length of time in care. Table 110 shows the results of these multivariate models.

Table 110. Massachusetts Likelihood of Experiencing Placement Stability by Duration in Foster Care by Intervention Site, Comparison Site, and Other Sites within State

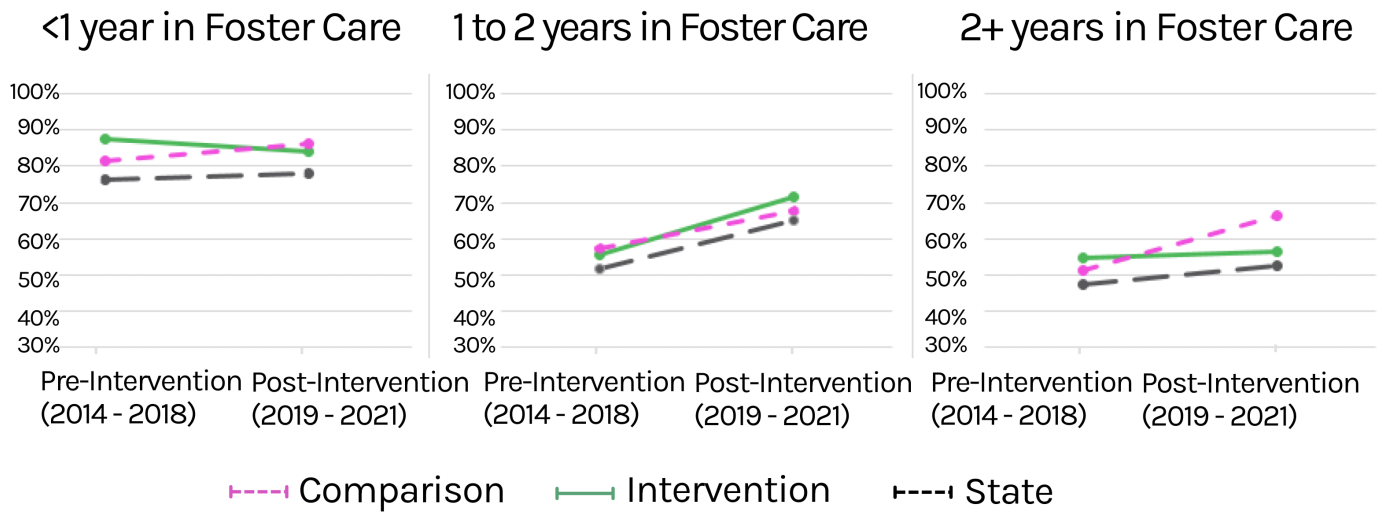
Characteristics	Episode < 1 year OR (95% CI)	Episode 1 to 2 years OR (95% CI)	Episode 2+ years OR (95% CI)
Site			
Intervention	ref	ref	ref
Comparison	0.62 (0.46, 0.82)**	1.08 (0.76, 1.55)	0.87 (0.67, 1.11)
State	0.45 (0.36, 0.56)***	0.85 (0.63, 1.13)	0.74 (0.61, 0.90)**
Time			
2014-2018	ref	ref	ref
2019-2021	0.75 (0.54, 1.05)	2.08 (1.36, 3.18)**	1.09 (0.67, 1.78)
Site * Time			
Comparison*2019-2021	1.94 (1.22, 3.10)**	0.75 (0.43, 1.33)	1.80 (0.92, 3.53)

Characteristics	Episode < 1 year OR (95% CI)	Episode 1 to 2 years OR (95% CI)	Episode 2+ years OR (95% CI)
State*2019-2021	1.49 (1.05, 2.11)*	0.86 (0.56, 1.33)	1.13 (0.68, 1.85)
Child age (in yrs)	1.00 (1.00, 1.01)	0.95 (0.94, 0.96)***	0.99 (0.98, 0.99)**
Child gender			
Female	ref	ref	ref
Male	1.07 (0.99, 1.15)	0.92 (0.84, 1.00)*	0.96 (0.90, 1.03)
Child race/ethnicity			
Black and not Latino/a	ref	ref	ref
Latino/a, any race	1.18 (1.06, 1.31)**	1.11 (0.97, 1.27)	0.95 (0.85, 1.06)
White and not Latino/a	1.37 (1.24, 1.52)***	1.68 (1.48, 1.91)***	1.31 (1.18, 1.45)***
Other race/multiracial and not Latino/a	1.20 (1.03, 1.39)*	1.33 (1.10, 1.60)**	1.03 (0.88, 1.19)
Child any disability			
Yes	ref	ref	ref
No / not yet determined	1.49 (1.34, 1.67)***	1.16 (1.03, 1.31)*	1.54 (1.41,1.68)***
Prior Episode			
None	ref	ref	ref
At least 1 prior episode	0.86 (0.79, 0.94)**	0.96 (0.87, 1.07)	0.61 (0.56, 0.67)***
Case Goal			
Reunify with Family	ref	ref	ref
Adoption	0.63 (0.48, 0.82)**	0.85 (0.74, 0.97)*	0.67 (0.62, 0.73)***
Guardianship	1.56 (0.88, 2.77)	1.62 (1.17, 2.26)**	0.75 (0.61, 0.92)**
LTFC/Emancipation	0.36 (0.27, 0.47)***	0.59 (0.47, 0.75)***	2.26 (2.00, 2.57)***
Unknown	1.29 (1.06, 1.58)*	1.51 (0.91, 2.50)	2.47 (1.75, 3.48)***
Model Fit			
LR Chi2 (df)	286.78(16)***	532.13 (16)***	744.88 (16)***
Pseudo R2	0.0152	0.0417	0.0409

Notes. * > .05, ** > .01, ** > .001. Less than one year in foster care *n* = 17,894; 1 to 2 years in foster care *n* = 9,340; and 2+ years in foster care *n* = 13,151.

To better understand the treatment effects reported in the prior table (site * time interaction), Figure 42 and Table 111 provide a summary of the probability of a child experiencing placement stability across sites by a child's duration in foster care and when a child entered foster care (i.e., pre-intervention time period between 2014-2018 or post-intervention time period between 2019-2021).

Figure 42. Massachusetts Estimated Probability of a Child Experiencing Placement Stability by Duration in Foster Care and Entry Cohort by Intervention Site, Comparison Site, and Other Sites within State



Notes. *N* = 40,385. Less than one year in foster care *n* = 17,894; 1 to 2 years in foster care *n* = 9,340; and 2+ years in foster care *n* = 13,151.

Table 111. Massachusetts Estimated Probability of a Child Experiencing Placement Stability by Duration in Foster Care and Entry Cohort by Intervention Site, Comparison Site, and Other Sites within State

Episode Length by & Foster Care Entry Year	Intervention % (95% CI) of Placement Stability	Comparison % (95% CI) of Placement Stability	State % (95% CI) of Placement Stability
Less than 1 year in foster care:			
2014-2018	87.6 (85.2, 90.0)	81.4 (78.6, 84.2)	76.3 (75.4, 77.1)
2019-2021	84.2 (80.8, 87.6)	86.4 (78.6, 84.2)	78.2 (77.1, 79.3)
1 to 2 years:			
2014-2018	55.7 (48.9, 62.4)	57.5 (52.4, 62.7)	51.7 (50.3, 53.0)
2019-2021	71.7 (65.5, 77.9)	67.7 (61.5, 72.9)	65.1 (63.5, 66.8)
2+ years in foster care:			
2014-2018	54.5 (50.1, 59.0)	51.2 (47.3, 55.1)	47.6 (46.7, 48.6)
2019-2021	56.5 (46.0, 67.1)	66.5 (57.3, 75.7)	52.4 (50.2, 54.7)

Notes. *N* = 40,385. Less than one year in foster care *n* = 17,894; 1 to 2 years in foster care *n* = 9,340; and 2+ years in foster care *n* = 13,151.

For children whose foster care episode has a duration of less than a year:

- Placement stability within the intervention sites slightly decreased on average between pre-intervention and post-intervention foster care entry cohorts; however, this change was not significantly significant (z = -1.66, Bonferroni p = 1.000). In other words, placement stability appeared to remain stable across entry cohorts within the Massachusetts Project intervention sites. It's important to note that the baseline stability rate is high at 87.6% of episodes that had a duration of less than a year.
- In contrast, we observed placement stability slightly increased on average during the post-intervention time period for both the comparison site (z = 2.30, Bonferroni p = 0.321) and other state sites (z = 2.15, Bonferroni p = 0.089), bringing their estimated proportions closer to intervention offices than during pre-intervention time periods. However, these changes were not statistically significant.

For children whose foster care episode has a duration of 1 to 2 years:

- We observed increases in likelihood of children experiencing placement stability across for intervention and other state sites for those children who entered foster care between 2019-2021 compared to those who entered foster care between 2014-2018 (Bonferroni p < 0.050).
- We observed not changes in likelihood of children experiencing placement stability within comparisons sites for those children who entered foster care between 2019-2021 compared to those who entered foster care between 2014-2018 (z = 2.42, Bonferroni p = 0.230).
- There was no significant treatment effect observed when comparing site level differences for youth entering foster care during pre-intervention and post-intervention time periods.

For children whose foster care episode has a duration of 2+ years:

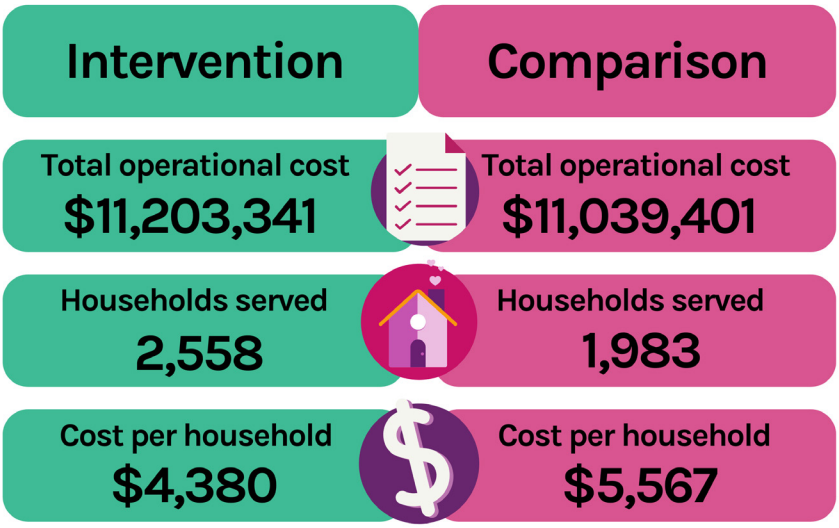
- We observed placement stability stayed relatively stable for both intervention and comparison sites for those children who entered foster care between 2019-2021 compared to those who entered foster care between 2014-2018 (Bonferroni p > 0.050).
- There was no significant treatment effect observed when comparing site level differences for youth entering foster care during pre-intervention relative to post-intervention time periods.

In sum, we did not observe significant increases in placement stability that can be attributed to the Approach for Massachusetts youth served by intervention sites.

COST STUDY

The Massachusetts Project completed two BATs – one for its intervention sites, which included Lawrence and Haverhill offices, and for its comparison sites, which included Lowell and Malden offices.

Figure 43. MA Intervention and Comparison Site Operational Cost, Households Served, and Cost Per Household (July 1, 2020 – June 30, 2021)



Service characteristics

Between July 1, 2020 – June 30, 2021, Massachusetts intervention sites served a total of 2,558 unique households, while the comparison sites provided services to 1,983 households or both the intervention and comparison sites, it was estimated that half (50%) of all cases involved IPV.

Total cost and cost per household

The total cost of operations for the intervention sites was calculated to be $11,203,341, resulting in a per household cost of $4,380. The cost for the comparison sites totaled $11,039,401, averaging $5,567 per household; a difference of $1,187 per household.

Summary of costs by cost category

Table 112 displays the total, percentage, and per family costs of service delivery by cost category for Massachusetts intervention and comparison sites during this timeframe. Two cost categories (labor and overhead and infrastructure) comprised 92.1% and 89.7% of total costs for the intervention and comparison sites, respectively. All other cost categories represented 1.3% or less of total costs. For the intervention sites, contracted services amounted to $147,500 and included funding from the QIC-DVCW to support service delivery for three domestic violence community programs for their staff to participate in the Project on implementation and management teams, as well as a direct contract for a consultant/ deputy project manager. The training costs for the intervention sites totaled $44,900 for the initial QIC-DVCW training for child welfare staff and monthly coaching calls. No training costs were reported for the comparison sites, as Massachusetts indicated that they were not able to calculate these costs. Consumable and non-consumable supplies, and travel costs for intervention and comparison sites were similar, and negligible to total costs.

Table 112. Summary Cost Metrics for Massachusetts Intervention and Comparison Sites, July 1, 2020 – June 30, 2021

Cost Category	Intervention			Comparison		
	Total Cost ($)	Total Cost (%)	Cost per Family Served	Total Cost ($)	Total Cost (%)	Cost per Family Served
Labor	$10,321,226	92.1%	$4,035	$9,900,625	89.7%	$4,993
Overhead and Infrastructure	$527,412	4.7%	$206	$987,296	8.9%	$498
Contracted Services	$147,500	1.3%	$58	$0	0.0%	$0
Tools and Screening	$0	0.0%	$0	$0	0.0%	$0
Training	$44,900	0.4%	$18	$0	0.0%	$0
Consumable Supplies	$54,034	0.5%	$21	$47,520	0.4%	$24
Non-consumable Supplies	$35,468	0.3%	$14	$34,214	0.3%	$17
Travel	$72,802	0.6%	$28	$69,747	0.6%	$35
Total Costs	$11,203,341	100%	$4,380	$11,039,401	100%	$5,567

Key cost drivers

The two key cost drivers for Massachusetts intervention and comparison sites were labor and overhead and infrastructure, accounting for more than 96.8% of total costs in intervention sites and 98.6% of total costs in comparison sites. The overhead and infrastructure costs reported by Massachusetts in the BAT only included office rent, utilities, and maintenance. The cost of office rent and utilities was higher for the comparison sites than for the intervention sites ($962,329 versus $497,457, respectively). The difference in costs is largely due to the higher cost for rent at the comparison sites. Massachusetts did not report any overhead costs (i.e., institutional indirect costs) for the intervention and comparison sites. This would include general and administrative costs to support agency operations, such as administrative staff and support, clerical support, payrolls taxes, etc. The overhead and infrastructure cost, as well the total operational cost, is expected to be much higher with more comprehensive reporting of overhead costs.

Because labor comprised the bulk of costs for both sites, Figure 44 and Figure 45 delve deeper into this category. Figure 44 details the staff roles and the number of full-time equivalents (FTEs) needed to implement and provide child welfare services for the intervention and comparison sites. The intervention sites, which served 575 more households, employed 99.3 FTEs while the comparison sites employed 96.7 FTEs. In terms of staffing structure, the intervention sites differed from the comparison sites in that it included 5 more FTEs for supervisors and had 3 less FTEs for Area Program Managers. The annual staff salaries for the intervention sites ranged from $68,235 to $116,028, with an average salary of $92,716. The annual staff salaries for comparison sites ranged from $66,081 to $116,028, with an average salary of $92,425.

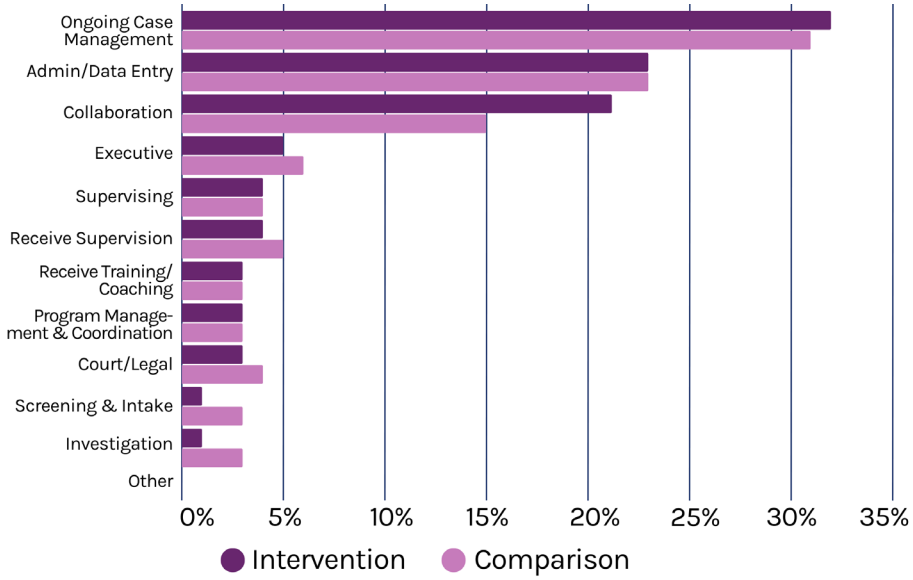
Figure 44. Staff Roles and Number of FTEs for Massachusetts Intervention and Comparison Sites, July 1, 2020 – June 30, 2021

99.3 Total FTEs Intervention	Job Title	96.7 Total FTEs Comparison
61.8	Social Worker	61.2
25.0	Supervisor	20.0
5.0	Area Program Manager	8.0
2.0	Area Clinical Managers	2.0
2.0	Area Directors	2.0
1.0	Regional Managers	1.0
0.5	Regional Specialists	0.5
1.5	Domestic Violence Unit Staff	1.5
0.5	Domestic Violence Unit Directors	0.5

Labor allocation by service activity

Figure 45 shows the allocation of labor across each of the 12 key service activities for the intervention and comparison sites. Collaboration, which was hypothesized to be greater for the intervention group due to the principles of the Approach, accounted for 21% of staff labor for the intervention sites, and 15% for the comparison sites. Ongoing case management, administration/data entry, and collaboration accounted for approximately 76% and 69% of all staff activity for intervention and comparison sites, respectively. For all other key activities, there was general consistency in the percentage of time spent in each activity, with no more than a 2-percent difference across the intervention and comparison sites in any key activity.

Figure 45. Labor Allocation Across Key Activities for Massachusetts Intervention and Comparison Sites, July 1, 2020 – June 30, 2021



SECTION 8. ILLINOIS PROJECT REPORT

Implementation Study

The implementation study was oriented around an overarching research question that asked:

What factors are associated with successful implementation and sustainability of an adult and child survivor-centered approach?

This component of the evaluation was informed by implementation science and the frameworks discussed above. The concept of "successful implementation" was operationalized to include Implementation Outcomes of adoption, acceptability, feasibility, fidelity, penetration, and sustainability. (Cost is also included in the Proctor framework from which we draw implementation outcomes; however, costs are covered in the Cost Study section of this report). Table 113 outlines the implementation study research questions and crosswalks them with the Implementation Outcome and data source. Results are provided in order of research questions shown in this table.

Table 113. Crosswalk of Implementation Study's Research Questions, Implementation Outcomes, and Data Source

Implementation Study Research Question	Implementation Outcome	Data Source
To what extent did the Approach spread to sites?	Penetration (spread)	Training participation roster Coaching participation roster Fidelity checklists
How did implementation drivers change?	Adoption Sustainability	Drivers Assessment
How did fidelity to the Approach change?	Fidelity	Fidelity Checklists
How long did it take to implement and how complete was implementation?	Adoption Sustainability	Universal Stages of Completion
What contributed and inhibited successful implementation?	Acceptability Feasibility Sustainability	Key Informant Interviews Coaching Focus Groups

RESEARCH QUESTION: TO WHAT EXTENT DID THE APPROACH SPREAD TO SITES?

This research question relates to the implementation outcome of **penetration** *(see page 10), which may also be referred to as intervention reach or spread. Ideally, measurement of spread would estimate the percentage of providers who used the Approach in their practice with children, adult survivors, and persons who use violence. Given our limits in observing the Approach in practice, we used several proxies to operationalize spread of the Approach. We considered three metrics to describe each sites' participation in training, coaching, and fidelity as follows:*

1. Percent of eligible caseworkers, supervisors, and community partners who participated in **training**
2. Percent of eligible supervisors who participated in **coaching**
3. Percent of eligible caseworkers for whom a **fidelity checklist** was completed

Table 114 provides percentages for each of the spread indicators. It shows the following:

- **Training**: In the Illinois intervention site, 50% of eligible participants participated in training.

- **Coaching**: In the Illinois intervention site, 56% of eligible participants participated in coaching.
- **Fidelity Checklists**: In the Illinois intervention site, Fidelity Checklist completion spread the least at 18% of eligible participants.

Taken together, these indicators of spread would suggest that the Approach penetrated the practice of those in direct service work with families at mainly moderate levels.

Table 114. Illinois Spread: Percent of Eligible People Who Participated in Training, Coaching, and Fidelity Checklist

Key Implementation Activity	Illinois
Training Number of eligible participants (n)	567
No training	46%
Partial (1 day or some of online)	4%
Full (2 days or all online)	50%
Coaching Number of eligible participants (n)	36
Possible coaching sessions attended*	56%
Fidelity Assessment Number of eligible participants (n)	95
At least 1 Fidelity Checklist Completed**	18%

Notes. N is the number of people eligible for the implementation activity. Percent is the percentage of those eligible who participated in the implementation activity. * This sample includes attendees who were a part of the self-survey target sample, identified and tracked through monthly rosters sent from sites. The denominator adjusted for excused absences, defined by leave of absence, emergency conflict, or illness. This demonstrates individual engagement level for the sessions when they were able to attend.

** Only includes participants who consented to participate in Fidelity Checklist data collection.

RESEARCH QUESTION: HOW DID IMPLEMENTATION DRIVERS CHANGE?

This research question was concerned with the extent to which implementation drivers were in place across sites and within each site, aiming to describe the Implementation Outcomes of **adoption** and sustainability. Implementation drivers were assessed to demonstrate that the infrastructure needed to support the Approach was put in place. This infrastructure was conceptualized as comprising three main domains as measured by a Drivers Assessment survey:

- Leadership drivers (3 items)
- Competency drivers (6 items)
- Organization drivers (6 items)

As described in the Method section, participants rated items on a scale from 0 to 2 where 0 = not in place; 1 = partially in place; and 2 = in place. For the purpose of our analysis, an average score of 1.5 was considered high and represented “nearly in place” or “in place.”

Table 115 presents the item level average scores for Illinois Project in a table format, providing average scores (see below table for which scores), standard deviations, and statistical test results.

Table 115. Illinois Drivers Assessment Domain Average Scores

Driver Domain & Time Period	Average (SD) Drivers Assessment Scores
	Illinois (N = 18)
Competency Driver	
Time 1	0.8 (0.7, 1.5)
Time 2	1.4 (0.8, 2.0)
Time 3	--
Test Statistic (p-value)	62.500 (0.027)*
Organization Driver	
Time 1	0.7 (0.0, 1.0)
Time 2	1.2 (0.2, 1.7)
Time 3	--
Test Statistic (p-value)	59.000 (0.019)*
Leadership Driver	
Time 1	1.5 (0.3, 2.0)
Time 2	1.3 (1.0, 2.0)
Time 3	--
Test Statistic (p-value)	37.500 (0.813)

Notes. N = 18 completed surveys.
Scores could range from 0 to 2 with 0 = not in place; 1 = partially in place; 2 = in place.
Median and (Minimum Value, Maximum Value) are reported for each time point.

Nonparametric analyses were used to test differences between groups for small samples. Mann-Whitney-U tests were used for Illinois. The *p*-value reports the probability of observing a false positive (null hypothesis) to be true; statistically significant p-values are denoted by an asterisk (*).

RQ: HOW DID FIDELITY TO THE APPROACH CHANGE?

This research question focused on fidelity to the Approach and how fidelity varied across sites and changed over time. Fidelity Checklists were completed by Supervisors (including CW and community partners who were trained and coached) associated with the Intervention sites. Fidelity was rated using a 9-point Likert scale where ratings of 1 to 3 indicated "needs work," ratings of 4 to 6 indicated "acceptable work," and ratings of 7 to 9 indicated "good work." Supervisors rated their supervisees' practice behaviors along five dimensions, including (1) Approach knowledge, (2) work with adult and child survivors, (3) work with person using violence and coercion, (4) principles practice, and (5) overall fidelity.

Fidelity Completion and Consent Status

Table 116 presents data on the number of Fidelity Checklists that were completed, showing them by consent status and completion status. Among caseworkers in Illinois that could have had Fidelity Checklist completed, 17 (18%) had at least 1 Fidelity Checklist completed and consented to participate in the study.

Table 116. Illinois Fidelity Checklist Completion and Consent Status by Site

Consent and Completion Status of Fidelity Checklist	Caseworkers: N (%)
	Illinois
Consent Received	
At Least 1 Checklist Complete	17 (18%)
No Checklist Received	10 (11%)
No Consent Received	
At Least 1 Checklist Complete	28 (29%)
No Checklist Received	40 (42%)
Total	**95 (100%)**

Table 117 presents information on the average number of Fidelity Checklists per caseworker, grouping this information by consent status. The average number of completed Checklists for caseworkers who consented to be in the study was about 5 per supervisee. Illinois average for consented caseworkers was 4.06 (SD = 2.82).

Table 117. Illinois Fidelity Checklist Average Number Completed per Caseworker by Site and Consent Status

Consent Status	Caseworkers: Average (SD) Fidelity Checklists Completed
	Illinois (N = 45)
Consent Received	4.06 (2.82)
No Consent Received	2.71 (1.90)

Notes. SD = Standard deviation.

Fidelity Average Scores

Table 118 displays Fidelity Checklist data for Illinois, using data from participants who consented to the study and showing the average scores in each domain and each year (2019 to 2021) for which the Project site had fidelity data available.

Table 118. Illinois Fidelity Checklist Average Scores by Domain, Site, and Year

Checklist Domain & Time Period	Caseworkers: Average (SD) Fidelity Score
	Illinois (N = 17)
Approach Knowledge	
2019	--
2020	6.71 (1.54)
2021	7.17 (1.59)
Work with Adult and Child Survivors	
2019	--
2020	6.92 (1.50)
2021	7.75 (1.06)
Work with Person Using Violence & Coercion	
2019	--
2020	6.21 (1.85)
2021	7.33 (1.30)
Principles Practices	
2019	--
2020	6.64 (1.69)

Checklist Domain & Time Period	Caseworkers: Average (SD) Fidelity Score
	Illinois (N = 17)
2021	7.50 (1.09)
Overall	
2019	--
2020	6.69 (1.44)
2021	7.33 (1.30)

Notes. N=17 that being the 17 case workers who consented to the study.

Counts were redacted for 2019 because 5 or less caseworkers had fidelity checklists completed; their scores would likely be unreliable and represent consenting workers and their supervisors, who were early adopters of the intervention.

Fidelity scores can range from 1 to 9 where 1-3 is *needs work;* 4-6 is *acceptable work*; and 7-9 is *good work*. SD = standard deviation.

OUTCOME STUDY

CHILD OUTCOMES

2.A.1 Child Safety

See Section 5. for full description of data source, sample, and analysis.

2.A.1.1 Decrease maltreatment by person using violence and/or adult survivor

In Illinois, within the sample of index children with identified maltreatment between January 2, 2019 and September 30, 2021, we identified a total of 46,997 children across sites. There were 2,811 children served by intervention sites; 2,137 children served by comparison sites; and 42,049 served by other state sites. See Table 119 for full description of characteristics of index children with identified maltreatment between 2019-21 by intervention, comparison, and other state sites.

Table 119. Illinois Baseline Characteristics of Focal Children with Identified Maltreatment between 2019-2021 by Intervention Site, Comparison Site, and Other Sites within State

Characteristic	Intervention n (%)	Comparison n (%)	State n (%)	X2 (df)	p
Child gender				0.116 (2)	0.944
Female	1,378 (49.0)	1052 (49.2)	20748 (49.3)		
Male	1433 (51.0)	1085 (50.8)	21301 (50.7)		
Child race/ethnicity				933.427 (6)	< 0.001*
Black and not Latino/a	795 (28.3)	886 (41.5)	14085 (33.5)		
Latino/a and any race	1053 (37.5)	332 (15.5)	6961 (16.6)		
Latino/a and Black	48 (1.7)	37 (1.7)	386 (0.9)		
Latino/a and White	978 (34.8)	280 (13.1)	6443 (15.3)		

Characteristic	Intervention n (%)	Comparison n (%)	State n (%)	X2 (df)	p
Latino/a and other race	27 (1.0)	15 (0.7)	132 (0.3)		
White and not Latino/a	816 (29.0)	814 (38.1)	19417 (46.2)		
Other race/multiracial and not Latino/a	147 (5.2)	105 (4.9)	1585 (3.8)		
Other race and not Latino/a	64 (2.3)	15 (0.7)	503 (1.2)		
Multiracial and not Latino/a	83 (2.9)	90 (4.2)	1082 (2.6)		
Maltreatment type				43.898 (10)	< 0.001*
Physical abuse	235 (8.4)	161 (7.5)	3960 (9.4)		
Neglect	1782 (63.4)	1403 (65.7)	25815 (61.4)		
Sex abuse/traffick	178 (6.3)	120 (5.6)	3243 (7.7)		
Other type	36 (1.3)	16 (0.8)	563 (1.3)		
Multiple types	151 (5.4)	103 (4.8)	2284 (5.4)		
Unknown	429 (15.3)	334 (15.6)	6184 (14.7)		
Prior maltreatment				11.327 (2)	0.003*
No	2123 (75.5)	1584 (74.1)	32347 (76.9)		
Yes	688 (24.5)	553 (25.9)	9702 (23.1)		
	M(SD)	M(SD)	M(SD)	F (df1, df2)	p
Child age (years)	5.6 (4.4)	4.8 (4.4)	5.3 (4.6)	17.29 (2, 46994)	< 0.001*
Number identified maltreatment events	1.2 (0.6)	1.3 (0.6)	1.2 (0.6)	5.49 (2, 46994)	0.004*

Notes. *N* = 46,997 unique children with complete cases; *n* = 2,811 for intervention sites, *n* = 2,137 for comparison sites, and *n* = 42,049 for other state sites.

- Child gender was limited to binary constructs of male/female within the administrative data systems.
- No significant differences were observed in prior maltreatment proportions between intervention and comparison sites; significant differences were primarily driven by differences in state distribution of cases.
- Median child age for intervention sites was 5 (Min = 0, Max = 17), for comparison sites was 4 (Min = 0, Max = 17), and for other state site was 5 (Min = 0, Max = 17).
- Median number of identified maltreatment events for intervention sites was 1 (Min = 1, Max = 6), for comparison sites was 1 (Min = 1, Max = 6), and for other state sites was 1 (Min = 1, Max = 8).
- Asterisk (*) denotes significant differences between sites observed.

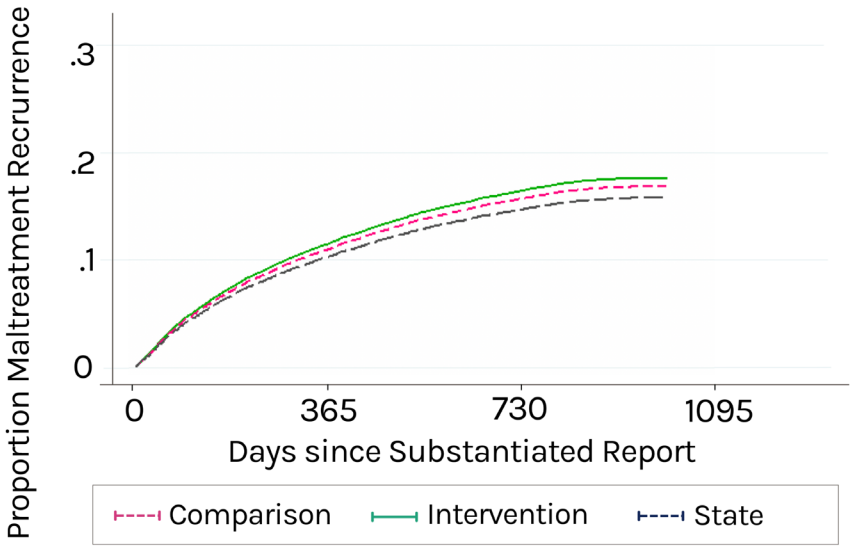
Table 120. Illinois Recurrence of Maltreatment between 2019-2021 by Intervention Site, Comparison Site, and Other Sites within State

Cross-site Child Maltreatment	Intervention M(SD) or n (%)	Comparison M(SD) or n (%)	State M(SD) or n (%)	X2 / F (df)	p
Maltreatment recurrence				10.765 (2)	0.005*
No	2284 (81.3)	1735 (81.2)	34935 (83.1)		
Yes	527 (18.7)	402 (18.8)	7114 (16.9)		
Days to recurrence	491.8 (219.2)	451.2 (285.8)	480.1 (287.3)	13.11 (2,46994)	< 0.001*

Notes. *N* = 46,997 unique children with complete cases; *n* = 2,811 for intervention sites, *n* = 2,137 for comparison sites, and *n* = 42,049 for other state sites. The median number of days to recurrence for intervention sites was 473 days (Min = 1, Max = 1003), for the comparison sites was 413 days (Min = 1, Max = 1003), and for other state sites was 454 days (Min = 1, Max = 1003). Asterisk (*) denotes significant differences between sites observed.

We observed no significant difference in rates of maltreatment recurrence between intervention and comparison sites for the Illinois Project. We did not observe significant differences between comparison and intervention sites ($HR_{comparison}$ = 0.95, 95% CI (0.83, 1.08), *p* = 0.444) when controlling for child age, gender, race/ethnicity, and initial maltreatment type. By 1,000 days, comparison sites had an estimated 16.8% of children who re-experienced maltreatment while intervention sites had an estimated 17.6% of children who re-maltreatment (all else being equal).

Figure 46. Illinois Maltreatment Recurrence Rate for Children Served between 2019-2021 by Intervention Site, Comparison Site, and Other Sites within State



Notes. *N* = 46,997. This figure represents the estimated maltreatment recurrence rate by site; a lower proportion, or lower rate of experiencing maltreatment recurrence, is identified as a desirable outcome.

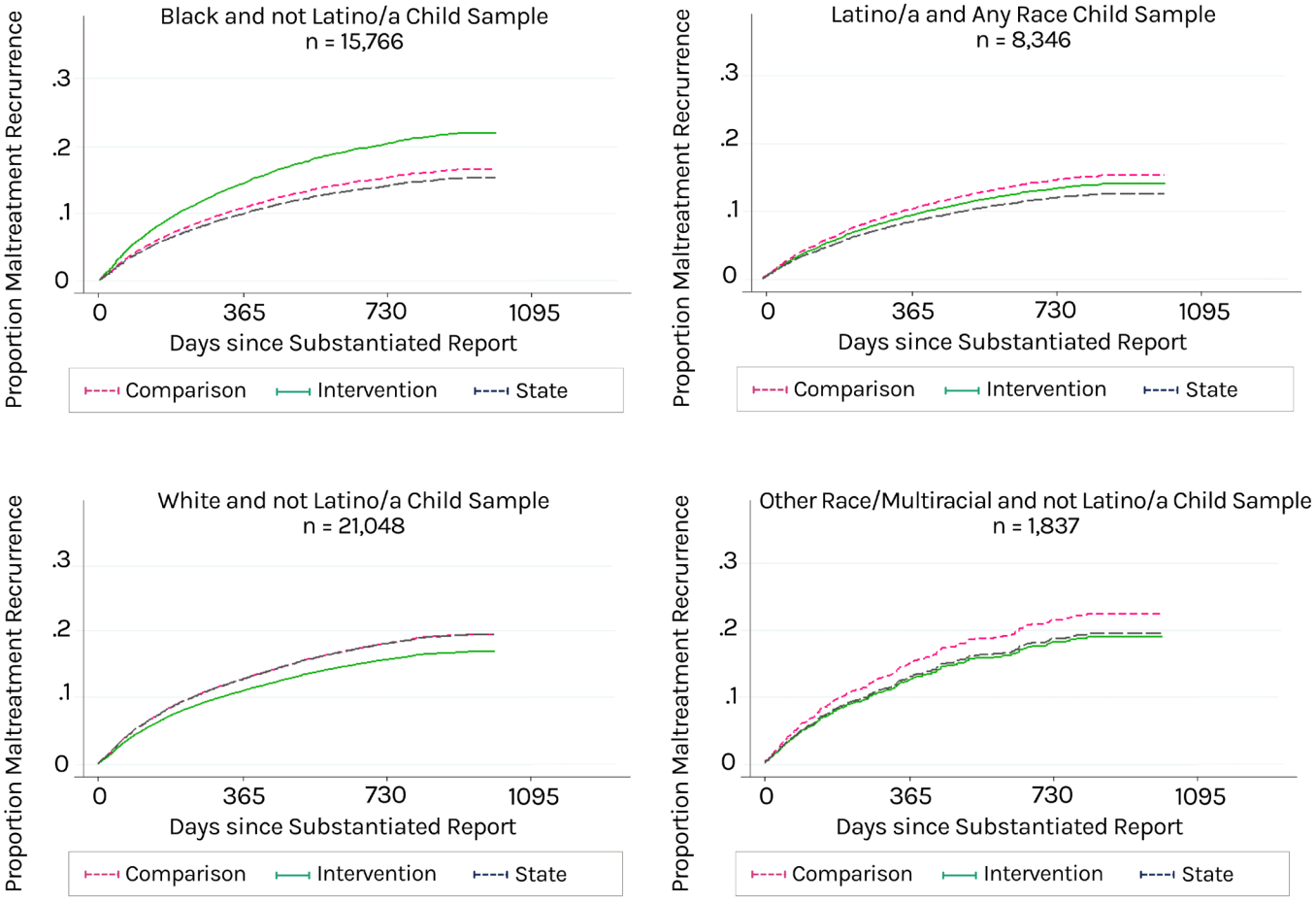
In contrast, we observed other state sites had a lower rate of maltreatment recurrence relative to intervention sites (HR_{state} = 0.88, 95% CI (0.81, 0.97), p = 0.007). By 1,000 days, other state sites had an estimated 15.7% of children who re-experienced maltreatment while intervention sites had an estimated 17.6% of children who re-experienced maltreatment (all else being equal).

When the sample was stratified by maltreatment type, prior maltreatment substantiation, or child age category, we did not observe any different patterns by type of maltreatment associated with the initial report after January 1, 2019.

When the sample was stratified by child race/ethnicity (see Figure 47):

- **We observed a significantly lower rate of maltreatment recurrence for children who were identified as Black and not Latino/a and served by the comparison site compared to their counterparts served by intervention sites.** *Holding all else equal, Black and not Latino/a children who were served by the comparison sites face a rate of maltreatment recurrence that is 27% lower than Black and not Latino/a children at the intervention site ($HR_{comparison}$ = 0.73, 95% CI (0.59, 0.90), p = 0.003). In addition, we observed* **children at other state sites faced a lower rate of maltreatment recurrence relative to the intervention sites for those identified as Black and non-Latino/a** *(HR_{state} = 0.67, 95% CI (0.57, 0.77), p < 0.001).*
- *We observed* **no significant differences in maltreatment recurrence for children identified as Latino/a and any race** *when comparing comparison sites to intervention sites ($HR_{comparison}$ = 1.10, 95% CI (0.81, 1.49), p = 0.538) or other state sites to intervention sites (HR_{state} = 0.89, 95% CI (0.76, 1.04), p = 0.156).*
- *We observed* **no significant differences in maltreatment recurrence for children identified as White and not Latino/a** *when comparing comparison sites to intervention sites ($HR_{comparison}$ = 1.17, 95% CI (0.93, 1.47), p = 0.178) or other state sites to intervention sites (HR_{state} = 1.17, 95% CI (0.98, 1.38), p = 0.076).*
- *We observed* **no significant differences in maltreatment recurrence for children identified as other race/multiracial and not Latino/a** *when comparing comparison sites to intervention sites ($HR_{comparison}$ = 1.20, 95% CI (0.69, 2.11), p = 0.517) or other state sites to intervention sites (HR_{state} = 1.02, 95% CI (0.69, 1.54), p = 0.888).*

Figure 47. Illinois Maltreatment Recurrence Rate by Racial/Ethnic Identification for Children Served between 2019-2021 by Intervention Site, Comparison Site, and Other Sites within State



Notes. **N** = 46,997. This figure represents the estimated maltreatment recurrence rate by site; a lower proportion, or lower rate of experiencing maltreatment recurrence, is identified as a desirable outcome.

- Only differences between observed for the Black and not Latino/a Child Sample were statistically significant, holding all else equal. Smaller sample sizes observed for children identified as other race/multiracial and not Latino/a may contribute to a lack of significant findings.
- In all but the Black and not Latino/a child sample, the intervention site has a substantively lower maltreatment recurrence rate on average than the comparison sites.

2.A.1.2. Decrease exposure to DV

For research question 2.A.1.2, we used a complete case analysis that focused only on index children with identified maltreatment who also had co-occurring domestic violence documented within their case file. Illinois provided information on all domestic violence risk assessments by year, allowing us to identify a total of 410 (8.3%) index children who were exposed to domestic violence out of 4,948 index child survivors identified across intervention and comparison sites between January 1, 2019 and September 30, 2021. See Table 121.

Table 121. Illinois Baseline Characteristics of Index Children with Identified Co-occurring Maltreatment & Domestic Violence between 2019-2021 by Intervention and Comparison Groups

Characteristic	Intervention n (%)	Comparison n (%)	X2 (df)	*p*
Child gender			0.601 (1)	0.438
Female	78 (50.0)	117 (46.1)		
Male	78 (50.0)	137 (53.9)		
Child race/ethnicity			26.512 (3)	< 0.001*
Black and not Latino/a	56 (35.9)	111 (43.7)		
Latino/a and any race	45 (28.9)	24 (9.5)		
Latino/a and Black	3 (1.9)	1 (0.4)		
Latino/a and White	39 (25.0)	21 (8.3)		
Latino/a and other race	3 (1.9)	2 (0.8)		
White and not Latino/a	45 (28.9)	102 (40.2)		
Other race/multiracial and not Latino/a	10 (6.4)	17 (6.7)		
Other race and not Latino/a	4 (2.6)	2 (0.8)		
Multiracial and not Latino/a	6 (3.9)	15 (5.9)		
Maltreatment type			2.432 (4)	0.657
Physical abuse	12 (7.7)	15 (5.9)		
Neglect	111 (71.2)	180 (70.9)		
Other type	7 (4.5)	9 (3.5)		
Multiple types	12 (7.7)	30 (11.8)		
Unknown	14 (9.0)	20 (7.9)		
Prior maltreatment			0.950 (1)	0.330
No	66 (42.3)	120 (47.2)		
Yes	90 (57.7)	134 (52.8)		
	M(SD)	**M(SD)**	**t (df)**	***p***
Child age (years)	4.6 (4.2)	4.3 (4.2)	-0.604 (408)	0.546
Number identified maltreatment events	1.9 (1.1)	1.7 (0.9)	-1.805 (408)	0.072

Notes. *N* = 410 unique children with complete cases; *n* = 156 for intervention sites and *n* = 254 for comparison sites.

- Child gender was limited to binary constructs of male/female within the administrative data systems.
- The median child age for intervention sites was 4 (Min = 0, Max = 16) and for comparison sites was 3 (Min = 0, Max = 17).
- The median number of identified maltreatment events for intervention sites was 2 (Min = 1, Max = 6) and for comparison sites was 2 (Min = 1, Max = 6).
- Asterisk (*) denotes significant differences between intervention and comparison sites observed.

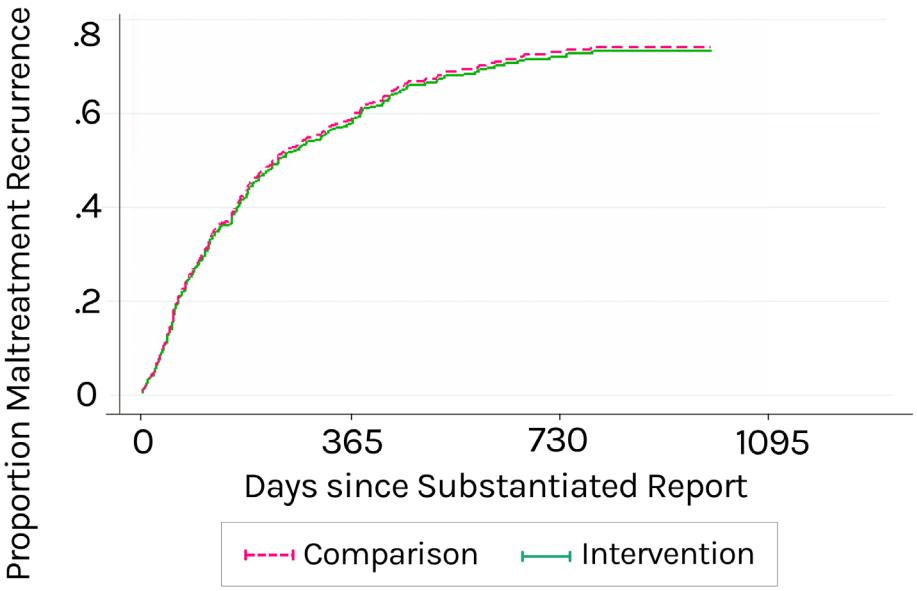
Table 122. Illinois Recurrence of Maltreatment between 2019-2021 for Co-occurring Sample by Intervention and Comparison Groups

Cross-site Child Maltreatment	Intervention M(SD) or n (%)	Comparison M(SD) or n (%)	X2 / t (df)	p
Maltreatment recurrence			0.137 (1)	0.712
No	72 (46.2)	122 (48.0)		
Yes	84 (53.9)	132 (52.0)		
Days to recurrence	372.2 (293.1)	369.4 (296.0)	-0.094 (408)	0.925

Notes. *N* = 410 unique children with complete cases; *n* = 156 for intervention sites and *n* = 254 for comparison sites. The median number of days to recurrence for intervention sites was 265 days (Min = 9, Max = 986) and for the comparison sites was 315 days (Min = 3, Max = 996).

We observed no significant differences in maltreatment recurrence for children with co-occurring maltreatment and domestic violence by intervention or comparisons sites ($HR_{comparison}$ = 1.02, 95% CI (0.77, 1.36), *p* = 0.872), controlling for child age, child gender, child race/ethnicity, prior maltreatment history, and maltreatment type. See Table 122.

Figure 48. Illinois Maltreatment Recurrence Rate for Children Exposed to Domestic Violence and Identified by the Child Welfare System between January 1, 2019 and September 30, 2021



Notes. *N* = 410. This figure represents the estimated maltreatment recurrence rate by site; a lower proportion, or lower rate of experiencing maltreatment recurrence, is identified as a desirable outcome.

This relationship remained true when the sample was stratified by child and case characteristics. Please note that further stratification resulted in small sample sizes that can limit statistical power.

2.A.2. Were there significant differences between the intervention and comparison sample in child permanency?

Table 123 provides details on the Illinois Project specific child demographics associated with unique foster care episodes used in the analysis. Table 124 provides details of Illinois Project specific foster care episode characteristics used in the analysis.

Table 123. Illinois Child Demographics Associated with Unique Foster Care Episodes by Intervention Site, Comparison Site, and Other Sites within State

Out-of-Home Care Sample	Intervention	Comparison	State	X2 (df)	p
Child gender				4.936 (2)	0.085
Female	631 (45.9)	1425 (48.8)	19747 (48.9)		
Male	744 (54.1)	1496 (51.2)	20606 (51.1)		
Child race/ethnicity				573.773 (6)	< 0.001*
Black and not Latino/a	487 (35.4)	1259 (43.1)	14979 (37.1)		
Latino/a, any race	360 (26.2)	220 (7.5)	3772 (9.3)		
Latino/a and Black	33 (2.4)	19 (0.7)	267 (0.7)		
Latino/a and White	293 (21.3)	187 (6.4)	3246 (8.0)		
Latino/a and other race/ multiracial	34 (2.5)	14 (0.5)	259 (0.6)		
White and not Latino/a	455 (33.1)	1255 (43.0)	20038 (49.7)		
Other race/multiracial and not Latino/a	73 (5.3)	187 (6.4)	1564 (3.9)		
Other race and not Latino/a	13 (1.0)	23 (0.8)	166 (0.4)		
Multiracial and not Latino/a	60 (4.4)	164 (5.6)	1395 (3.5)		
Any diagnosed disability?				22.968 (4)	< 0.001*
Yes	174 (12.7)	464 (15.9)	5210 (12.9)		
No	1165 (84.7)	2364 (80.9)	33863 (83.9)		
Not yet determined	36 (2.6)	93 (3.2)	1280 (3.2)		
Reason for FC Involve				141.542 (8)	< 0.001*
Physical abuse	110 (8.0)	207 (7.1)	3353 (8.3)		
Neglect	940 (68.4)	2114 (72.4)	25838 (64.0)		
Other	16 (1.2)	58 (2.0)	470 (1.2)		
Multiple reasons	282 (20.5)	530 (18.1)	10224 (25.3)		
Unknown	27 (2.0)	12 (0.4)	463 (1.2)		

Out-of-Home Care Sample	Intervention	Comparison	State	X2 (df)	p
	M(SD)	M(SD)	M(SD)	F (df 1, df 2)	p
Child Age @ Entry	5.4 (5.3)	5.3 (5.1)	5.6 (5.4)	5.02 (2, 44646)	0.007*

Notes. **N** = 44,649 unique foster care episodes; **n** = 1,375 for intervention sites, **n** = 2,921 for comparison sites, and **n** = 40,353 for other state sites.

- Child gender was limited to binary constructs of male/female within the administrative data systems.
- Racial/ethnic groups were collapsed to provide sufficient power for subsequent analyses; composition of groups that compose "Latino/a, any race" and "Other race/multiracial and not Latino/a" are provided in gray for information only.
- The median child age for intervention sites was 4 (Min = 0, Max = 17), for comparison sites was 4 (Min = 0, Max = 17), and for other state sites was 4 (Min = 0, Max = 17).
- Asterisks (*) denote significant differences across sites.

Table 124. Illinois Foster Care Episode Characteristics by Intervention Site, Comparison Site, and Other Sites within State

Out-of-Home Care Sample	Intervention	Comparison	State	X2 (df)	p
Entry Cohort				136.048 (14)	< 0.001*
2014	112 (8.2)	356 (12.2)	4491 (11.1)		
2015	141 (10.3)	396 (13.6)	4386 (10.9)		
2016	93 (6.7)	339 (11.6)	4089 (10.1)		
2017	115 (8.4)	288 (9.9)	4579 (11.3)		
2018	177 (12.9)	427 (14.6)	5262 (13.0)		
2019	243 (17.7)	439 (15.0)	6387 (15.8)		
2020	308 (22.4)	403 (13.8)	6688 (16.6)		
2021	186 (13.5)	273 (9.3)	4471 (11.1)		
Most Recent Case Goal				448.821 (8)	< 0.001*
Reunify with Family	823 (59.9)	1590 (54.4)	19309 (47.9)		
Adoption	296 (21.5)	848 (29.0)	8444 (20.9)		
Guardianship	38 (2.8)	49 (1.7)	2423 (6.0)		
LTFC/Emancipation	155 (11.3)	285 (9.8)	8025 (19.9)		
Not Established/ Unknown	63 (4.6)	149 (5.1)	2152 (5.3)		
Placement Stability				18.522 (2)	< 0.001*
≤ 2 placements / year	728 (52.9)	1548 (53.0)	22762 (56.4)		
3+ placement / year	647 (47.1)	1373 (47.0)	17591 (43.6)		
Prior Episodes				4.635 (2)	0.099
None	1216 (88.4)	2545 (87.1)	35692 (88.5)		

Out-of-Home Care Sample	Intervention	Comparison	State	X2 (df)	p
1 or More	159 (11.6)	376 (12.9)	4661 (11.5)		
Reason for Discharge				267.679 (10)	< 0.001*
Reunify with Family	475 (34.6)	833 (28.5)	10371 (25.7)		
Adoption	164 (11.9)	597 (20.4)	5267 (13.1)		
Guardianship	10 (0.7)	21 (0.7)	1133 (2.8)		
Emancipation	23 (1.7)	40 (1.4)	923 (2.3)		
Transfer/Runaway/Death	7 (0.5)	8 (0.3)	156 (0.4)		
Not Applicable/Unknown	696 (50.6)	1422 (48.7)	22503 (55.8)		
	M(SD)	M(SD)	M(SD)	F (df 1, df 2)	p
Days in Foster Care	701.5 (612.5)	832.8 (615.9)	861.3 (641.7)	43.39 (2, 44664)	< 0.001*

Notes. ***N*** = 44,649 unique foster care episodes; ***n*** = 1,375 for intervention sites, ***n*** = 2,921 for comparison sites, and ***n*** = 40,353 for other state sites.

- ***Not Established/Unknown*** and ***Not Applicable/ Unknown*** indicates when information was not provided for an episode due to this action not yet being determined in the record or having missing information.
- The median days in foster care for intervention sites was 563 days (Min = 1, Max = 2793), for comparison sites was 735 days (Min = 0, Max = 2822), and for other state sites was 734 (Min = 0, Max = 2829).
- Asterisks (*) denote significant differences across sites.

2.A.2.1. Increase of Intact Family vs. Family Removal

The system has the choice of providing intact family services or child removals into out-of-home care when child maltreatment has been substantiated or indicated. We observed different trends over time in the proportion of children removed from their homes.

Pre-intervention between 2014 and 2018, we observed the intervention sites reported significantly lower child removal rates than the comparison sites. For the post-intervention time period (both prior to and after Covid-19), we observed no significant treatment effects when comparing intervention and comparison sites. In other words, we continue to observe intervention sites reporting significantly lower removal rates over time; however, the trends over time did not differ significantly between sites.

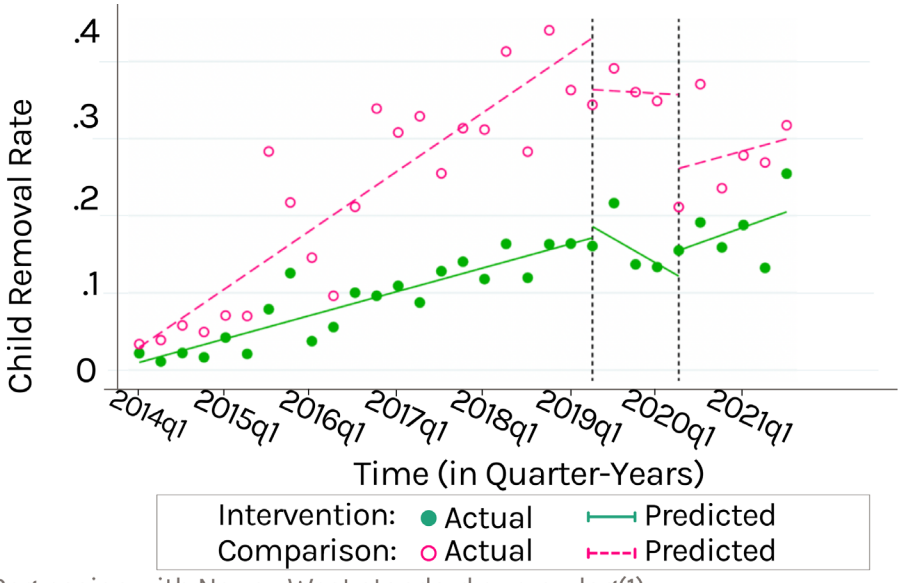
As a result, we cannot conclude that there were significant changes in foster care removal rates as a result of the Approach being implemented.

Table 125. Illinois Interrupted Time Series Analysis of Child Removal Rates per 100 Children by Project Sites comparing Trends during Pre-intervention, Post-intervention, and Post-Covid Time Periods

Variables	b (se)	*p*
Time	0.02 (0.00)	< 0.001*
Intervention	-0.01 (0.03)	0.753
Time * Intervention	-0.01 (0.00)	< 0.001*
Post-2019	-0.07 (0.02)	0.001*
Time * Post-2019	-0.02 (0.01)	0.005*
Intervention * Post-2019	0.08 (0.03)	0.004*
Time * Intv * Post-2019	0.00 (0.01)	0.786
Post-Covid	-0.10 (0.03)	0.005*
Time * Post-Covid	0.01 (0.01)	0.444
Intervention * Post-Covid	0.13 (0.04)	0.002*
Time * Intv * Post-Covid	0.02 (0.02)	0.315
Constant	0.01 (0.02)	0.670
F (11, 50)	129.55	< 0.001*

Notes. *N* = 62. Significant partial slopes are indicated by an asterisk (*).

Figure 49. Illinois Interrupted Time Series Analysis of Child Removal Rates per 100 Children by Project Sites comparing Trends during Pre-intervention, Post-intervention, and Post-Covid Time Periods



Notes. *N* = 62 quarter-years. Quarter years are formatted as year and quarter; for example, 2014q1 represents children with reports during quarter 1 of the year 2014. Actual quarterly rates are visualized as data points while estimated trends are visualized by lines.

- Training was implemented during March 2019 at the Intervention sites; the dotted line for 2019q2 is visualized within the

graph.

- Covid-19 Pandemic started in March 2020; the dotted line for 2020q2 is visualized within the graph.
- Lower child removal rates are a more desirable outcome. Intervention sites consistently reported lower child removal rates compared to comparison sites over time. We observed comparable changes in rates over time for both post-intervention and post-Covid time periods.

2.A.2.2. Increased Reunification Rate

For this sample, we followed all episodes involving Illinois youth entering foster care between January 1, 2014 and September 30, 2021. Reunification was defined as a child being reunited with a parent/original caregiver and/or living with family. If a child was not reunited with family upon discharge from foster care or remained in care at the end of the observation period, they were coded as "not reunified." All models assessed a site by time interaction and controlled for child characteristics and episode characteristics.

We then assessed the relative rate of a child being reunified with family between intervention, comparison, and other state sites. Holding all else equal, we observed likelihood of being reunified with family post-intervention was significantly lower for child survivors who entered foster care after January 1, 2019 and served by comparison sites relative their counterparts served by intervention (reference) sites ($HR_{Comparison}$ = 0.53, 95% CI (0.44, 0.64), $p < 0.001$). We observed similar trends when comparing other state sites to the intervention (reference) sites (HR_{State} = 0.47, 95% CI (0.41, 0.54), $p < 0.001$).

Table 126. Illinois Estimated Proportion of Foster Care Episodes that Resulted with Children being Reunified with Families by Time Period and by Intervention Site, Comparison Site, and Other Sites Within State

Time Period	Intervention % Reunified with Family by 1,000 Days	Comparison % Reunified with Family by 1,000 Days	State % Reunified with Family by 1,000 Days
2014-2018	48.1%	47.5%	46.4%
2019-2021	40.4%	23.8%	21.5%

Notes. *N* = 44,649.

Between 2019 to 2021 within the intervention sites, we observed 17.1% of foster care episodes within the first 12 months of care were associated with children being reunified with family. The proportion of episodes resulting in reunification with family rose another 16.3% for youth who stayed in care from 12 to 24 months and additional 6.8% for youth who stayed in care over 24 months. By 1,000 days, or the 2.7 years that we collected data post-intervention, the adjusted models estimated 40.4% of foster care episodes ended with youth being returned to the care of their family.

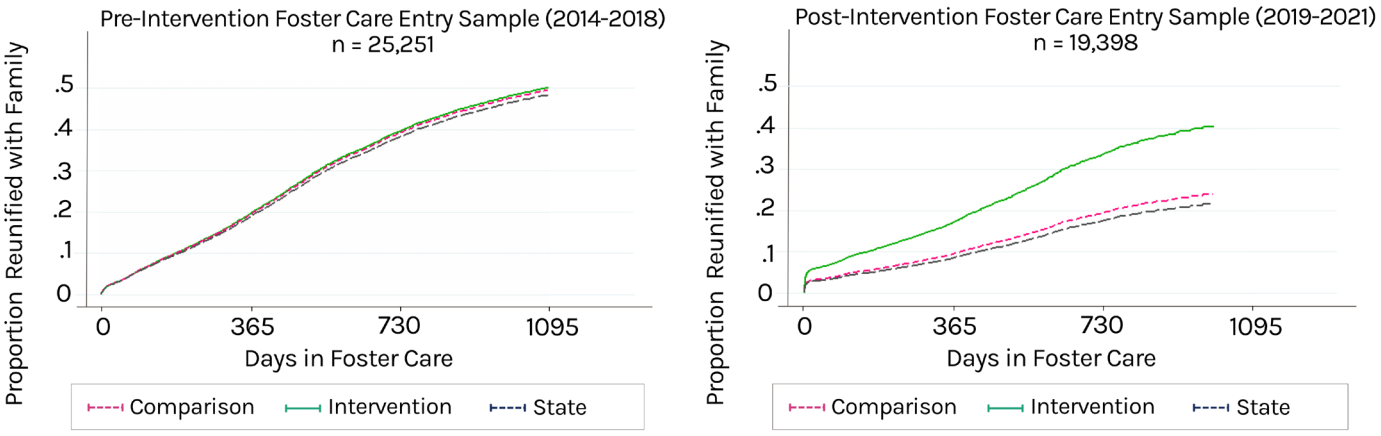
Between 2019 to 2021 within the comparison sites, we observed 9.4% of foster care episodes within the first 12 months of care were associated with children being reunified with family. The proportion of episodes resulting in reunification with family rose another 9.9% for youth who stayed in care from 12 to 24 months and additional 4.5% for youth who stayed in care over 24 months. By 1,000 days, or 2.7 years, the adjusted models estimated 23.8% of foster care episodes ended with youth being returned to the care of their family.

Using a difference-in-difference model, we observed IL intervention sites had an increase in the relative rate of children being reunified with families before and after the intervention was implemented. In other words, IL comparison sites

faced an additional 41% lower rate of experiencing reunification for youth entering foster care during the post-intervention time period compared to their counterparts at the intervention (reference) sites ($HR_{Comparison \times Post\text{-}Intervention}$ = 0.59, 95% CI (0.47, 0.75), $p < 0.001$). Similar results were observed when other state sites were compared to intervention (reference) sites ($HR_{State \times Post\text{-}Intervention}$ = 0.57, 95% CI (0.47, 0.69), $p < 0.001$).

This translates to a relative difference in favor of the intervention sites. By 1,000 days, the difference in proportion of children reunified between intervention and comparison sites increased from 0.6% during the pre-intervention time period to 16.6% during the post-intervention time period. Figure # provides a visualization of relative difference in reunification rates by site for pre-intervention and post-intervention time periods.

Figure 50. Illinois Reunification Rates Comparing FC Entry Cohorts 2014-2018 and 2019-2021 by Intervention Site, Comparison Site, and Other Sites within State



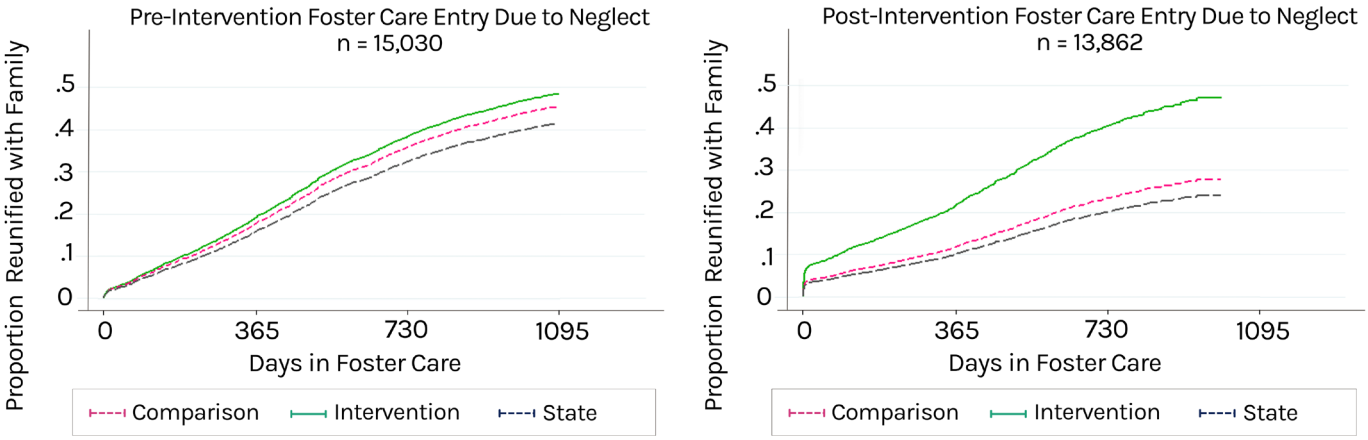
Notes. **N** = 44,649. This figure reports the estimated proportion of foster care episodes that result in reunification with family over days in foster care, holding all else equal.

- Every time a child is estimated to reunify with a family, the cumulative proportion of youth increases. A good outcome is associated with a higher proportion of foster care episodes resulting in reunification with family.
- Differences in relative rate for reunification across pre- and post-intervention foster care entry significantly differed. In other words, the differences in relative odds of a child being reunified with their family was even larger during the post-intervention period for intervention sites compared to comparison and other state sites.

While there were significant treatment effects as described above, it's important to note that we see a lower proportion of youth reunifying across all sites during the post-intervention time period that was affected by several historical events, including the onset of the Covid-19 pandemic.

When the sample was stratified by maltreatment type, we only observed a significant treatment effect for child survivors whose reason for entering foster care was identified as neglect only (*n* = 28,892). We observed an additional 44% lower rate of experiencing reunification among children served by the comparison sites relative to the intervention (reference) sites during the post-intervention time period ($HR_{Comparison \times Post\text{-}Intervention}$ = 0.56, 95% CI (0.42, 0.74), $p < 0.001$). We observed similar trends when comparing other state sites to the intervention sites ($HR_{State \times Post\text{-}Intervention}$ = 0.53, 95% CI (0.43, 0.67), $p < 0.001$).

Figure 51. Illinois Reunification Rates for Children entering Foster Care due to Neglect during Pre-Intervention (2014-2018) and Post-Intervention (2019-2021) Time Periods by Intervention Site, Comparison Site, and Other Sites within State



Notes. *N* = 28,892 episodes involving children entering foster care due to neglect. This figure reports the estimated proportion of foster care episodes that result in reunification with family over days in foster care, holding all else equal.

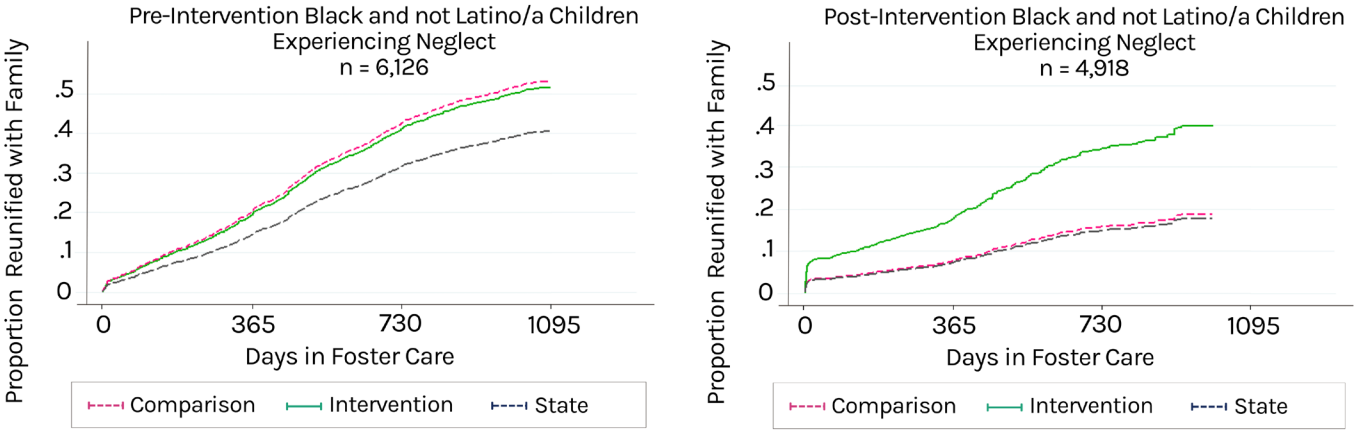
- Every time a child is estimated to reunify with a family, the cumulative proportion of youth increases. A good outcome is associated with a higher proportion of foster care episodes resulting in reunification with family.
- Differences in relative rate for reunification across pre- and post-intervention foster care entry significantly differed. In other words, the differences in relative rate of a child being reunified with their family was significantly higher for intervention sites compared to comparison and other state sites during the post-intervention period; however, there were not significant differences in reunification rates during the pre-intervention period.

In sum, treatment effects were primarily driven by improvements in reunification among families whose children entered foster care for neglect only compared to entering foster care for other reasons (such as physical or sexual abuse) or multiple complex reasons (e.g., neglect in addition to parental alcohol/substance misuse or physical abuse).

When this child neglect only sample was further stratified by race/ethnicity, we observed a significant treatment effect for child survivors across several racial/ethnic groups.

For children who entered foster care for neglect and were identified as Black and not Latino/a (n = 11,044), we see a dramatic treatment effect where reunification rates did not differ between intervention and comparison sites during pre-intervention foster care entry time periods; however, we see a significantly higher reunification rates among intervention sites (relative to comparison sites) during post-intervention foster care entry time periods. Specifically, we observed a substantive and significant decrease in reunification rates among children served by the comparison sites relative to the intervention (reference) sites during the post-intervention time period ($HR_{\text{Comparison x Post-Intervention}}$ = 0.37, 95% CI (0.24, 0.57), $p < 0.001$). We observed similar trends when comparing other state sites to the intervention sites ($HR_{\text{State x Post-Intervention}}$ = 0.52, 95% CI (0.36, 0.74), $p < 0.001$), holding all else equal.

Figure 52. Illinois Reunification Rates for Children experiencing Neglect and who were identified as Black and not Latino/a during Pre-Intervention (2014-2018) and Post-Intervention (2019-2021) Time Periods by Intervention Site, Comparison Site, and Other Sites within State

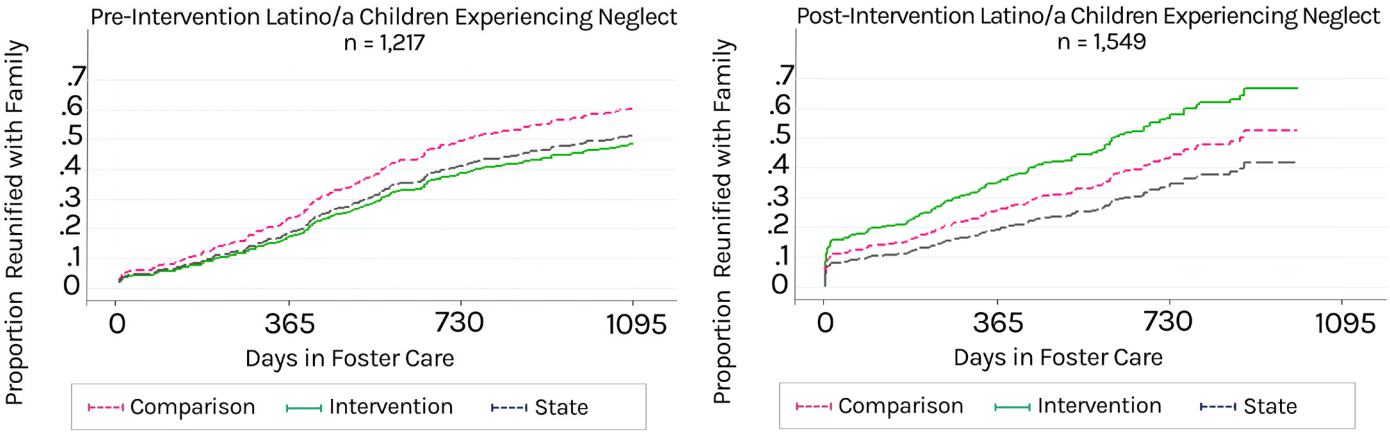


Notes. *N* = 11,044 episodes due to neglect involving children identified as Black and not Latino/a. This figure reports the estimated proportion of foster care episodes that result in reunification with family over days in foster care, holding all else equal.

- Every time a child is estimated to reunify with a family, the cumulative proportion of youth increases. A good outcome is associated with a higher proportion of foster care episodes resulting in reunification with family.
- Differences in relative rate for reunification across pre- and post-intervention foster care entry significantly differed. In other words, we observed similar outcomes for the intervention sites (compared to comparison sites) during the pre-intervention period, but we observed better outcomes for the intervention sites (compared to the comparison and other state sites) during the post-intervention period.

For children who entered foster care for neglect and were identified as Latino/a and any race (n = 2,766), we see a treatment effect where reunification rates did not differ between intervention and comparison sites during pre-intervention foster care entry time periods; however, we see a significantly higher odds of reunification among intervention sites (relative to comparison sites) during post-intervention foster care entry time periods. Specifically, we observed a substantive and significant decrease in reunification rates among children served by the comparison sites relative to the intervention (reference) sites during the post-intervention time period ($HR_{Comparison \times Post\text{-}Intervention}$ = 0.47, 95% CI (0.23, 0.95), p = 0.035). We observed similar trends when comparing other state sites to the intervention sites ($HR_{State \times Post\text{-}Intervention}$ = 0.44, 95% CI (0.27, 0.72), p = 0.001), controlling for child and episode characteristics.

Figure 53. Illinois Reunification Rates for Children experiencing Neglect and who were identified as Latino/a and Any Race during Pre-Intervention (2014-2018) and Post-Intervention (2019-2021) Time Periods by Intervention Site, Comparison Site, and Other Sites within State



Notes. *N* = 2,766 episodes due to neglect involving children identified as Latino/a and any race. This figure reports the estimated proportion of foster care episodes that result in reunification with family over days in foster care, holding all else equal.

- Every time a child is estimated to reunify with a family, the cumulative proportion of youth increases. A good outcome is associated with a higher proportion of foster care episodes resulting in reunification with family.
- Differences in relative rate for reunification across pre- and post-intervention foster care entry significantly differed. In other words, we observed slightly lower reunification rates for intervention sites compared to comparison sites during the pre-intervention period. In contrast, we observed better outcomes for the intervention sites (compared to the comparison and other state sites) during the post-intervention period.

For children who entered foster care for neglect and were identified as White and not Latino/a (n = 13,881), we did not observe a significant different in reunification rates faced by children served by the comparison sites relative to the intervention (reference) sites during the post-intervention time period ($HR_{Comparison \times Post\text{-}Intervention}$ = 0.81, 95% CI (0.50, 1.30), p = 0.379). However, we did observe the intervention site had better reunification outcomes at any given point in time compared to other state sites during the post-intervention period when accounting for pre-intervention differences ($HR_{State \times Post\text{-}Intervention}$ = 0.58, 95% CI (0.39, 0.86), p = 0.007), holding all else equal.

For children who entered foster care for neglect and identified as other race/multiracial and not Latino/a (n = 1,201), we did not observe a significant treatment effect for the comparison sites relative to the intervention sites ($HR_{Comparison \times Post\text{-}Intervention}$ = 1.34, 95% CI (0.51, 3.49), p = 0.554) or other state sites relative to the intervention sites ($HR_{State \times Post\text{-}Intervention}$ = 0.93, 95% CI (0.42, 2.07), p = 0.863), controlling for child and episode characteristics.

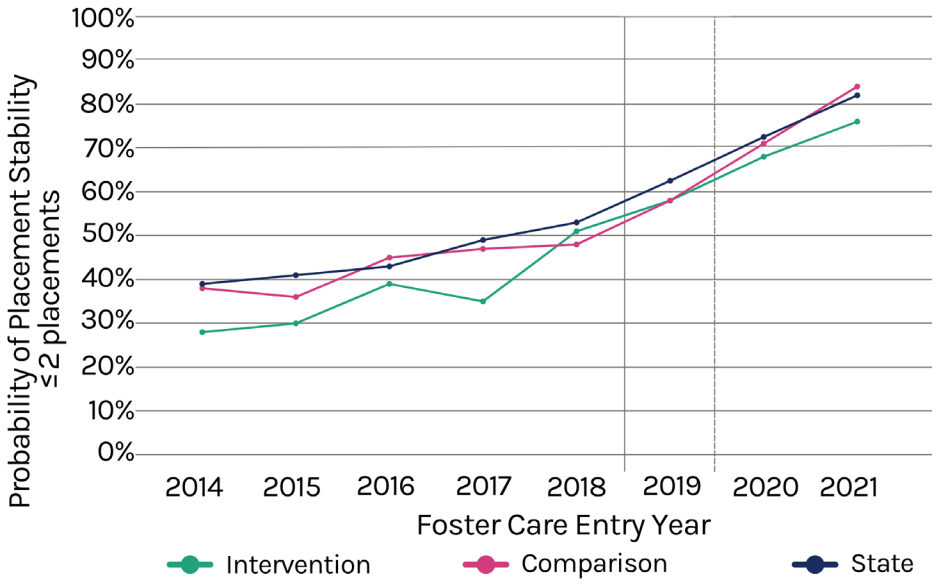
In sum, significant treatment effects were observed primarily for reunification rates among children who entered foster care for neglect only and were identified as either as Black and not Latino/a or as Latino/a and any race. This aligns with the Approach's focus on co-occurring domestic violence and child maltreatment, which we observed through the case record review was primarily substantiated as neglect when domestic violence was the primary concern. In addition, the Approach's focus on racial and gender equity aligns with these targeted improvements in reunification rates.

2.A.2.3. Increased Stability

We used the Illinois foster care sample of *N* = 44,649 to answer this research question.

In the models that assessed for differences between sites by foster care entry cohort and controlled for child and episode characteristics, we observed consistently higher likelihood of placement stability when comparing the comparison and intervention (reference) sites ($OR_{comparison}$ = 1.60, 95% CI (1.00, 2.57), p = 0.049) and when comparing other state sites to intervention (reference) sites (OR_{state} = 1.65, 95% CI (1.08, 2.51), p = 0.021). When placement stability was compared across sites by foster care entry year, we did not observe any significant differences between sites from 2018 to 2021. Figure 54 compares site-level differences in the probability of youth experiencing 2 or less placements for youth entering foster care between 2014 to 2021.

Figure 54. Illinois Probability of Experiencing Placement Stability by Entry Cohort by Intervention Site, Comparison Site, and Other Sites within State



Notes. *N* = 44,649 unique foster care episodes; *n* = 1,375 for intervention sites, *n* = 2,921 for comparison sites, and *n* = 40,353 for other state sites. The intervention start date was January 1, 2019 indicated by the vertical solid line. The onset of Covid-19 is indicated by the vertical dash line. Visual inspection of Figure 54 reveals that the highest line on the graph represents the other state sites (dark blue line), suggesting higher placement stability among other state sites, followed by the comparison site (pink line), with the lowest placement stability (green line) observed for the intervention site.

We ran additional models stratified by duration of the foster care episode to assess for differences in stability rates by children's length of time in care. Table 127 show the results of these multivariate models.

Table 127. Illinois Likelihood of Experiencing Placement Stability by Duration in Foster Care

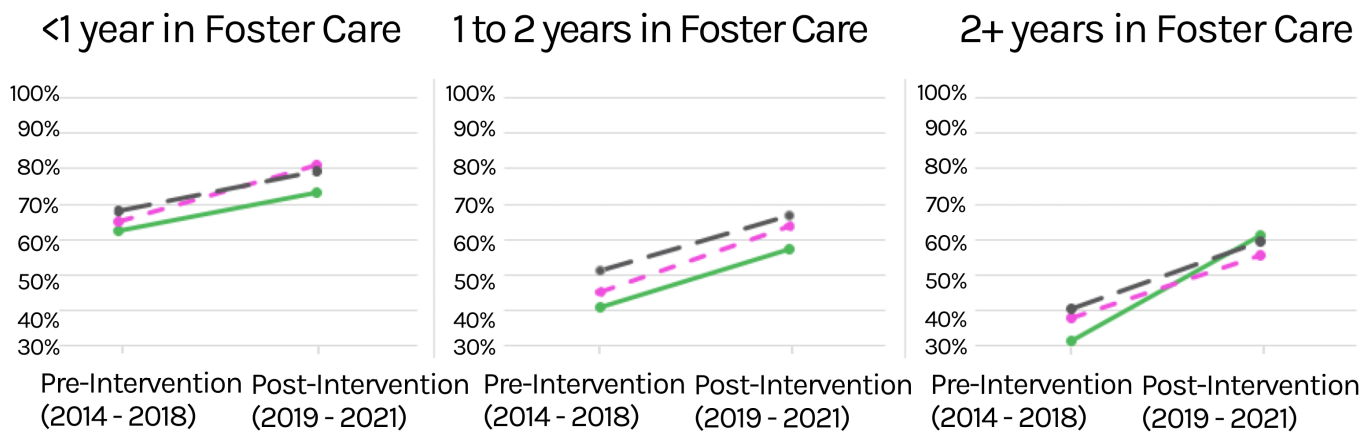
Characteristics	Episode < 1 year OR (95% CI)	Episode 1 to 2 years OR (95% CI)	Episode 2+ years OR (95% CI)
Site			
Intervention	ref	ref	ref
Comparison	1.12 (0.69, 1.80)	1.18 (0.76, 1.85)	1.37 (1.07, 1.75)*
State	1.29 (0.86, 1.94)	1.53 (1.03, 2.27)*	1.54 (1.24, 1.91)***
Time			
2014-2018	ref	ref	ref
2019-2021	1.69 (1.06, 2.70)*	1.98 (1.24, 3.15)**	3.73 (2.35, 5.93)***
Site * Time			
Comparison*2019-2021	1.40 (0.78, 2.50)	1.12 (0.64, 1.95)	0.58 (0.34, 0.99)*
State*2019-2021	1.09 (0.68, 1.76)	1.00 (0.62, 1.60)	0.60 (0.38, 0.96)*
Child age (in yrs)	0.95 (0.94, 0.96)***	0.94 (0.93, 0.95)***	0.91 (0.91, 0.92)***
Child gender			
Female	ref	ref	ref
Male	1.02 (0.93, 1.12)	0.97 (0.90, 1.05)	0.93 (0.88, 0.98)**
Child race/ethnicity			
Black and not Latino/a	ref	ref	ref
Latino/a and any race	1.07 (0.92, 1.25)	1.46 (1.27, 1.67)***	1.20 (1.08, 1.33)***
White and not Latino/a	1.24 (1.12, 1.37)***	1.44 (1.32, 1.57)***	1.43 (1.34, 1.51)***
Other race/multiracial and not Latino/a	1.30 (1.02, 1.65)*	1.27 (1.05, 1.55)*	1.14 (0.99, 1.32)
Child any disability			
Yes	ref	ref	ref
No / not yet determined	1.18 (1.03, 1.35)*	0.98 (0.87, 1.11)	0.87 (0.80, 0.95)**
Prior Episode			
None	ref	ref	ref
At least 1 prior episode	1.00 (0.87, 1.15)	0.93 (0.82, 1.06)	1.10 (1.00, 1.20)*
Case Goal			
Reunify with Family	ref	ref	ref
Adoption	2.93 (2.33, 3.68)***	1.24 (1.08, 1.42)**	0.97 (0.91, 1.04)
Guardianship	0.93 (0.65, 1.32)	1.97 (1.49, 2.60)***	1.51 (1.37, 1.67)***
LTFC/Emancipation	1.11 (0.99, 1.25)	1.05 (0.93, 1.18)	0.96 (0.88, 1.05)
Unknown	2.08 (1.80, 2.40)***	1.16 (0.90, 1.50)	2.77 (2.21, 3.46)***
Model Fit			
LR Chi2 (df)	535.71 (16)***	676.26 (16)***	1961.98 (16)***
Pseudo R2	0.0439	0.0447	0.0644

Notes: * > .05, ** > .01, ** > .001. Less than one year in foster care *n* = 11,109; 1 to 2 years in foster care *n* = 11,304; and 2+ years in

foster care *n* = 22,236. For any diagnosed disability, children with "no" or "not yet determined" were collapsed into one category because of the low proportion of children coded as "not yet determined" within this State.

To better understand the treatment effects reported in the prior table (site * time interaction), Figure 55 and Table 128 provide a summary of the probability of a child experiencing placement stability across sites by a child's duration in foster care and when a child entered foster care (i.e., pre-intervention time period between 2014-2018 or post-intervention time period between 2019-2021).

Figure 55. Illinois Estimated Probability of a Child Experiencing Placement Stability by Duration in Foster Care and Entry Cohort



Notes. *N* = 44,649. Less than one year in foster care *n* = 11,109; 1 to 2 years in foster care *n* = 11,304; and 2+ years in foster care *n* = 22,236.

Table 128. Illinois Estimated Probability of a Child Experiencing Placement Stability by Duration in Foster Care and Entry Cohort

Episode Length by & Foster Care Entry Year	Intervention % (95% CI) of Placement Stability	Comparison % (95% CI) of Placement Stability	State % (95% CI) of Placement Stability
Less than 1 year in foster care:			
2014-2018	62.5 (53.5, 71.4)	64.9 (59.1, 70.7)	68.0 (66.1, 69.9)
2019-2021	73.4 (68.9, 78.0)	81.0 (77.5, 84.4)	79.5 (78.5, 80.4)
1 to 2 years:			
2014-2018	41.1 (32.0, 50.3)	45.1 (39.9, 50.3)	51.3 (49.6, 53.0)
2019-2021	57.4 (51.5, 63.3)	63.8 (59.0, 68.6)	67.0 (65.9, 68.2)
2+ years in foster care:			
2014-2018	31.3 (27.0, 35.6)	38.0 (35.3, 40.6)	40.6 (39.9, 41.4)
2019-2021	61.0 (51.8, 70.1)	55.8 (50.0, 61.5)	59.3 (57.7, 60.9)

Notes. *N* = 44,649. Less than one year in foster care *n* = 11,109; 1 to 2 years in foster care *n* = 11,304; and 2+ years in foster care *n* = 22,236.

For children whose foster care episode has a duration of less than a year:

- We observed no pre-intervention differences between intervention sites and both comparison sites (z = 0.45, Bonferroni p = 1.000) and other state sites (z = 1.23, Bonferroni p = 1.000).
- We did not observe significant post-intervention differences between intervention sites and both comparison sites (z = 2.66, Bonferroni p = 0.119) and other state sites (z = 2.75, Bonferroni p = 0.090).
- There was no significant treatment by time interaction, holding all else equal. In other words, we observed consistent increases in stability across all sites when comparing pre-intervention (2014-2018) and post-intervention (2019-2021) foster care entry time periods, supporting observations from the multivariate model that there are no treatment effects.

For children whose foster care episode has a duration of 1 to 2 years:

- We observed no pre-intervention differences between intervention sites and both comparison sites (z = 0.73, Bonferroni p = 1.000) and other state sites (z = 2.11, Bonferroni p = 0.521).
- We do not observe significant post-intervention differences between intervention sites and comparison sites (z = 1.65, Bonferroni p = 1.000); however, we did observe other state sites had a significantly higher likelihood of placement stability compared to intervention sites (z = 3.27, Bonferroni p = 0.016) during the post-intervention time period.
- We observed a consistent increase across all sites when comparing pre- and post-intervention foster care entry time periods with no significant treatment effect (Bonferroni p < 0.001), indicating no significant treatment effect for placement stability.

For children whose foster care episode has a duration of 2+ years:

- We observed no pre-intervention differences between intervention sites and both comparison sites (z = 2.52, Bonferroni p = 0.174); however, we observed a significant pre-intervention difference between intervention sites and other state sites (z = 3.96, Bonferroni p = 0.001).
- We do not observe significant post-intervention differences between intervention sites and both comparison sites (z = -0.94, Bonferroni p = 1.000) and other state sites (z = -0.36, Bonferroni p = 1.000).
- That being said, we observed a significant treatment effect for these youth when comparing changes in placement stability over time. Placement stability for the intervention site was lower relative to the comparison and other state sites during the pre-intervention period (2014-2018) and higher during the post-intervention period (2019-2021).

In sum, we observe significant increases in stability for Illinois youth served by intervention sites and who were in foster care for 2 or more years. Specifically, we observed a significantly larger increase in placement stability within the intervention sites (relative to other sites) when comparing pre- and post-intervention foster care entry cohorts within the Illinois Project sites.

SECTION 9. ALLEGHENY COUNTY, PA PROJECT REPORT

Implementation Study

The implementation study was oriented around an overarching research question that asked:

What factors are associated with successful implementation and sustainability of an adult and child survivor-centered approach?

This component of the evaluation was informed by implementation science and the frameworks discussed above. The concept of "successful implementation" was operationalized to include Implementation Outcomes of adoption, acceptability, feasibility, fidelity, penetration, and sustainability. (Cost is also included in the Proctor framework from which we draw implementation outcomes; however, costs are covered in the Cost Study section of this report). Table 30 outlines the implementation study research questions and crosswalks them with the Implementation Outcome and data source. Results are provided in order of research questions shown in this table.

Table 129. Crosswalk of Implementation Study's Research Questions, Implementation Outcomes, and Data Source

Implementation Study Research Question	Implementation Outcome	Data Source
To what extent did the Approach spread to sites?	Penetration (spread)	Training participation roster Coaching participation roster Fidelity checklists
How did implementation drivers change?	Adoption Sustainability	Drivers Assessment
How did fidelity to the Approach change?	Fidelity	Fidelity Checklists
How long did it take to implement and how complete was implementation?	Adoption Sustainability	Universal Stages of Completion
What contributed and inhibited successful implementation?	Acceptability Feasibility Sustainability	Key Informant Interviews Coaching Focus Groups

RESEARCH QUESTION: TO WHAT EXTENT DID THE APPROACH SPREAD TO SITES?

This research question relates to the implementation outcome of **penetration** (see page 10), which may also be referred to as intervention reach or spread. Ideally, measurement of spread would estimate the percentage of providers who used the Approach in their practice with children, adult survivors, and persons who use violence. Given our limits in observing the Approach in practice, we used several proxies to operationalize spread of the Approach. We considered three metrics to describe each sites' participation in training, coaching, and fidelity as follows:

- Percent of eligible caseworkers, supervisors, and community partners who participated in **training**
- Percent of eligible supervisors who participated in **coaching**
- Percent of eligible caseworkers for whom a **fidelity checklist** was completed

Table 130 provides percentages for each of the spread indicators. It shows the following:

- **Training**: *In the Allegheny County intervention sites, 85% of eligible participants participated in training.*

- **Coaching**: *In the Allegheny County intervention sites, a slightly lower percentage of eligible participants participated in coaching – 75%.*
- **Fidelity Checklists**: *In the Allegheny County intervention sites, Fidelity Checklist completion spread the least at 20% of eligible participants.*

Taken together, these indicators of spread would suggest that the Approach penetrated the practice of those in direct service work with families at mainly moderate levels.

Table 130. Allegheny County, PA Spread: Percent of Eligible People Who Participated in Training, Coaching, and Fidelity Checklist by Site

Key Implementation Activity	Allegheny County
Training	
Number of eligible participants	460
No training	11%
Partial (1 day or some of online)	4%
Full (2 days or all online)	85%
Coaching	
Number of eligible participants	33
Possible coaching sessions attended*	75%
Fidelity Assessment	
Number of eligible participants	104
At least 1 Fidelity Checklist Completed**	20%

Notes. N is the number of people eligible for the implementation activity. Percent is the percent of those eligible who participated in the implementation activity. * This sample includes attendees who were a part of the self-survey target sample, identified and tracked through monthly rosters sent from sites. The denominator adjusted for excused absences, defined by leave of absence, emergency conflict, or illness. This demonstrates individual engagement level for the sessions when they were able to attend.

** Only includes participants who consented to participate in Fidelity Checklist data collection.

RESEARCH QUESTION: HOW DID IMPLEMENTATION DRIVERS CHANGE?

This research question was concerned with the extent to which implementation drivers were in place across sites and within each site, aiming to describe the Implementation Outcomes of **adoption** and **sustainability**. Implementation drivers were assessed to demonstrate that the infrastructure needed to support the Approach was put in place. This infrastructure was conceptualized as comprising three main domains as measured by a Drivers Assessment survey:

- Leadership drivers (3 items)
- Competency drivers (6 items)
- Organization drivers (6 items)

As described in the Method section, participants rated items on a scale from 0 to 2 where 0 = not in place; 1 = partially in place; and 2 = in place. For our analysis, an average score of 1.5 was considered high and represented “nearly in place” or “in place.”

Table 131 presents the item level average scores for Allegheny County Project in a table format, providing average scores, standard deviations, and statistical test results.

Table 131. Allegheny County, PA Drivers Assessment Domain Average Scores

Driver Domain & Time Period	Average (SD) Drivers Assessment Scores
	Allegheny County (N = 43)
Leadership Driver	
Time 1	--
Time 2	1.7 (0.7, 2.0)
Time 3	1.3 (0.7, 2.0)
Test Statistic (p-value)	167.500 (0.572)
Competency Driver	
Time 1	--
Time 2	1.5 (0.2, 2.0)
Time 3	1.3 (0.7, 2.0)
Test Statistic (p-value)	167.000 (0.472)
Organization Driver	
Time 1	--
Time 2	1.3 (0.2, 2.0)
Time 3	1.0 (0.5, 2.0)
Test Statistic (p-value)	162.500 (0.484)

Notes. N = 43 completed surveys.

Scores could range from 0 to 2 with 0 = not in place; 1 = partially in place; 2 = in place.

Median and (Minimum Value, Maximum Value) are reported for each time point.

Nonparametric analyses were used to test differences between groups for small samples. Mann-Whitney-U tests were used for Allegheny County.

RESEARCH QUESTION: HOW DID FIDELITY TO THE APPROACH CHANGE?

This research question focused on fidelity to the Approach and how fidelity varied across sites and changed over time. Fidelity Checklists were completed by Supervisors (including CW and community partners who were trained and coached) associated with the Intervention sites. Fidelity was rated using a 9-point Likert scale where ratings of 1 to 3 indicated "needs work," ratings of 4 to 6 indicated "acceptable work," and ratings of 7 to 9 indicated "good work." Supervisors rated their supervisees' practice behaviors along five dimensions, including (1) Approach knowledge, (2) work with adult and child survivors, (3) work with person using violence and coercion, (4) principles practice, and (5) overall fidelity.

Fidelity Completion and Consent Status

Table 132 presents data on the number of Fidelity Checklists that were completed, showing them by consent status and completion status. Among caseworkers in Allegheny County intervention sites that could have had Fidelity Checklist completed, 21 (20%) had at least 1 Fidelity Checklist completed and consented to participate in the study.

Table 132. Allegheny County, PA Fidelity Checklist Completion and Consent Status by Site

Consent and Completion Status of Fidelity Checklist	Caseworkers: N (%)
	Allegheny County
Consent Received	
At Least 1 Checklist Complete	21 (20%)
No Checklist Received	28 (27%)
No Consent Received	
At Least 1 Checklist Complete	25 (24%)
No Checklist Received	30 (29%)
Total	**104 (100%)**

Table 133 presents information on the average number of Fidelity Checklists per caseworker, grouping this information by consent status in Allegheny County. The average number of completed Checklists for caseworkers who consented to be in the study was about 5 per supervisee. Allegheny County's average for consented caseworkers was 4.43 (SD = 3.88).

Table 133. Allegheny County, PA Fidelity Checklist Average Number Completed per Caseworker Consent Status

Consent Status	Caseworkers: Average (SD) Fidelity Checklists Completed
	Allegheny County (N = 46)
Consent Received	4.43 (3.88)
No Consent Received	2.68 (3.42)

Notes. SD = Standard deviation.

Fidelity Average Scores

Table 134 displays Fidelity Checklist data for Allegheny County, using data from participants who consented to the study and showing the average scores in each domain and each year (2019 to 2021) for which the site had fidelity data available.

Table 134. Allegheny County, PA Fidelity Checklist Average Scores by Domain and Year

Checklist Domain & Time Period	Caseworkers: Average (SD) Fidelity Score
	Allegheny County (N = 21)
Approach Knowledge	
2019	--
2020	6.33 (1.72)
2021	6.75 (1.22)
Work with Adult and Child Survivors	
2019	--
2020	6.80 (1.61)
2021	6.92 (1.38)
Work with Person Using Violence & Coercion	
2019	--
2020	6.08 (1.24)
2021	6.56 (0.73)
Principles Practices	
2019	--
2020	6.40 (1.50)
2021	7.08 (1.17)
Overall	
2019	--
2020	6.80 (1.37)
2021	6.83 (1.27)

Notes. N = 21 that being the 21 case workers who consented to the study.

Counts were redacted for 2019 because 5 or less caseworkers had fidelity checklists completed; their scores would likely be unreliable and represent consenting workers and their supervisors, who were early adopters of the intervention.

Fidelity scores can range from 1 to 9 where 1-3 is *needs work*; 4-6 is *acceptable work*; and 7-9 is *good work*. SD = standard deviation.

OUTCOME STUDY

CHILD OUTCOMES

2.A.1 Child Safety

See Section 5. for full description of data source, sample, and analysis.

2.A.1.1 Decrease maltreatment by person using violence and/or adult survivor

For the Allegheny County, PA Project, within the sample of index children with identified maltreatment between January 2, 2019 and June 30, 2020, we identified a total of 9,874 children across sites. There were 989 children served by intervention sites, 1,171 served by comparison sites, and 7,714 served by other state sites. See Table 135 for full description of characteristics of index children with identified maltreatment between 2019-2020 by intervention, comparison, and other state sites.

Table 135. Allegheny County, PA Baseline Characteristics of Index Children with Identified Maltreatment between 2019-2020 by Intervention Site, Comparison Site, and Other Sites within State

Characteristic	Intervention n (%)	Comparison n (%)	State n (%)	X2 (df)	*p*
Child gender				68.860 (2)	< 0.001*
Female	488 (49.3)	580 (49.5)	4585 (59.4)		
Male	501 (50.7)	591 (50.5)	3129 (40.6)		
Child race				920.626 (6)	< 0.001*
Black/Afr Amer	591 (59.8)	515 (44.0)	1760 (22.8)		
White	269 (27.2)	483 (41.3)	5194 (67.3)		
Multiracial	123 (12.4)	168 (14.4)	591 (7.7)		
Other	6 (0.6)	5 (0.4)	169 (2.2)		
Maltreatment type				3000.000 (10)	< 0.001*
Physical abuse	102 (10.3)	114 (9.7)	2940 (38.1)		
Neglect	629 (63.6)	731 (62.4)	1010 (13.1)		
Sex abuse/trafficking	61 (6.2)	60 (5.1)	3007 (39.0)		
Other type	163 (16.5)	232 (19.8)	674 (8.7)		
Unknown	34 (3.4)	34 (2.9)	83 (1.1)		
	M(SD)	M(SD)	M(SD)	F (df1, df2)	*p*
Child age (years)	7.1 (5.6)	7.1 (5.3)	8.9 (5.5)	89.06 (2, 9871)	< 0.001*
Number identified maltreatment events	1.4 (0.8)	1.4 (0.8)	1.1 (0.3)	427.22 (2, 9871)	< 0.001*

Notes. *N* = 9,874 unique children with complete cases; *n* = 989 for intervention sites, *n* = 1,171 for comparison sites, and *n* = 7,714 for other state sites.

- Child gender was limited to binary constructs of male/female within the administrative data systems.
- Child ethnicity was not available across all sites, so only child race can be reported across Projects.

The median child age for intervention sites was 7 (Min = 0, Max = 17), for comparison sites was 7 (Min = 0, Max = 17), and for other state sites was 10 (Min = 0, Max = 17). No significant differences were observed in the comparison between intervention and comparison sites ($p = 0.844$).

- The median number of identified maltreatment events for intervention sites was 1 (Min = 1, Max = 8), for comparison sites was 1 (Min = 1, Max = 7), and for other state sites was 1 (Min = 1, Max = 7). No significant differences were observed in the comparison between intervention and comparison sites ($p = 0.139$).
- Asterisks (*) denote significant differences between sites observed.

Table 136. Allegheny County, PA Recurrence of Maltreatment between 2019-2020 by Intervention Site, Comparison Site, and Other Sites within State

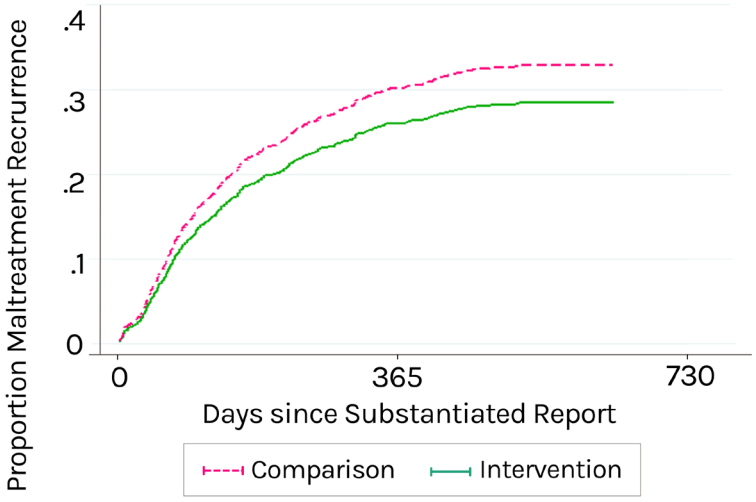
Cross-site Child Maltreatment	Intervention M(SD) or n (%)	Comparison M(SD) or n (%)	State M(SD) or n (%)	X2 / F (df)	p
Maltreatment recurrence				855.409 (2)	< 0.001*
No	762 (77.1)	842 (71.9)	7327 (95.0)		
Yes	227 (22.9)	329 (28.1)	387 (5.0)		
Days to recurrence	333.3 (184.5)	329.7 (188.5)	341.5 (177.1)	2.78 (2, 9871)	0.0622

Notes. *N* = 9,874 unique children with complete cases; *n* = 989 for intervention sites, *n* = 1,171 for comparison sites, and *n* = 7,714 for other state sites. The median number of days to recurrence for intervention sites was 333 days (Min = 1, Max = 638), for the comparison sites was 331 days (Min = 1, Max = 637), and for other state sites was 343 days (Min = 1, Max = 638). Asterisk (*) denotes significant differences between sites observed.

Given difference in data sources between Allegheny County and other Pennsylvania state sites, we only report comparisons between intervention and comparison offices to offset any differences in how the administrative data was validated and prepared by varying sources.

We observed **significant differences where the children served by intervention sites re-experienced maltreatment at a lower rate than those served by comparison sites at any point in time.** Controlling for child age, gender, and initial maltreatment type, children served by comparison sites re-experienced maltreatment at a rate that was 19% higher than children served by intervention sites (HR = 1.19, 95% CI (1.00, 1.41), p = 0.047).

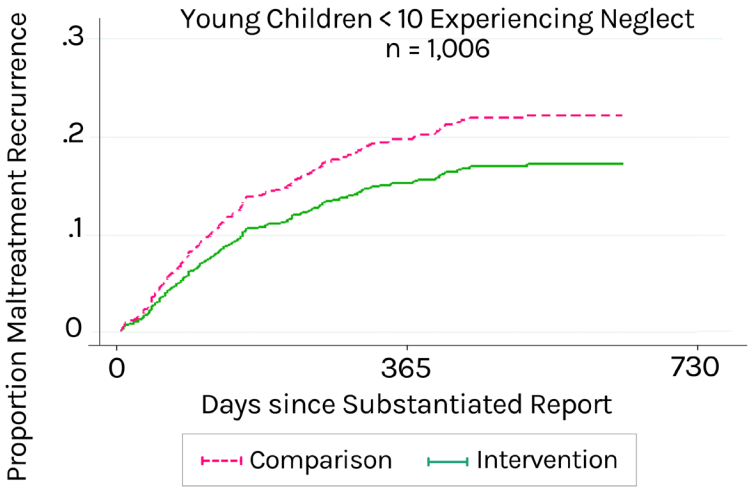
Figure 56. Allegheny County, PA Maltreatment Recurrence Rate by Intervention and Comparison Sites between 2019 and 2020



Notes. *N* = 2,160. This figure represents the estimated maltreatment recurrence rate by site; a lower proportion, or lower rate of experiencing maltreatment recurrence, is identified as a desirable outcome.

When the data was stratified by child and case characteristics, we only observed significant differences between intervention and comparison sites rate in maltreatment recurrence for children under 10 years of age who had an initial allegation of neglect. Specifically, young children experiencing neglect and served by the comparison site faced a maltreatment recurrence rate that was 36% higher than their counterparts served by the intervention site, holding all else equal (HR = 1.33, 95% CI (1.00, 1.76), p = 0.043). Refer to Figure 57 for results of the cumulative proportion.

Figure 57. Allegheny County, PA Maltreatment Recurrence Rate for Young Children Experiencing Neglect and by Intervention and Comparison Groups



Notes. *N* = 2,160. This figure represents the estimated maltreatment recurrence rate by site; a lower proportion, or lower rate of experiencing maltreatment recurrence, is identified as a desirable outcome.

2.A.1.2. Decrease exposure to DV

For research question 2.A.1.2, we used a complete case analysis that focused only on index children with identified maltreatment who also had co-occurring domestic violence documented within their case file. Allegheny County, PA provided information on all domestic violence risk assessments with their corresponding dates, allowing us to identify a total of 318 (14.7%) index children who were exposed to domestic violence out of 2,160 index child survivors identified across intervention and comparison sites between January 1, 2019 and June 30, 2020. See Table 137.

Table 137. Allegheny County, PA Baseline Characteristics of Index Children with Identified Co-occurring Maltreatment & Domestic Violence between 2019-2021 by Intervention and Comparison Groups

Characteristic	Intervention *n* (%)	Comparison *n* (%)	*X2* (df)	*p*
Child gender			0.619 (1)	0.431
Female	78 (52.3)	81 (47.9)		
Male	71 (47.7)	88 (52.1)		
Child race			1.078 (2)	0.029*
Black/African Amer	76 (51.0)	65 (38.5)		
White	49 (32.9)	80 (47.3)		
Multiracial/Other	24 (16.1)	24 (14.2)		
Maltreatment type			2.407 (3)	0.492
Physical abuse	19 (12.7)	16 (9.5)		
Neglect	86 (57.7)	108 (63.9)		
Other type	36 (24.2)	40 (23.7)		
Unknown	8 (5.4)	5 (2.9)		
	M(SD)	**M(SD)**	***t* (df)**	***p***
Child age (years)	7.5 (5.0)	6.6 (4.6)	-1.742 (316)	0.083
Number identified maltreatment events	1.5 (1.1)	1.5 (0.9)	-0.090 (316)	0.929

Notes. ***N*** = 318 unique children with complete cases; ***n*** = 149 for intervention sites and ***n*** = 169 for comparison sites.

- Child gender was limited to binary constructs of male/female within the administrative data systems.
- Child ethnicity was not available, so only child race can be reported across Projects.
- The median child age for intervention sites was 7 (Min = 0, Max = 17) and for comparison sites was 6 (Min = 0, Max = 17).
- The median number of identified maltreatment events for intervention sites was 1 (Min = 1, Max = 6) and for comparison sites was 1 (Min = 1, Max = 6).
- Asterisk (*) denotes significant differences between intervention and comparison sites observed.

Table 138. Allegheny County, PA Recurrence of Maltreatment between 2019-2021 for Co-occurring Sample by Intervention and Comparison Groups

Cross-site Child Maltreatment	Intervention M(SD) or *n* (%)	Comparison M(SD) or *n* (%)	*X2* (df)	*p*
Maltreatment recurrence			2.145	0.143
No	110 (72.8)	112 (66.3)		
Yes	39 (26.2)	57 (33.7)		
Days to recurrence	324.8 (187.9)	293.8 (195.4)	-1.438	0.152

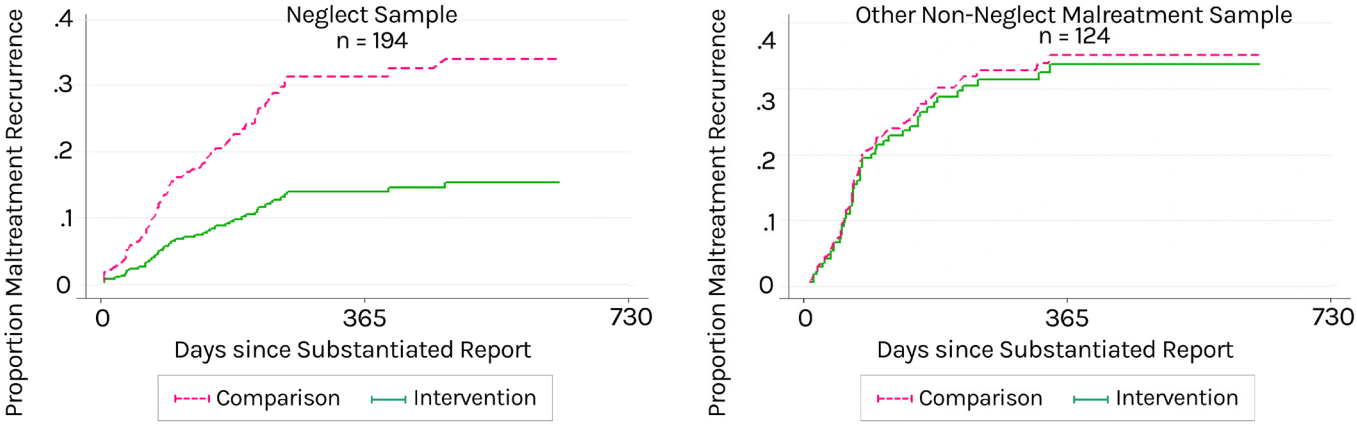
Notes. ***N*** = 318 unique children with complete cases; ***n*** = 149 for intervention sites and ***n*** = 169 for comparison sites. Median number of days to recurrence for intervention sites was 330 days (Min = 2, Max = 632) and for the comparison sites was 260 days (Min = 6, Max = 636).

We observed no significant differences in maltreatment recurrence for children with co-occurring maltreatment and domestic violence by intervention or comparisons sites ($HR_{comparison}$ = 1.48, 95% CI (0.97, 2.26), p = 0.066), controlling for child age, child gender, child race, and maltreatment type. We observed similar results when results were stratified by child age, gender, and race.

observed a significant difference between sites for children experiencing co-occurring domestic violence and neglect (HR $HR_{comparison}$ = 2.49, 95% CI (1.28, 4.84), p = 0.007), holding all else equal. In other words, children served by comparison sites who were exposed to domestic violence and identified as experiencing neglect re-experienced maltreatment at a rate 149% higher than their counterparts served by intervention sites.

When stratified by maltreatment type, we

Figure 58. Allegheny County, PA Maltreatment Recurrence Rate by Initial Maltreatment Type for Children Exposed to Domestic Violence and Identified by the Child Welfare System Between January 1, 2019 and September 30, 2021



Notes. *N* = 318. This figure represents the estimated maltreatment recurrence rate by site; a lower proportion, or lower rate of experiencing maltreatment recurrence, is identified as a desirable outcome.

2.A.2. Were there significant differences between the intervention and comparison sample in child permanency?

Table 139 provides details on the Allegheny County Project specific child demographics associated with unique foster care episodes used in the analysis. Table 140 provides details of Allegheny County, PA Project specific foster care episode characteristics used in the analysis.

Table 139. Pennsylvania Child Demographics associated with Unique Foster Care Episodes

Out-of-Home Care Sample	Intervention	Comparison	State	X2 (df)	p
Child gender				6.406 (2)	0.041*
Female	1180 (50.3)	932 (49.3)	33727 (47.9)		
Male	1166 (49.7)	958 (50.7)	36651 (52.1)		
Child race/ethnicity				1300 (6)	< 0.001*
Black and not Latino/a	1414 (60.3)	840 (44.4)	22755 (32.3)		
Latino/a, any race	28 (1.2)	33 (1.7)	10255 (14.6)		
Latino/a and Black	12 (0.5)	11 (0.6)	1724 (2.5)		
Latino/a and White	11 (0.5)	10 (0.5)	7449 (10.6)		
Latino/a and other race/ multiracial	5 (0.2)	12 (0.6)	1082 (1.5)		
White and not Latino/a	689 (29.4)	778 (41.2)	32477 (46.1)		
Other race/multiracial and not Latino/a	215 (9.2)	239 (12.7)	4891 (6.9)		
Other race and not Latino/a	3 (0.1)	0 (0.0)	381 (0.5)		
Multiracial and not Latino/a	212 (9.0)	239 (12.7)	4510 (6.4)		
Any diagnosed disability?				3700 (4)	< 0.001*
Yes	683 (29.1)	541 (28.6)	13904 (19.8)		
No	490 (20.9)	456 (24.1)	45301 (64.4)		
Not yet determined	1173 (50.0)	893 (47.3)	11173 (15.9)		
Reason for FC Involve				894.181 (12)	< 0.001*
Physical abuse	91 (3.9)	88 (4.7)	3585 (5.1)		
Neglect	534 (22.8)	434 (23.0)	6575 (9.3)		
Parent alc/drug use	375 (16.0)	285 (15.1)	10508 (14.9)		
Parent inability cope	128 (5.5)	85 (4.5)	5825 (8.3)		
Other	246 (10.5)	182 (9.6)	8463 (12.0)		
Multiple reasons	572 (24.4)	555 (29.4)	24675 (35.1)		
Unknown	400 (17.1)	261 (13.8)	10747 (15.3)		
	M(SD)	M(SD)	M(SD)	F (df 1, df 2)	p
Child Age @ Entry	8.3 (5.7)	8.1 (5.6)	8.2 (6.1)	0.31 (2, 74611)	0.730

Notes. *N* = 74,614 unique foster care episodes; *n* = 2,346 for intervention sites, *n* = 1,890 for comparison sites, and *n* = 70,378 for other state sites.

- Child gender was limited to binary constructs of male/female within the administrative data systems.
- Racial/ethnic groups were collapsed to provide sufficient power for subsequent analyses; composition of groups that compose "Latino/a, any race" and "Other race/multiracial and not Latino/a" are provided in gray for information only.
- The median child age for intervention sites was 8 (Min = 0, Max = 17), for comparison sites was 8 (Min = 0, Max = 17), and for other state sites was 8 (Min = 0, Max = 17).
- Asterisks (*) denote significant differences across sites.

Table 140. Pennsylvania Foster Care Episode Characteristics

Out-of-Home Care Sample	Intervention	Comparison	State	X2 (df)	p
Entry Cohort				248.397 (14)	< 0.001*
2014	281 (12.0)	251 (13.3)	10540 (15.0)		
2015	352 (15.0)	305 (16.1)	10626 (15.1)		
2016	392 (16.7)	318 (16.8)	10024 (14.2)		
2017	368 (15.7)	330 (17.5)	10101 (14.3)		
2018	362 (15.4)	260 (13.8)	9300 (13.2)		
2019	339 (14.5)	255 (13.5)	8379 (11.9)		
2020	201 (8.6)	144 (7.6)	6302 (8.9)		
2021	51 (2.2)	27 (1.4)	5106 (7.3)		
Most Recent Case Goal				461.474 (8)	< 0.001*
Reunify with Family	1764 (75.2)	1378 (72.9)	49251 (70.0)		
Adoption	248 (10.6)	244 (12.9)	14288 (20.3)		
Guardianship	248 (10.6)	216 (11.4)	3511 (5.0)		
LTFC/Emancipation	77 (3.3)	49 (2.6)	2692 (3.8)		
Not Established/Unknown	9 (0.4)	3 (0.2)	636 (0.9)		
Placement Stability				294.687 (2)	< 0.001*
< 2 placements / year	2037 (86.8)	1633 (86.4)	52772 (75.0)		
3+ placement / year	309 (13.2)	257 (13.6)	17606 (25.0)		
Prior Episodes				23.524 (2)	< 0.001*
None	1674 (71.4)	1421 (75.2)	53287 (75.7)		
1 or More	672 (28.6)	469 (24.8)	17091 (24.3)		
Reason for Discharge				663.413 (10)	< 0.001*
Reunify with Family	1238 (52.8)	1012 (53.5)	37966 (53.9)		
Adoption	226 (9.6)	228 (12.1)	10620 (15.1)		
Guardianship	296 (12.6)	256 (13.5)	3424 (4.9)		
Emancipation	77 (3.3)	55 (2.9)	3553 (5.1)		
Transf/Runaway/Death	65 (2.8)	37 (2.0)	3632 (5.2)		
Not Applicable/Unknown	444 (18.9)	302 (16.0)	11183 (15.9)		
	M(SD)	**M(SD)**	**M(SD)**	**F (df 1, df 2)**	**p**
Days in Foster Care	487.4 (429.2)	507.7 (420.4)	451.6 (449.2)	21.13 (2, 74611)	< 0.001*

Notes. **N** = 74,614 unique foster care episodes; ***n*** = 2,346 for intervention sites, ***n*** = 1,890 for comparison sites, and ***n*** = 70,378 for other state sites.

- *Not Established/Unknown* and *Not Applicable/ Unknown* indicates when information was not provided for an episode due to this action not yet being determined in the record or having missing information.
- The median days in foster care for intervention sites was 415 days (Min = 1, Max = 2574), for comparison sites was 463.5 days (Min = 0, Max = 2420), and for other state sites was 313 (Min = 0, Max = 2827). •
  - Asterisks (*) denote significant differences across sites.

2.A.2.1. Increase of Intact Family vs. Family Removal

The system has the choice of providing intact family services or child removals into out-of-home care when child maltreatment has been substantiated or indicated. We observed different trends over time in the proportion of children removed from their homes.

Pre-intervention between 2014 and 2018, we observed no significant differences between intervention and comparison site removal rates. **Post-intervention we observed a significant treatment effect where child removal rates decreased for intervention sites on average while they increased for comparison sites on average.** However, the time period for observation was short (only about 1.25 years) due to the availability of data.

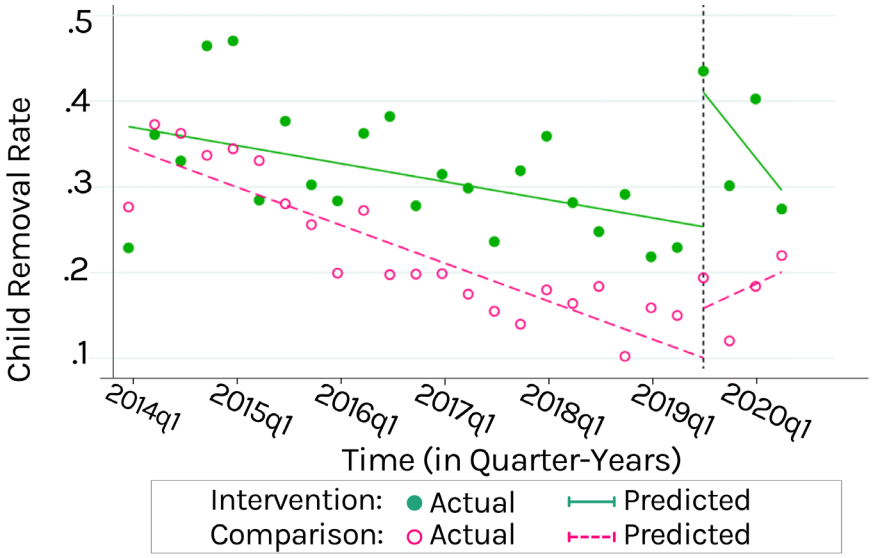
These results provide some initial evidence that the Approach may have contributed to a decrease in child removals after training was implemented in June 2019. This information should be triangulated with implementation data that discusses partners' perceptions of how behaviors changed relative to the decision of keeping families intact or removing children from the homes.

Table 141. Allegheny County, PA Interrupted Time Series Analysis of Child Removal Rates per 100 Children by Project Sites comparing Trends during Pre-intervention, Post-intervention, and Post-Covid Time Periods

Interrupted Time Series	b (se)	*p*
Time	-0.01 (0.00)	< 0.001*
Intervention	0.02 (0.05)	0.686
Time * Intervention	0.01 (0.00)	0.059
Post-2019	0.06 (0.03)	0.040*
Time * Post-2019	0.03 (0.01)	0.041*
Intervention * Post-2019	0.10 (0.05)	0.033*
Time * Intv * Post-2019	-0.06 (0.02)	0.002*
Constant	0.36 (0.02)	< 0.001*
F (7, 44)	26.29	< 0.001*

Notes. N = 52. Significant partial slopes are indicated by an asterisk (*).

Figure 59. Allegheny County, PA Interrupted Time Series Analysis of Child Removal Rates per 100 Children by Project Sites comparing Trends during Pre-intervention, Post-intervention, and Post-Covid Time Periods



Regression with Newey-West standard errors – lag(1)

Notes. *N* = 52 quarter-years. Quarter years are formatted as year and quarter; for example, 2014q1 represents children with reports during quarter 1 of the year 2014. Actual quarterly rates are visualized as data points while estimated trends are visualized by lines.

- Training was implemented during June 2019 at the Intervention sites; the dotted line for 2019q3 is visualized within the graph.
- Lower child removal rates is a more desirable outcome. We observed significant post-intervention differences in the child removal trends between intervention and comparison sites.

2.A.2.2. Increased Reunification Rate

For this sample, we followed all episodes involving Pennsylvania youth entering foster care between January 1, 2014 and September 30, 2021. Reunification was defined as a child being reunited with a parent/original caregiver and/or living with family. If a child was not reunited with family upon discharge from foster care or remained in care at the end of the observation period, they were coded as "not reunified." All models assessed a site by time interaction and controlled for child characteristics and episode characteristics.

We then assessed the relative rate of a child being reunified with family between intervention, comparison, and other state sites. Holding all else equal, we observed no significant differences in the likelihood of being reunified with parents post-intervention for child survivors who entered foster care after January 1, 2019 and served by comparison sites relative their counterparts served by intervention (reference) sites ($HR_{Comparison}$ = 1.01, 95% CI (0.82, 1.26), p = 0.891). We observed other state sites had higher reunification rates relative to the intervention (reference) sites (HR_{State} = 1.71, 95% CI (1.47, 1.98), $p < 0.001$) during this post-intervention time period, holding all else equal.

Table 142. Pennsylvania Estimated Proportion of Foster Care Episodes that Resulted with Children being Reunified with Families by Site and Time Period

Time Period	Intervention % Reunified with Family by 1,000 Days	Comparison % Reunified with Family by 1,000 Days	State % Reunified with Family by 1,000 Days
2014-2018	37.3%	36.1%	40.5%
2019-2021	32.2%	32.6%	48.6%

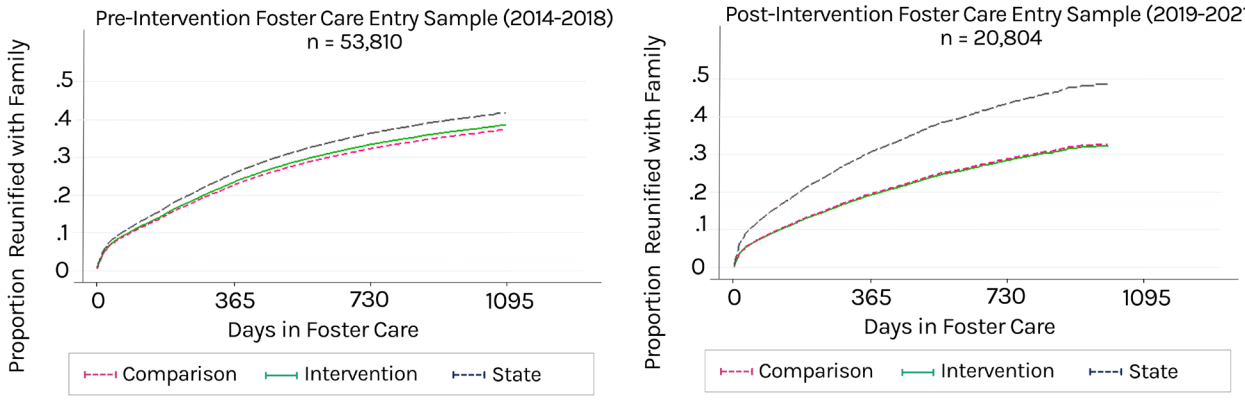
Notes. *N* = 40,385.

Between 2019 to 2021 within the intervention sites, we observed 19.0% of foster care episodes within the first 12 months of care were associated with children being reunified with family. The proportion of episodes resulting in reunification with family rose another 9.2% for youth who stayed in care from 12 to 24 months and additional 3.9% for youth who stayed in care over 24 months. By 1,000 days, or the 2.7 years that we collected data post-intervention, the adjusted models estimated 32.2% of foster care episodes ended with youth being returned to the care of their family.

Between 2019 to 2021 within the comparison sites, we observed 19.4% of foster care episodes within the first 12 months of care were associated with children being reunified with family. The proportion of episodes resulting in reunification with family rose another 9.3% for youth who stayed in care from 12 to 24 months and additional 3.9% for youth who stayed in care over 24 months. By 1,000 days, or 2.7 years, the adjusted models estimated 32.6% of foster care episodes ended with youth being returned to the care of their family.

Using a difference-in-difference model, we observed no significant treatment effect when comparing differences in reunification rates across sites for youth entering foster care between 2014-2018 and for youth entering foster care between 2019-2021. In other words, comparison sites faced a similar likelihood of experiencing reunification for youth entering foster care during the post-intervention time period compared to their counterparts at the intervention (reference) sites ($HR_{\text{Comparison x Post-Intervention}}$ = 1.07, 95% CI (0.85, 1.36), p = 0.541). We observed a significant increase in reunification rates during the post-intervention time period for other state sites compared to intervention (reference) sites ($HR_{\text{State x Post-Intervention}}$ = 1.49, 95% CI (1.27, 1.75), p < 0.001).

Figure 60. Pennsylvania Reunification Rates Comparing FC Entry Cohorts 2014-2018 and 2019-2021 by Intervention Site, Comparison Site, and Other Sites within State



Notes. *N* = 74,614. This figure reports the estimated proportion of foster care episodes that result in reunification with family over days in foster care, holding all else equal.

- Every time a child is estimated to reunify with a family, the cumulative proportion of youth increases. A good outcome

is associated with a higher proportion of foster care episodes resulting in reunification with family.
- Differences in relative rate for reunification across pre- and post-intervention foster care entry did not significantly differ between intervention and comparison sites.

When the sample was stratified by maltreatment type, we observed similar patterns for child survivors by all reasons for entry into foster care. In other words, we see results similar to those presented for the full sample by youth entering foster care for physical abuse only, neglect only, other types of maltreatment only, and multiple types of maltreatment.

When the sample of children entering foster care was stratified by race/ethnicity, we observed no differences in patterns for child survivors by racial/ethnic identification. In other words, we see results similar to those presented for the full sample by youth entering foster care across all racial/ethnic identification.

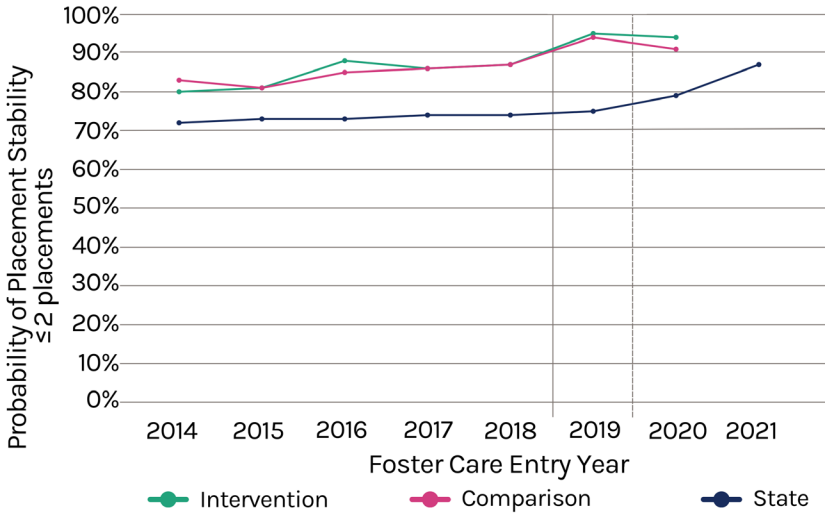
In sum, we observed no significant differences between reunification rates for comparison and intervention sites within the Allegheny County Project site. Other state sites consistently showed increases in reunification rates during the post-intervention time period relative to intervention sites across different maltreatment types and racial/ethnic groups.

2.A.2.3. Increased Stability

We used Pennsylvania foster care sample of *N* = 74,536 reported in the methods to answer this research question.

In the models that assessed for differences between sites by foster care entry cohort and controlled for child and episode characteristics, we observed no significant main effect for the differences in the odds of a child survivor experiencing placement stability between the comparison and intervention (reference) sites ($OR_{comparison}$ = 1.24, 95% CI (0.79, 1.95), p = 0.354). In contrast, we observed other state sites have lower placement stability across foster care entry cohorts compared to intervention (reference) sites (OR_{state} = 0.64, 95% CI (0.47, 0.86), p = 0.004). Figure 61 compares site-level differences in the probability of youth experiencing 2 or less placements for youth entering foster care between 2014 to 2020. Please note that counts were too low within comparison and intervention sites during 2021 to estimate probability of placement stability.

Figure 61. Pennsylvania Probability of Experiencing Placement Stability by Entry Cohort



Notes. **N** = 74,536 unique foster care episodes; ***n*** = 2,346 for intervention sites, ***n*** = 1,890 for comparison sites, and ***n*** = 70,378 for other state sites. Intervention start date was January 1, 2019 indicated by the vertical solid line. The onset of Covid-19 is indicated by the vertical dash line.

We ran additional models stratified by duration of the foster care episode to assess for differences in rates by children's length of time in care. Table 143 shows the results of these multivariate models and Table 144 reports the estimated probability by site and time across these three models.

Table 143. Pennsylvania Likelihood of Experiencing Placement Stability by Duration in Foster Care

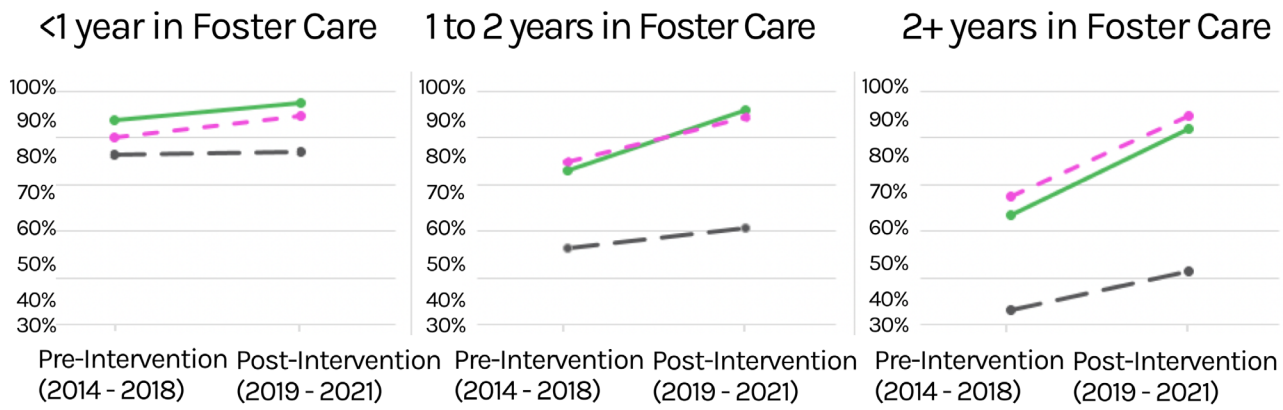
Characteristics	Episode < 1 year OR (95% CI)	Episode 1 to 2 years OR (95% CI)	Episode 2+ years OR (95% CI)
Site			
Intervention	ref	ref	ref
Comparison	0.58 (0.40, 0.85)**	1.15 (0.76, 1.73)	1.29 (0.95, 1.76)
State	0.41 (0.31, 0.54)***	0.36 (0.27, 0.47)***	0.36 (0.29, 0.45)***
Time			
2014-2018	ref	ref	ref
2019-2021	2.57 (1.20, 5.51)*	5.17 (2.76, 9.69)**	4.79 (2.43, 9.44)
Site * Time			
Comparison*2019-2021	0.82 (0.29, 2.36)	0.64 (0.26, 1.60)	1.28 (0.44, 3.70)
State*2019-2021	0.42 (0.19, 0.90)*	0.24 (0.13, 0.45)***	0.31 (0.16, 0.61)**
Child age (in yrs)	0.95 (0.95, 0.96)***	0.91 (0.91, 0.92)***	0.90 (0.89, 0.90)***
Child gender			
Female	ref	ref	ref
Male	1.00 (0.94, 1.06)	1.02 (0.95, 1.10)	0.96 (0.90, 1.02)
Child race/ethnicity			
Black and not Latino/a	ref	ref	ref
Latino/a, any race	1.20 (1.09, 1.31)***	1.17 (1.05, 1.30)**	0.99 (0.90, 1.09)
White and not Latino/a	1.63 (1.52, 1.74)***	1.43 (1.32, 1.56)***	1.15 (1.07, 1.23)***
Other race/multiracial and not Latino/a	1.29 (1.14, 1.47)***	1.34 (1.15, 1.55)***	1.19 (0.04, 1.35)**
Child any disability			
Yes	ref	ref	ref
No / not yet determined	1.55 (1.45, 1.66)***	1.43 (1.31, 1.55)***	1.49 (1.38,1.62)***
Prior Episode			
None	ref	ref	ref
At least 1 prior episode	0.91 (0.84, 0.97)**	0.89 (0.82, 0.97)**	0.92 (0.85, 1.00)
Case Goal			
Reunify with Family	ref	ref	ref
Adoption	0.70 (0.58, 0.83)***	2.00 (1.80, 2.21)***	1.51 (1.39, 1.63)***
Guardianship	0.96 (0.79, 1.17)	2.15 (1.87, 2.47)***	1.82 (1.61, 2.05)***

Characteristics	Episode < 1 year OR (95% CI)	Episode 1 to 2 years OR (95% CI)	Episode 2+ years OR (95% CI)
LTFC/ Emancipation/ Unknown	0.78 (0.68, 0.89)***	0.82 (0.47, 0.75)*	0.91 (0.78, 1.07)
Model Fit			
LR Chi2 (df)	1235.40 (15)***	2446.89 (15)***	2454.47 (15)***
Pseudo R2	0.0397	0.1181	0.1018

Notes: * > .05, ** > .01, ** > .001. Less than one year in foster care *n* = 40,239; 1 to 2 years in foster care *n* = 16,810; and 2+ years in foster care *n* = 17,565.

To better understand the treatment effects reported in the prior table (site * time interaction), Figure 62 and Table 144 provide a summary of the probability of a child experiencing placement stability across sites by a child's duration in foster care and when a child entered foster care (i.e., pre-intervention time period between 2014-2018 or post-intervention time period between 2019-2021).

Figure 62. Pennsylvania Estimated Probability of a Child Experiencing Placement Stability by Duration in Foster Care and Entry Cohort



Notes. *N* = 74,614. Less than one year in foster care *n* = 40,239; 1 to 2 years in foster care *n* = 16,810; and 2+ years in foster care *n* = 17,565.

Table 144. Pennsylvania Estimated Probability of a Child Experiencing Placement Stability by Duration in Foster Care and Entry Cohort

Episode Length by & Foster Care Entry Year	Intervention % (95% CI) of Placement Stability	Comparison % (95% CI) of Placement Stability	State % (95% CI) of Placement Stability
Less than 1 year in foster care:			
2014-2018	93.8 (92.2, 95.4)	90.0 (87.6, 92.2)	86.4 (86.0, 86.8)
2019-2021	97.4 (95.7, 99.2)	94.9 (91.7, 98.1)	87.2 (86.6, 87.8)
1 to 2 years:			
2014-2018	83.2 (79.8, 86.7)	84.9 (81.2, 88.6)	66.5 (65.6, 67.3)
2019-2021	95.9 (93.8, 98.1)	94.6 (91.6, 97.5)	70.6 (69.4, 71.8)
2+ years in foster care:			
2014-2018	73.4 (69.8, 77.0)	77.6 (74.0, 81.1)	53.1 (52.3, 53.9)
2019-2021	92.0 (87.5, 96.5)	94.9 (91.2, 98.6)	61.5 (59.4, 63.5)

For children whose foster care episode has a duration of less than a year:

- Placement stability remained relatively stable across all sites when comparing pre-intervention (2014-2018) and post-intervention (2019-2021) cohorts (Bonferonni $p > 0.200$).
- Intervention and comparison sites had comparable placement stability rates for pre-intervention ($z = -2.77$, Bonferroni $p = 0.085$) and post-intervention ($z = -1.47$, Bonferroni $p = 1.000$) foster care entry cohorts.
- Both Allegheny County, PA intervention and comparison sites remained consistently higher than state placement stability rates (Bonferonni $p < 0.001$).

For children whose foster care episode has a duration of 1 to 2 years:

- We observed increases in likelihood of children experiencing placement stability across all sites for those children who entered foster care between 2019-2021 compared to those who entered foster care between 2014-2018 ($p < 0.010$).
- Intervention and comparison sites had comparable placement stability rates for pre-intervention ($z = 0.65$, Bonferroni $p = 1.000$) and post-intervention ($z = -0.74$, Bonferroni $p = 1.000$) foster care entry cohorts.
- Both Allegheny County, PA intervention and comparison sites remained consistently higher than state placement stability rates (Bonferonni $p < 0.001$).

For children whose foster care episode has a duration of 2+ years:

- We observed increases in likelihood of children experiencing placement stability across all sites for those children who entered foster care between 2019-2021 compared to those who entered foster care between 2014-2018 ($p < 0.001$).
- Intervention and comparison sites had comparable placement stability rates for pre-intervention ($z = 1.64$, Bonferroni $p = 1.000$) and post-intervention ($z = 0.97$, Bonferroni $p = 1.000$) foster care entry cohorts.
- Both Allegheny County, PA intervention and comparison sites remained consistently higher than state placement stability rates (Bonferonni $p < 0.001$).

In sum, we did not observe significant increases in placement stability that can be attributed to the Approach for Allegheny County, PA youth served by intervention sites.

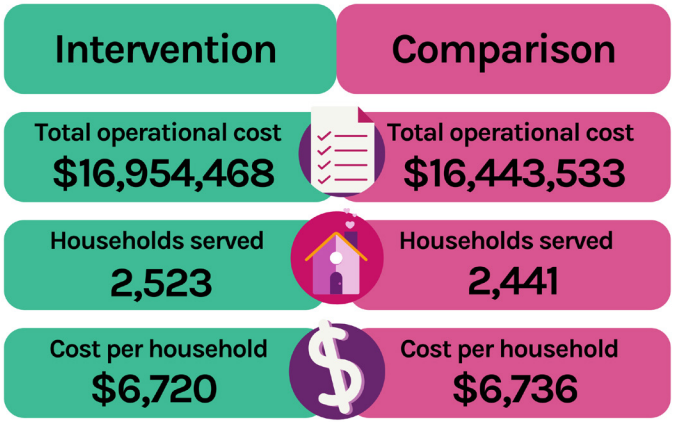
COST STUDY

The Allegheny County, PA locale completed two BATs – one for its intervention sites, which included its Central Regional Office and East Regional Office, and also for its comparison sites, which included its Mon Valley Regional Office and North Regional Office.

Service characteristics

Between July 1, 2020 – June 30, 2021, the Allegheny County, PA sites implementing the Approach served a total of 2,523 unique households. The comparison sites served 82 fewer households and provided services to 2,441 households (Figure 63). The number of completed household contacts was similar across sites, with an average of 47 contacts per intervention household and 45 contacts per comparison household. The incidence of cases involving IPV also were reportedly similar across sites, with approximately 23% of intervention cases and 21% of comparison cases involving IPV.

Figure 63. Allegheny County, PA Intervention and Comparison Site Operational Cost, Households Served, and Cost Per Household (July 1, 2020 – June 30, 2021)



Total cost and cost per household

The total cost of service delivery for the intervention sites was estimated to be $16,954,468, for a per household cost of $6,720. The total costs were similar across sites. For the comparison sites, the total cost amounted to $16,443,533, resulting in a per household average of $6,736, a difference of $16 per household.

Summary of costs by cost category

Figure 62 displays the total, percentage, and per family costs of service delivery by cost category for the Allegheny County, PA intervention and comparison sites during this timeframe. Labor, overhead and infrastructure, and contracted services comprised 98% of total costs for both the intervention and comparison sites. All other cost categories represented less than 1% of total costs. Training costs for the intervention sites totaled $65,865, which included caseworker initial training, and initial QIC-DVCW training for child welfare staff, and monthly QIC-DVCW coaching calls. In contrast, training for the comparison sites included only the initial caseworker training. Consumable, non-consumable, and travel costs for the intervention and comparison sites again were similar, and negligible to total costs.

Table 145. Summary Cost Metrics for Allegheny County, PA Intervention and Comparison Sites, July 1, 2020 – June 30, 2021

Cost Category	Intervention			Comparison		
	Total Cost ($)	Total Cost (%)	Cost per Family Served	Total Cost ($)	Total Cost (%)	Cost per Family Served
Labor	$7,972,297	47.0%	$3,160	$8,123,784	49.4%	$3,328
Overhead and Infrastructure	$5,942,565	35.1%	$2,355	$5,360,641	32.6%	$2,196
Contracted Services	$2,791,612	16.5%	$1,106	$2,695,061	16.4%	$1,104
Tools and Screening	$0	0%	$0	$0	0%	$0
Training	$65,865	0.4%	$26	$35,665	0.2%	$15
Consumable Supplies	$31,541	0.2%	$13	$32,236	0.2%	$13
Non-consumable Supplies	$48,564	0.3%	$19	$50,812	0.3%	$21
Travel	$102,024	0.6%	$40	$145,334	0.9%	$60
Total Costs	$16,954,468	100%	$6,720	$16,443,533	100%	$6,736

Key cost drivers

For Allegheny County, PA, the key cost drivers for both the intervention and comparison sites were labor, overhead and infrastructure, and contracted services, all of which comprised slightly more than 98% of total costs. Overhead and infrastructure costs included institutional indirect costs and rent. Institutional indirect costs are general and administrative costs to support agency operations, and include costs for support specialists (e.g., peer coaches, father engagement specialists, in-home navigator specialists) and clerical staff positions. Institutional indirect costs were the same for both intervention and comparison sites ($4,745,794), but office rent and utilities were higher for the intervention sites than for the comparison sites ($1,196,771 versus $614,847, respectively). Rent costs vary by site based on the location of offices.

Contracted services included three general categories: data services to support the county's case management system, service delivery, and information technology (IT) services. While the cost of data services and IT were the same for both the intervention and comparison sites, the contracted service delivery services were higher for the intervention sites. Allegheny County, PA contracts with over 90 agencies for service delivery. However, costs of contracted services specifically included in the BAT were those whose staff participated in the intervention (e.g., staff attended the trainings, participated on implementation teams, and were involved in evaluation activities). Those contracted staff positions included in the cost study and who received the Approach training were:

- A county solicitor who represents the county during hearings. This position is employed by the county, but through a separate department.
- Behavioral health specialists are co-located with the child welfare agency but are employed through the Office of Behavioral Health.
- Alliance for Infants and Toddlers (AFIT) staff are also co-located with child welfare and conduct assessments of children ages 0-3 for developmental delays and connect them to services.
- Nurses are also co-located and are employed by Children's Hospital. For any child welfare

cases where there are medical issues, the nurses are available to provide support.

- Holy Family Institute (HFI) staff conduct in-home services and are contracted through the child welfare agency to support caseworkers. They help families develop goals and provide support for families to reach those goals.
- Allegheny Family Network (AFN) has family support partners who serve as peers for the adults involved in the child welfare system. All AFN employees have experience being a parent in the mental health system.

Labor costs comprised the greatest percentage of total costs - between 47% and 49% for the intervention and comparison sites, respectively. Figure 64 and Figure 65 explore labor costs in greater detail. Figure 64 details the staff roles and the number of FTEs needed to implement and provide child welfare services for the intervention and comparison sites. The intervention sites, which served 82 more households, employed 104.5 FTEs while the comparison sites employed 108.1 FTEs. In general, the staff roles for the intervention and comparison sites were the same, but the FTEs varied. The intervention sites had at least twice the number of FTEs for IPV program managers and IPV specialists than the comparison sites. For both intervention and comparison sites, annual staff salaries within the child welfare agency ranged from $35,000 to $91,086, with an average of $63,769. The staff positions included within the Labor cost category of the BAT included county staff as well as a few contracted staff (i.e., IPV Specialist, IPV Manager, and Training Manager).

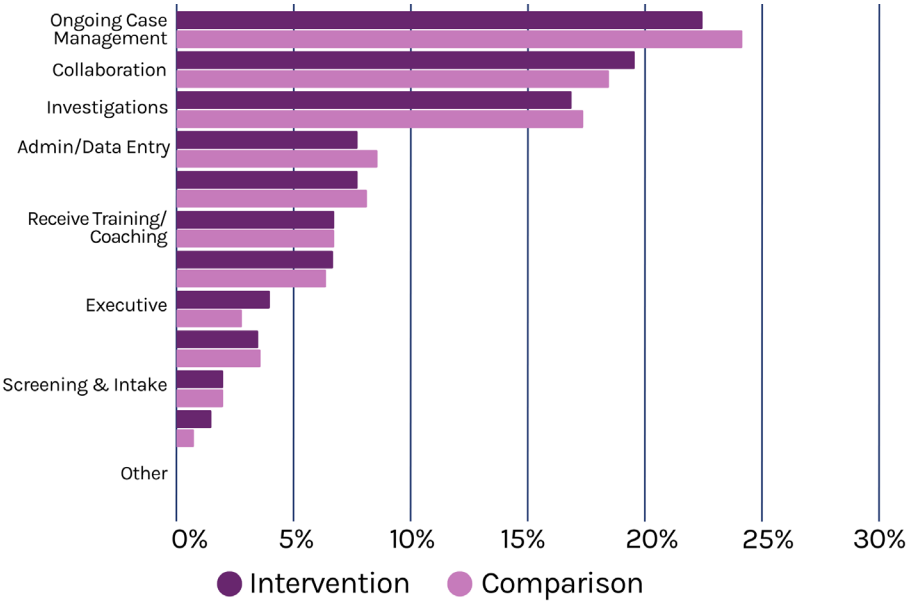
Figure 64. Staff Roles and Number of FTEs for Allegheny County, PA Intervention and Comparison Sites, July 1, 2020 – June 30, 2021

104.5 Total FTEs Intervention	Job Title	108.1 Total FTEs Comparison
2	Regional Office Director	2
2	Clinical Manager	2
18	Supervisor	18
8	Caseworker 1	9
47	Caseworker 2	48
12	Caseworker 3	17
3	Peer Coach Specialist	3
2	In-home Navigator Specialist	2
2	Father Engagement Specialist	1
2	Best Practice Specialist	2
2	Managed Care Liaison	2
.40	Manager of Training	.20
.35	Best Practice Manager	.30
.40	Project Manager	.20
.80	Program Manager, IPV	.10
.40	Program Manager, IPS	.20
1.6	IPV Specialist	.80
.50	IPV Specialist Manager	.25

Labor allocation by service activity

Figure 65 shows the percentage of time staff engaged in each of the 12 key service activities for the intervention and comparison sites. Ongoing case management, collaboration, and investigations accounted for the bulk of the staff labor. Together, these three activities accounted for 58.1% of staff time in the intervention sites and 59.4% in comparison sites. Comparing activities across sites, staff involvement in the key activities was relatively consistent. Differences in time spent were greatest for ongoing case management (2.2% greater for comparison sites), collaboration (1.5% greater for the intervention sites), and executive activities (1.3% more for the intervention sites). Collaboration, which was hypothesized to be greater for the intervention group due to the principles of the Approach, accounted for 19.6% of staff labor for the intervention sites, and 18.2% for the comparison sites.

Figure 65. Labor Allocation Across Key Activities for Allegheny County, PA Intervention and Comparison Sites, July 1, 2020 – June 30, 2021



SECTION 10. DISCUSSION AND APPLICATION OF RESULTS

The following discussion and application of results is organized by the three QIC-DVCW studies: implementation, outcome, and cost. For our purposes, the discussion includes brief summaries of the results, including quantitative and qualitative, and the application provides the reader with what we believe can be applied in future work – practice, research, and policy – at the intersection of domestic violence and child welfare. The application of these results is important to highlight as we consider what is to be learned about the Approach implementation, and what those working at the intersection of DV and CW can glean from the three studies of the QIC-DVCW evaluation.

IMPLEMENTATION STUDY

The Implementation Study was guided by an overarching research question:

What factors are associated with successful implementation and sustainability of an adult and child survivor–centered approach?

This component of the evaluation was informed by implementation science and the frameworks discussed above. The concept of "successful implementation" was operationalized to include Implementation Outcomes of adoption, acceptability, feasibility, fidelity, penetration, and sustainability.

Summary of Implementation Outcomes

Table 146 summarizes the primary findings of the implementation study by implementation outcome. Overall, the implementation study data suggests successful implementation for three of the implementation outcomes: penetration, adoption, and, for the most part, fidelity. The data on these three implementation outcomes point to significant effort to take up, use, and spread the Approach. In contrast, the data on acceptability, feasibility, and sustainability signified challenges in implementation. A major challenge theme was woven throughout these less successful implementation outcomes. In brief, the Approach was viewed as conceptually appealing. However, the practical aspects of putting the Approach into routine practices and procedures and sustaining it with fidelity were the major trouble spots.

Table 146. Summary of Implementation Study Findings by Implementation Outcome

Implementation Outcome	Data Source	Primary Findings
Penetration (Approach spread across organization or target population)	Monitoring Training, Coaching, Fidelity Participation Universal Stages of Implementation Completion	• Highest spread indicated by training participation; modest spread indicated by coaching participation; lowest spread indicated by fidelity participation • Proportion of completed implementation phases was high among all three sites, ranging from 87% to 100% in pre-implementation phase and from 83% to 91% in implementation phase • Taken together, these indicators suggest that the Approach penetrated the practice of those in direct service work with families at mainly moderate to high levels

Implementation Outcome	Data Source	Primary Findings
Adoption (Decision to use/try Approach)	Drivers Assessment Universal Stages of Implementation Completion (Uni-SIC)	• Lower adoption was observed in earlier implementation stages; adoption increased over time as expected Drivers Assessment indicated implementation drivers were more "in place" in later implementation stages as expected ▪ Leadership high in all time periods ▪ Competency increased over time and ended at moderately high levels ▪ Organizational increased but was lower than other domains in all time periods Uni-SIC data on proportion of completed implementation activities suggest that uptake was relatively high across all sites Uni-SIC data on duration of implementation ▪ In the pre-implementation stage indicates that sites took much longer to complete pre-implementation as compared to "competent sites" and ▪ In the implementation stage indicates that all three sites experienced either shorter or similar duration as compared to "competent sites" • Overall, these data indicate that adoption of the Approach increased over time, was relatively high by the end of the project period, took longer in the earlier stages than would be desired, took about as long as would be expected or desired in the later stages, and may have experienced the most challenges with establishing supportive structures at the organization level
Acceptability (Approach viewed as agreeable, palatable, satisfactory)	Key Informant Interviews	• Mixed views were observed on acceptability • The Approach was widely accepted at a conceptual level; however, interviews indicated dissatisfaction with lack of operationalization of the Approach • A significant barrier was reconciling keeping children safe vs keeping families intact in real-world practice • The Approach challenged and contradicted the current child welfare system structure (e.g., coercive, hierarchical power)
Feasibility (Approach viewed as suitable or practical for everyday use)	Key Informant Interviews	• Views on feasibility largely suggested that the Approach's ideas were suitable; however, using the Approach in every day practice was less clear mainly because it lacked clear definition and operationalization

Implementation Outcome	Data Source	Primary Findings
Fidelity (Approach delivered as intended)	Fidelity Checklist	Fidelity Checklists were completed at low rates • Completed data showed average scores increasing over time as expected • Statistically significant change was observed in two domains (1) work with person using violence, and (2) principles practice • Although not showing statistically significant increases over time, all domains of the Fidelity Checklist average scores were at 7.2 or above by the last time period, which represented fidelity in the "good work" range
Sustainability (Approach is maintained or continued; also routinized and integrated)	Key Informant Interviews Universal Stages of Implementation Completion (Uni-SIC)	• Although "sustainability" discourse was not directly included in the KII, caution about belief in the future of the Approach was described • Uni-SIC data on the sustainment phase indicated low sustainability as none of the sustainability activities were initiated or completed.

Factors that Contributed or Inhibited Successful Implementation

The implementation data that aimed to identify factors that contributed or inhibited successful implementation of the Approach help to make sense of the implementation outcomes data.

Viewed through the lens of Implementation Drivers (see page 12), the key informant interviews and the coaching focus groups identified facilitators and inhibitors in each of the major driver domains – competency drivers, organization drivers, and leadership drivers as summarized in Table 147.

Table 147. Summary of Implementation Facilitators and Inhibitors by Implementation Driver

Implementation Driver Domain	Summary of Facilitators and Inhibitors
Competency	**Facilitators** • Training was foundational to implementing the Approach • Coaching provided important, dedicated time and space for transfer of learning and relationship building • Good facilitation, safe and non-judgmental spaces for learning, and peer learning were noted as qualities of effective coaching **Inhibitors** • Logistical challenges were noted for both training and coaching, including time and workload, format, frequency, delivery, and participation • Covid-19 presented unpredictable obstacles and required new approaches to training and coaching • Due to feasibility concerns with the Approach, coaching was needed to reduce complexity and increase concreteness and specificity for supervisors

Implementation Driver Domain	Summary of Facilitators and Inhibitors
Organization	**Facilitators** • Project managers and other individuals, inside and outside of child welfare, were important for championing the Approach **Inhibitors** • Communication and structural level issues, including changing language and lack of specific practice guidance on the Approach
Leadership	**Facilitators** • Implementation teams were identified as important for establishing and maintaining a focus on the Approach **Inhibitors** • When leadership attention and buy-in were low, it was problematic • As indicated by the above points, leadership was needed for technical problem solving (e.g., to address logistical issues) and adaptive problem solving (e.g., to reconcile value misalignment between the Approach and current policies/procedures)

Application of the Implementation Study Results

The QIC-DVCW Implementation Plan set out to implement the Approach with guidance from implementation science frameworks. As such, the plan included four key implementation strategies: (1) implementation teams, (2) implementation stages, (3) implementation drivers, and (4) improvement cycles. While the Implementation Study did not ask about each of these directly, data emerged that underscored the importance of several aspects of these implementation strategies. Specifically, these data seem to affirm the value of Implementation Teams and Implementation Drivers. First, Implementation Teams were acknowledged as key to supporting and shepherding the Approach's implementation. Second, several parts of the Implementation Drivers were noted as important, including the competency drivers of training and coaching, the organizational drivers of facilitative administration and systems intervention, and the leadership drivers. Additionally, the finding that fidelity (one of the Implementation Drivers) being the lowest spread is noteworthy. The Approach was about centering and enabling critical thinking among professionals who serve DV impacted families who are CW involved. Perhaps more concrete strategies to help them operationalize would have made a difference. In all, these findings suggest that future implementations should work to support high-quality Implementation Teams and to facilitate the development of an infrastructure that is enlivened by the application of Implementation Drivers.

The implementation strategies that were not specifically named by study participants are implementation staging and improvement cycles. These may have been omitted because they were less noticeable, not fully or robustly used, or not seen by study participants as critically important to this implementation. However, some of the study's findings on less successful implementation outcomes and inhibitors to successful implementation may point to needing these two implementation strategies. For example, an expanded use of staging may have provided more space for usability testing which is specifically aimed at spotting and resolving problems with an intervention prior to moving forward with full implementation. Likewise, additional use of improvement cycles might have provided opportunities for examining processes in using the Approach, identifying glitches or gaps, and making adjustments accordingly. Adding these two implementation strategies may very likely require a longer grant period that allows for

relationship-building and high-quality planning and execution of plans.

Another implementation framework that was new when the QIC-DVCW Implementation Plan was developed, and therefore not adopted, is known as Usable Innovations. This framework says: "Usable Innovations are operationalized, so they are teachable, learnable, doable, and assessable in practice. Usable Innovations are effective when used as intended. Usable Innovations have a way to detect the presence and strength of the innovation as it is used in everyday practice" (Fixsen, Blase, & Van Dyke, 2019, p. 69). Application of Useable Innovations framework may have addressed some of the factors that inhibited successful implementation, such as issues with the complexity of the implementation and lack of clarity and specificity in the application of the Approach.

As noted in the report's introduction, the "formula for success" includes an Enabling Context. The implementation study results emphasized the relevance of environmental barriers. Study participants suggested that the child welfare system did not change or reshape to support the Approach. Given these identified challenges with implementation, more attention may be needed to create and maintain a hospitable environment for the Approach, including full attention and continuous (not in fits and starts) efforts, and tenacious change agents. Systems change work requires high level leadership involvement and perhaps union and human resources involvement as well.

OUTCOMES STUDY

Service Delivery Outcomes

Within the QIC-DVCW logic model, the outcome category of service delivery is the term used to encompass the three practice behaviors areas of study: enhanced child welfare practice (1.B.1), enhanced community partner practice (1.B.2), and enhanced cross organizational communication and collaboration (1.B.3.). Because change in practice behaviors was a central focus of the QIC-DVCW, each of the three practice behaviors areas encompassed many discrete constructs.

Summary of Enhanced Child Welfare Practice Outcomes

Overall, of the eight enhanced child welfare practice outcomes, we observed significant differences by intervention and comparison samples in three outcomes (CW self-report - Self Survey, Family Survey): (1) 1.B.1.1. planning, decision-making & practice addressing Protective Factors Framework, (2) 1.B.1.2. planning, decision-making & practice addressing Relational & Systems Accountability Framework, and (3) 1.B.1.2.b. survivor -informed engagement, accountability, and support for PUV. However, two things should be noted. First, the result for 1.B.1.2.b. was that comparison samples reported higher frequency of contact with PUVs, the opposite of what we hoped to see. Second, the data source for these significant outcomes was CW staff self-report. However, there were no parallel significant findings from the Adult Survivor Field Survey. For child welfare practice result summaries by outcome and data source, see Table 148, Table 149, Table 150, and Table 151.

In addition to the data sources that were used to measure the enhanced child welfare practice outcome change, context data sources also provided insight. Within the (intervention only) Coaching Focus Group data source, which is child welfare and community partner reports, there was description of limited changes in practice with PUV (1.B.1.2) within child welfare practice. At the same time, the overall the people with lived experience (adult survivors in the Adult Survivor interviews - mostly intervention sample and fathers in the Strong Fathers Focus Groups - all intervention sample only one project) shared evidence of a lack of consistent Approach-informed child welfare practice, although some examples of helpful practice were identified. Additionally, while the practice of caseworkers and supervisors was a clear focus of these context findings, the system of child welfare (as an organizational culture and entity) was also named and identified by the participants with lived experience as a larger force at play in their families' lives.

Table 148. Summary Enhanced CW Practice 1.B.1.1 Results

Data Source	1.B.1.1. Planning, Decision-Making & Practice Protective Factors for Survivors framework
Caseworker/ Supervisor Survey	SIG
Adult Survivor Field Survey	NS
CRR	CO: Lack of substantive differences

Notes. NS= no statistically significant difference, SIG= statistically significant difference.

****No relevant context data
X=Not included
CO = Context only, not test of difference, but all projects

Table 149. Summary Enhanced CW Practice 1.B.1.2. Results

Data Source	1.B.1.2. Planning, Decision-Making & Practice RSA Framework	1.B.1.2.a. early and ongoing identification and assessment of domestic violence	1.B.1.2.b. Survivor-Informed Engagement, Accountability, and support for pUV	1.B.1.2.c. AS engaged by Cw relative to PUV
Caseworker/ Supervisor Survey	SIG	X	X	X
Family Survey	X	NS	SIG (lower PUV contact invention)	NS
Adult survivor field Survey	X			
CRR	CO: Lack of substantive differences	CO: Lack of substantive differences	****	****
Coaching Focus group (Intervention only)	Within intervention groups, observed some change	****	****	****
Strong Fathers (Intervention only)	CO: • CW relationship uncertain “end zone moves” • Desire for more clarity about expectations	****	****	****
Adult Survivor Interviews	****	****	****	CO: • Doubt the CW can do anything to change PUV or to help adult survivor

Notes. NS= no statistically significant difference, SIG= statistically significant difference.

****No relevant context data

X=Not included

CO = Context only, not test of difference, but all projects

Table 150. Summary Enhanced CW 1.B.1.3. Results

Data Source	1.B.1.3. DV-informed and dynamic practice
Caseworker/ Supervisor Survey	X
Adult Survivor Field Survey	NS
CRR	CO: Lack of substantive differences Similar, with Higher frequency of survivor-initiated PO
Adult Survivor Interviews	CO: • Being a DV Survivor means being at risk of or losing children • PUV impacts the survivor within CW • Range neutral to very negative • Some helpful experiences • "They say jump, you got to say how high?" Didn't get desired resources

Notes. NS= no statistically significant difference, SIG= statistically significant difference.

****No relevant context data

X=Not included

CO = Context only, not test of difference, but all projects

Table 151. Summary Enhanced CW Practice 1.B.1.4.-1.B.1.5. Results

Data Source	1.B.1.4. Actively Work toward racial, ethnic, and gender equity – families' access to resources and services	1.B.1.5. CW-Partner Communication and Collaboration in Case activities
Caseworker/ Supervisor Survey	NS for behaviors (but upward trend for intervention), but SIG for preparation and behaviors	NS
Adult Survivor Field Survey	NS	NS
CRR	****	Not documented in case files.

Notes. NS= no statistically significant difference, SIG= statistically significant difference. X=Not included

****No relevant context data

CO = Context only, not test of difference, also, in only collected for intervention and only 2 projects

Summary of Enhanced Community Partner Outcomes

In the four community partner practice outcomes, there was no evidence of statistically significant differences by intervention and comparison samples, including self-report samples (Self Survey) and lived experience samples (Adult Survivor Field Survey). However, it is noteworthy that we observed changes in the two community partner practice outcomes parallel to those CW practice outcomes with significant differences

(1.B.2.1. Community partner planning, decision-making & practice addressing Protective Factors Framework; and 1.B.2.2. Community Partner planning, decision-making & practice addressing Relational & Systems Accountability Framework). Additionally, noteworthy is that these two outcomes measure change in the two Approach frameworks that were central to the Approach training and coaching. For community practice result summaries by outcome and data source, see Table 152 and Table 153.

One standout finding was that Adult Survivor Field Survey participants reported higher scores for advocates than caseworkers when assessing their Approach informed practice behaviors. The project created items for measuring caseworker and DV advocate practice behaviors in the Adult Survivor Field Survey that intentionally mirrored each other to be able to compare adult survivors' perceptions of these two important positions in their experience at the intersection of DV and CW.

Table 152. Summary Community Partner 1.B.2.1-1.B.2.3. Results

Data Source	1.B.2.1. Community partner planning, Decision-making & practice addressing Protective Factors for Survivors framework	1.B.2.2. Community partner planning, Decision-making & practice addressing RSA Framework	1.B.2.3. Community partner dv-informed, individualized, dynamic practice
Community partner Self Survey	NS (however intervention did increase T2 to T3)	NS (however SIG beliefs correlate with practice behaviors)	X
Adult Survivor Field Survey	NS • AS report advocate scores higher than CW worker • In intervention, SIG alignment between the adult survivor's experience of advocate and CW practitioner practice behaviors	NS	NS

Notes. NS= no statistically significant difference, SIG= statistically significant difference. X=Not included

Table 153. Summary Community Partner 1.B.2.4.-1.B.2.6. Results

Data Source	1.B.2.4. Actively Work toward racial, ethnic, and gender equity – families' access to resources and services	1.B.2.5. CW-Partner Communication and Collaboration in Case activities
Community Partner SelfSurvey	NS	NS
Adult Survivor Field Survey	NS	X
CRR	****	CO
Coaching Focus Groups		Some increase in collaboration described

Notes. NS= no statistically significant difference, SIG= statistically significant difference.

****No relevant context data
X=Not included
CO = Context only, not test of difference, also, in only collected for intervention and only 2 projects

Summary of Enhanced Cross-Organization Communication & Collaboration

Lastly, in the six cross-organization CW-Partner communication and collaboration outcomes there was more evidence of change, but it is equally important to note two considerations, (1) the comparison was "differences at different time points, and (2) the data sources used were only from the intervention groups. This is in contrast to the other two practice behavior areas that compared differences between intervention and comparison samples, and therefore used data sources with interventions and comparisons. Refer to Table 154 and Table 155 for summaries of cross-organization CW-partner results.

Table 154. Summary Cross-Organization CW-Partner 1.B.3.1.-1.B.3.3. Results

Data Source	1.B.3.1. CW-Partner COmmunication at management Level	1.B.3.2. CW-Partner COllaboration at management Level	1.B.3.3. shared principles
Centering Racial equity in collaboration survey	NS in Communication domain; SIG 2/4 Conflict Resolution items change; SIG 1/4 Cultural Humility items change	SIG overall	SIG 1/5 item • People in our collaborative group can describe ways that the project works to identify and alleviate and gender inequities.
Coaching Focus group (Intervention only)	****	****	CO: Approach language change
Key informant interviews (Intervention only)	****	CO: 1) IPV Specialist/DV advocate specific collaboration benefits (2) collaboration support by implementation and management teams and project managers	****

Notes. NS= no statistically significant difference, SIG= statistically significant difference.

****No relevant context data

X=Not included in data source

CO = Context only, not test of difference, also, in only intervention but all projects

Table 155. Summary CW-Partner 1.B.3.4-1.B.3.6. Results

Data Source	1.B.3.4. Shared frameworks (PF and RSA)	1.B.3.5. Data-driven/ community stakeholder inclusion & feedback	1.B.3.6. actively work toward racial, ethnic, and gender equity in their collaborative work together
Centering Racial equity in collaboration survey	SIG 2/4 item • Operate from a shared understanding of the RSA. • Utilize a continuum of programs and responses to hold PUV accountable.	SIG 1/4 item • The collaboration uses participatory (e.g., storytelling, practice based evidence) to gather data. Top areas of improvement: • People in our collaborative group have mechanisms in place to get regular feedback from diverse community stakeholders and the people served.	SIG 1/4 item Diverse Engagement & Inclusion; SIG 1/4 Cultural Humility items change; SIG 1/5 times Principles
Coaching Focus group (Intervention only)	CO	****	CO
Key informant interviews (Intervention only)	CO	Did not surface explicitly.	****

Notes. NS= no statistically significant difference, SIG= statistically significant difference.

****No relevant context data

X=Not included

CO = Context only, not test of difference, also, in only intervention but all projects

Application of the Service Delivery Outcomes

The expression "changing hearts and minds" was used within the QIC-DVCW to describe the Approach implementation process to engage the projects, particularly in the Approach coaching cohorts, where the most concentrated Approach dosage (i.e., transmission and incorporation of Approach principles and Frameworks) was administered, but also the training, and the implementation and management teams. The limited change in CW practice specifically between intervention and comparison groups in Approach service delivery outcomes suggests differences are needed for future implementations of innovations like this one that sought to re-design the complex systems at the intersection of DV and child welfare.

First, one consideration is the mechanism of coaching, and specifically what was provided in terms of concrete materials, such as Approach based practice profiles, and more directed content and structure to facilitate the deep discussion and application of the practice profiles/case scenarios. Early in the Approach implementation, the QIC-DVCW focused more on 'teaching people how to think critically' about the Approach, rather than 'telling people what to do'. We rejected a "checklist" mode of teaching about how to apply the Approach in practice. An alternative to this either/or that could be applied in future innovations is a both/and combination of deep engagement of individuals' hearts and minds using question-based coaching in addition to concrete, case scenario and role play based applications of concepts, utilized in coaching time

and also distributed in electronic documentation to share out with office and agency staff to increase spread of the innovation and institutionalize the desired changes. Additionally, a more explicit support and coaching to the operationalization of the Approach into practice and policies using the implementation strategies and frameworks may have served as an organizing anchor for coaching.

Second, based on adult survivors' experiences, shared in the Adult Survivor Field Survey and the Adult Survivor Interviews, child welfare practice has room to grow in their DV-informed work with adult survivors and their children. While there was evidence of helpfulness as described in the Adult Survivor Interviews, DV adult survivors relayed clear and ubiquitous examples of how their experience with child welfare was often shaped by power and control, parallel to their experiences with their harmful and violent partners. From the experience of the survivors, the child welfare systems' role in adult survivors and their children's lives continues to be shaped by beliefs around whose "safety" is prioritized (child survivor over adult survivor), and who is blamed and then held accountable for violence (adult survivors). These beliefs then result in more prescriptive and compliance-oriented engagement with families than collaborative partnering with the CW agency and/or courts being the ultimate decision maker. Although the QIC-DVCW aimed to get at the root of those beliefs and subsequent practices by developing the Approach Principles and Protective Factors for Survivors and Relational and Systemic Accountability frameworks, and then training and coaching based on those resources, barriers limiting changes at the service delivery levels remained. These results are important syphers for the fields of DV and child welfare, and require rigorous examination held in concert with the other findings from the QIC-DVCW evaluation studies.

Third, the QIC-DVCW prioritized more transformational collaboration than business as usual between organizations and systems working at the intersection of DV and child welfare and the results focused on assessing the child welfare and partner dynamic (1.B.3. Enhanced Cross-Organization Communication & Collaboration) demonstrated significant changes in collaboration domains. When contextualized within the implementation science framework of teams, which was utilized in the QIC-DVCW, these changes in collaboration provide hope to other movement building organizations who are working partnership with other organizations in a collaborative group that change is possible. We would suggest that the measurement of collaborative functioning of the Implementation and Management teams using the Centering Racial Equity in Collaboration survey, developed internally for the QIC-DVCW, is an excellent tool to focus on and create a feedback loop for collaborative groups to promote transformational collaboration that zeroes in on racial equity an integral part of the work.

CHILD OUTCOMES

At the cross-project level, across the three main child outcomes – safety, permanency, and well-being – and nested sub-outcomes, limited significant differences were observed, demonstrating limited evidence of the Approach's effectiveness in this outcome area. Summaries are organized at the main child outcome level, followed by an overall application of the child outcome results.

Child Safety

At the cross-project level, there were no significant differences between children in the comparison and intervention offices in (1) maltreatment by the person using violence and/or adult survivor or (2) exposure to DV. Project-specific results were more complex and reported fully in the project specific sections of this report. See Table 156 for cross-project summary and project specific summary.

Table 156. Summary 2.A.1. Child Safety Outcome Results

Data Source	2.A.1.1 decrease maltreatment by puv and/or AS	2.a.1.2 Decrease exposure to DV
Cross Project Site	NS	NS
Il	NS – overall; SIG - Black and not Latino/a lower in comparison and other state sites, than intervention	NS
MA	NS – overall; SIG – prior hx of maltreatment lower for comparison site	NS
AC	SIG – overall, lower in intervention; SIG – children <10yrs, lower in intervention	NS overall; SIG – neglect and DV lower in intervention

Notes. NS= no statistically significant difference, SIG= statistically significant difference.

Child Permanency

Overall, there were mixed child permanency results at the cross-project level analysis of the three permanency sub-outcomes. See Table 157. For the first permanency sub-outcome (2.A.2.1) decreased rate of foster care removals, cross-project analysis was not feasible due to data variability at the project level. Project-specific results are reported in detail in earlier sections of this report. However, overall, significant differences in rates of foster care removals were observed only in the Allegheny County project. For the second permanency sub-outcome (2.A.2.2.), at the cross-project level, there were no significant differences in increased reunification rates during the post-intervention (2019-2021). We also observed no significant differences in increased stability, the third permanency sub-outcome (2.A.2.3.).

Table 157. Summary 2.A.2. Child Permanency Outcomes Results

Data Source	2.A.2.1 DeCreased rate of foster care removals	2.a.2.2 increased reunification rate	2.A.2.3. increased stability
Cross Project Site	[no cross-project results due to data variability]	NS	NS
Il	NS	SIG (lower for comparison) overall; SIG - neglect only; SIG SIG - neglect only and (1) Black and not Latino/a or (2) Latino/a and any race (increase rate in intervention sites)	NS – overall; SIG – increase stability for children in foster care for 2 or more years in intervention sites
MA	NS	NS	NS
AC	SIG	NS	NS

Notes. NS= no statistically significant difference, SIG= statistically significant difference.

Child Well-Being

Limited change was observed in child well-being outcomes. For only one item, a QIC-DVCW-created scale to measure social emotional abilities, was a significant difference found between the intervention and comparison sample, by caseworker report. As will be described in the Evaluation Strengths and Limitations, these results should be considered in the light of measurement and sampling constraints.

Table 158. Summary 2.A.3. Child Well-being Outcomes Results

Data Source	2.A.3.1. Increase in emotional and social development and physical health	2.a.3.1. Increase supportive relationships with specific individuals
Family Survey	SIG - 1/10 items social emotional abilities, NS -4 items on overall development/health	NS
Adult survivor field Survey	NS	X

Notes. NS= no statistically significant difference, SIG= statistically significant difference. X=Not included

Adult Survivor Outcomes

The adult survivor outcome results require further discussion. The results indicate limited, if any, statistically significant differences between the intervention and comparison groups. For a summary of adult survivor safety and stability results by data source see Table 159. For a summary of adult survivor well-being by data source see Table 160.

Table 159. Summary Adult Survivor Safety & Stability Outcome Results

Data Source	2.B.1.1. Decreased DV-related Risk Level b/t AS & PUV	2.B.1.2. Decreased Abuse of AS, including use of children & systems	2.B.1.3. Increased Stability	2.b.1.4. increase empowerment related to safety
Family Survey	NS	NS, decreased for I and C	SIG 1/4 items (higher on average for intervention) • "AS identifies strategies to counter the negative impact of domestic violence on their children" NS other three items	X
Adult Survivor Field Survey	X	NS	• SIG in current living situation (less stable for intervention) • NS in (1) number of moves, (2) school enrollment or paid employment, (3) essential expenses not being met, and (4) relationship with PUV	SIG (lower for intervention)

Notes. NS= no statistically significant difference, SIG= statistically significant difference. X=Not included

Table 160. Summary Adult Survivor Well-being Outcome Results

Data Source	2.B.2.1. Increased social, cultural & Spiritual connections	2.B.2.2. Increased resilience & growth mindset	2.B.2.3. INCREASED SOCIAL & emotional abilities	2.B.2.4. Increased nurturing parent & child interactions	2.B.2.5. Decrease trauma Symptoms & depression
Family Survey	NS	SIG, 3/5 items (higher on average for intervention) • "AS expresses confidence that they can achieve positive goals." • "AS recognizes tough or bad situations as temporary." • "AS perseveres even when they encounter challenges."	SIG, 1/3 items (higher on average for intervention) • "AS has told their children that the PUV is responsible for the violence– it is nobody else's fault"	X	X
Adult Survivor Field Survey	NS (one item)	SIG (lower rating for intervention)	X	NS	Trauma: SIG (invention higher) Depression: NS

Notes. NS= no statistically significant difference, SIG= statistically significant difference, X=Not included

First, when we examine the adult survivor results summaries by informant type, we observe that there are slight differences in the caseworkers' report (in the Family Survey) and the adult survivors' report (in the ASFS) on the same outcomes. However, in some regards the overall findings are similar in the scale and scope of the differences between intervention and comparison groups. That being said, one standout data source difference was that in the ASFS, the only statistically significant differences did not favor the adult survivors in the intervention offices. This included that adult survivor participants in the intervention offices were:

- less likely in their current living situation to rent or own (stability),
- less likely to rate themselves as having empowering beliefs about oneself, including resilience and growth mindset items (resilience & growth mindset), and
- more likely to rate higher, meaning more severe, trauma symptoms in number and frequency.

In the caseworkers' report (in the Family Survey), statistically significant findings were observed in several of the key Protective Factor measures (QIC-DVCW-created), including increased resilience and growth mindset and social & emotional abilities.

Understanding the difference between the informants is important because positionality plays a role within the dynamic of framing the experience of adult survivors within the child welfare system. The purpose of triangulating the data for the adult survivor outcomes was in part to put these different positionalities into conversation, as they are in the real-life experience of adult survivors. It was not to cross-check or doubt the unique perspectives of the informants. Instead, the different informant perspectives give a nuanced prism standpoint into these adult survivor outcomes.

Persons Using Violence Outcomes

As previously described, due to the lack of completed surveys by persons using violence (PUV), there was no data to measure most of the PUV outcomes. See Table 161 to see a summary of the PUV results by data source. Analysis of available data (Family Survey and ASFS, not from the PUVs as informants) for the two sub-research questions showed no statistically significant differences over time between intervention and comparison groups. Both were under 2.C.2. PUV positive beliefs, attitudinal, & behavioral change:

- 2.C.2.1: increase demonstration of motivation to change; and
- 2.C.2.3: increase nurturing parent and child interactions.

The loss of almost the entire PUV outcome category was major and will be discussed in detail in the forthcoming Study Strengths & Limitations and Implications sections. It is why we chose to include the Strong Fathers Focus Group data to provide context to the outcome constructs. With this approach in mind, we did hear descriptions of fathers' perspectives and experiences related to the PUV outcomes, if very limited by number of participants and focus groups, only in intervention office and only at one Project. Based on the lack of PUV Survey participation at the time we designed the Strong Father Focus groups, we anticipated that the focus groups might be our only PUV voice data source.

It should be noted, as it is in Methods, that we purposefully asked the adult survivor about their perception of the PUV outcomes, informed both by the literature about trusting survivors' descriptions and to triangulate data with other study sources.

Table 161. PUV Results Summary by Data Source

Data Source	2.C.1. PUV blaming adult survivor and justification for violence		2.C.2. PUV positive beliefs, attitudinal, & behavioral change			2.C.3. PUV increase well-being & supports	
	2.C.1.1 Increase understanding of the impact of DV on adult and child survivors	2.C.1.2. Decrease blaming adult survivor and justification for violence	2.C.2.1: Increase demonstration of motivation to change	2.C.2.2: Increase understanding of healthy relationships,	2.C.2.3: Increase nurturing parent and child interactions	2.C.3. PUV increase well-being & supports	2.C.3.1: Decrease trauma symptoms, depression, anxiety, and stress
PUV Survey	**	**	**	**	**	**	**
Family Survey	X	X	NS	X	X	X	X
ASFS	X	X	X	X	NS	X	X
Strong Fathers	CO	****	****	CO	CO	CO	****

Notes. NS= no statistically significant difference, SIG= statistically significant difference

**Intended to measure with this survey. No data, see Methods PUV Survey

****No relevant context data

X=Not included

CO = Context only, not test of difference, also, in only intervention, and only one project site

COST STUDY

The research question of the Cost Study was: **What are the costs associated with the implementation and maintenance of an adult and child survivor-centered approach, and how do these costs compare to the costs of "practice as usual"?**

The simple bottom line when examining the results of the cost study is that overall it was only slightly less costly to implement the Approach than conducting "business as usual." In other words, it did not cost child welfare agencies more money per family to implement the Approach than it did to conduct business as usual. This is encouraging news for this one aspect of implementation feasibility for the Approach.

In addition, the cost study provided insight into where the cost is highest, which is staffing. One implication from this cost study is that given that so much of the cost in both sites is going to their staffing (their human capital) it makes a good case that what CW agencies want to do is make sure their staff are responsive, reflective thinkers. Staff (i.e., labor) is driving the system and its outcomes. Moving forward, there are several uses of the BAT data. Examples of how the data can be used by the QIC-DVCW and locales are described below.

Monitoring Agency Operations

Cost metrics from the BAT can be used to monitor child welfare agency operations and spending; specifically, the data indicate which cost categories (e.g., labor, training, supplies) have the highest and lowest spending levels. The following metrics are calculated automatically in the summary tab of the BAT and can provide useful information:

- **Average total cost per family** can be compared across sites implementing the Approach within a locale to determine differences in average total cost per family. Cost comparisons can also be made across locales and across points in time to better understand how costs to serve each family vary based on geographical area and timeframe.
- **Total operational costs and allocation of costs across cost categories** can be examined to determine which cost categories make up the largest share of costs. For example, agencies can examine the costs that take up a larger total portion of overall costs to identify which specific cost categories drive overall expenditures, then examine specific cost entries within those categories along with service area context to understand contributing cost drivers. Additionally, agencies can track cost categories over time to identify shifts in how resources are allocated. For instance, for locales fully implementing the Approach, it might be expected that the percentage of consumable and non-consumable costs increase as a result of redistribution or rethinking of resources available to support families.
- **Allocation of total salary and personnel (i.e., labor) costs** are reported in the summary tab of the BAT. Looking at this metric across key child welfare service activities can help identify which activities have the highest and lowest percentage of labor costs allocated to them. Agencies can use this information to assess the extent to which total costs are supporting core activities of the Approach, such as collaboration with partners.

Developing Comprehensive Budgets for Sustainability or Expansion

The operational cost estimates can be used for budgeting future program activities. They may be especially useful if agencies are planning to serve more families in other service areas. The average cost per family served that is calculated from the BAT data can be used to estimate the number of families that can feasibly be served with a given budget. The cost information generated would be most generalizable for sites within the same jurisdiction, since local costs and context has a strong influence on operational costs. It can also

help locales develop more precise budgets and funding requests to continue implementing the Approach.

Conducting an Economic Evaluation of the Approach

Metrics from the BAT can be used to analyze how operational costs to support implementation of the Approach compare with benefits; to estimate the return on investment for this type of practice and systems change effort. To conduct this type of analysis, cost data from the BAT should be combined with data on outputs and outcomes from a rigorous evaluation of the Approach. Sum the economic gains from all evaluation outcomes to obtain an estimate of the total economic benefit of the Approach. It is important that return on investment is conducted only when an evaluation design includes a comparison group or some other method of controlling for confounding factors that may limit causal interpretation of cost estimates. Without any methods controlling for confounding factors, evaluation estimates represent correlation between the Approach and outcomes, not causal effects needed for return-on-investment analysis. This process can provide a better understanding of the economic benefits associated with individual and collective outcomes of implementing the Approach within a child welfare agency.

SECTION 11. EVALUATION STRENGTHS & LIMITATIONS

EVALUATION STRENGTHS

Project Collaboration & Data Sharing

The use of original data collection and administrative data both required active partnership with the Projects. Project managers and data specialists within the Illinois Department of Children & Family Services, Massachusetts Department of Children & Families, and Allegheny County Office of Children, Youth, & Families, along with Pennsylvania Department of Human Services, worked over the life of the project to support the evaluation efforts in numerous ways. This included liaising between the Evaluation Team and the appropriate state or local staff person, assisting in the execution of multiple data sharing agreements, and promoting buy-in at the staff/participant level and at the administrative level.

Design and Methods Overall

The QIC-DVCW evaluation design and methods overall exhibited several important strengths. First, the most rigorous design possible was executed, using comparison and intervention groups, across multiple time points over a two-year period (see Section 2 for details). Second, the three studies – outcome, implementation, and cost – contributed an examination of not only if change occurred and for whom, but also the implementation mechanisms and the cost associated. Third, the mixed-method approach and multiple data collection methods that included surveys, interviews, focus groups, case record reviews, administrative data, process, and implementation tracking, provided a rich variety of data to tell a more complex data story. Fourth, the multi-informant approach, including caseworkers, supervisors, DV advocates, adult survivors, persons who use violence, community partners, and Project Implementation and Management teams, facilitated the integration of diverse perspectives used to test the Approach and more deeply understand the experience of survivors of domestic violence in child welfare. Fifth, overall, we had sufficient sample sizes for almost all of the targeted analyses.

Spotlighted Safety & Trauma-Informed Practices

We prioritized safety and trauma-informed research practices throughout the process of creating and implementing ways to include adult survivors' perspectives in the QIC-DVCW evaluation and used that same prism in decision making about how to initiate contact with people that use violence. As described in the Methods section, the safety protocol included the development and administration of the Release of Information step for contacting adult survivors to initiate the invitation to participate in the Adult Survivor Field Survey and Adult Survivor Interviews. We credit this specific safety step at the request of one of the Project managers. In addition, trauma-informed practices were woven throughout the survey protocols, with the intention to decrease any distress caused by the number and intensity of the questions. For example, text like the following was written into the survey to ensure that interviewers were attending to the well-being of participants at specific points in the interview:

> *I am so sorry you had to experience that. Thank you for taking the time and effort to go through those very personal questions. I know this is a difficult series of questions and I can imagine that this may bring up many different feelings. Please remember that you can choose to skip any question you do not want to answer. Before we continue, I wanted to check in with you. The next part of the interview is about other types of threatening or harmful behavior you may have experienced during the last six months. I want to mention again that you only need to share what you are comfortable with, and you can pause, skip a question, or*

end the interview at any time. How do you feel about continuing?

We also intentionally ordered the flow of the survey items with decreasing stressful impact, ending with a section with more future-oriented, hopeful items. Additionally, as part of their participation in the Field Survey, adult survivors were asked if the Evaluation Team could contact their partners (or former partners) to recruit for the Person Using Violence Survey.

Prioritized Partner Level Collective Process & Decision Making

We also prioritized the collective process in evaluation planning, development, and administration. This priority threaded through the implementation, outcome, and cost study. The QIC-DVCW organizational partners, with the Evaluation Team facilitating the process, worked to co-develop each of the 19 data sources and tools used to measure change and to describe experiences. This included development of constructs, survey items, response categories, interview guides, data collection protocol, and interviewer training. Successes included the development and use of new conceptual and multi-dimensional Centering Racial Equity in Collaboration Survey, along with the adaptation of many of NIRNs AIF tools used as part of the implementation and service delivery outcome surveys.

EVALUATION LIMITATIONS

Time and Covid–19 Limitations

Multiple time and Covid-19 factors limited the three studies. First, the initial Approach training for Projects ran from February-May 2019 (MA February/March 2019, IL March/April 2019, AC May 2019). From an intervention timeframe standpoint, the window of data collection was less than three years, with some data collection ending after two years, per the commitment made to the Projects. When observing change over time, a two - three year window for such an intervention is quite limited. Second, Covid-19 restrictions impacted the evaluation mechanisms overall by slowing things down and influencing Projects' priorities, as well as in specific ways, as was described in the Methods section by data source.

Sample & Uptake of Research Participation Limitations

Overall, sample-related limitations impacted most of the data collection efforts across all the data sources where human subjects were invited to participate. For the purposes of this report, examples of sample related limitations are provided because a full accounting per data source is prohibitive. For example, for the Self-Survey (designed to be a four time-point administration) attrition was severe by Time 4. This resulted in limiting the planned analysis strategy for the Self-Survey. Another example was the Fidelity Checklist completion rate. The target for completion was never met for any of the Projects. This means that we are limited by what can be reported on fidelity to the Approach, at the project and cross-project levels.

In addition, the lack of a consistent, reliable identification of DV in system data across the projects created many sample-related challenges. For example, in the Family Survey sampling frame, the projects provided DV cases as directed. However, when caseworkers were sent a Family Survey with one of those DV cases, more than half responded it did not meet the study's DV definition. Along with these "not-DV" case responses, the Family Survey response rate was very low. This also meant that the original sampling frame for the Adult Survivor Field Survey (ASFS) had to change, because a low Family Survey response rate meant fewer caseworkers were talking to the identified adult survivor about their interest in participating in the ASFS. After months of low numbers of completed Adult Survivor Field Survey Releases of Information from caseworkers, a pivot was made to de-couple the Family Survey and ASFS samples, in order to salvage the latter. This also required dropping inclusion criteria, such as sampling only families who had been

engaged after Approach implementation. This means that adult survivor participants were reporting on their experience during the Approach implementation (as the surveys intended), but their overall lived experience with child welfare may have begun beforehand.

Lastly, noting the sampling differences between the Family Survey and ASFS is important. While selection bias is present in both, there are distinctions that may be relevant. The Family Survey sampling frame was administrative data with cases flagged as involving DV, and then cases were randomly selected, and a case specific survey emailed to case workers. We cannot know why certain caseworkers completed the Family Survey (at the first and/or second time point) in some cases and not others. For the ASFS, the sampling frame changed over the life of the data collection, but it generally was adult survivors in the intervention and comparison offices who (1) were told – by a caseworker or DV advocate/IPV specialist – about the study, and (2) completed the Release of Information. There was no randomization, no control for bias in the subsequent sample. It may partially explain why a larger percentage of adult survivor participants were from the intervention offices, assuming that direct line staff members the intervention offices may have been more invested in introducing the study to adult survivors. However, this explanation is conjecture.

Measurement Limitations

The primary use of new and untested measures for outcomes directly limited what was usable. Out of all surveys used across the project, only one in two cases, both in the Adult Survivor Field Survey, were tested scales used to measure two constructs. One measurement limitation was low correlation/reliability across item constructs. For example, within some developed measures there was low correlation/reliability across items, and we were unable to construct a composite score as a result. In the Family Survey specifically, there were several important measurement limitations. Large standard errors are present which limit precision of detecting differences between groups. Methodological choices, such as use of scales that have not been validated and normed to the population, planned missingness with a small sample and use of a slider scale may have contributed to a lack of findings between intervention and comparison groups. In addition, in the Family Survey, the measure/definition of DV that served as an inclusion criterion for survey completion may have been too narrow, causing a loss of cases and therefore impacting the sample.

Cost Study Limitations

The cost study findings should be interpreted in the context of the following limitations:

The BAT captures costs for a 12-month period. The cost study reflects the costs of implementing child welfare services for a specific timeframe, July 1, 2020 – June 30, 2021, when intervention sites were in full implementation. Therefore, the data presented do not include start-up and initial training costs, which would drive up the total operational cost for the intervention sites.

The data provides an average cost per family. The BAT generates an average cost per family type for intervention and comparison sites. However, child welfare agencies interested in understanding the variation in costs across cases may benefit from conducting a more rigorous and precise case-level cost analysis to understand more precise costs for serving a family (James Bell Associates, 2017). A case-level cost analysis can help locales to better understand the variation in service costs based on demographic characteristics of families and staff.

Limited sample size. While the cost study findings show potential cost efficiencies for the sites implementing the Approach, the study only reflects costs incurred for two Projects. More observations across additional locales would help identify trends to generalize cost utilization patterns for other child welfare jurisdictions.

Further interpretations of return on investment or benefit-cost require linkages to outcome data. While this information can be helpful for budgeting and planning purposes, cost savings

cannot be directly linked to the Approach without assigning a monetary value to outcomes that have been shown in a rigorous evaluation to be attributed to the intervention.

Changes to service delivery due to Covid-19. The cost study reporting timeframe covers a period where the impact of the pandemic on service delivery may have changed how child welfare case management in general was implemented. Therefore, costs and service outputs reported for this period may not reflect those expected when the Approach or practice as usual is implemented as intended. For instance, both MA and Allegheny County, PA indicated that travel costs may be lower than typical years due to shift to virtual meetings and service delivery aligning with Covid-19 Protection Protocols.

SECTION 12. IMPLICATIONS FOR FUTURE WORK

People experiencing DV who become involved in child welfare want real help, yet too often the help they ask for is not forthcoming. In a groundbreaking conversation between survivors of color who are or have been involved in child welfare and national policymakers contemporaneous with the QIC-DVCW, survivors shared story after story of unhelpful or harmful interventions by the child welfare system. Our own interviews of adult survivors found that survivors of DV do not find child welfare to be helpful in accessing services or resources, nor in holding their abusive partner accountable for the harm they have caused. Only 42% described some positive interactions with a caseworker and almost all described negative interactions.

Too often, the child welfare response to domestic violence (DV) establishes a fixed menu for responding to adult survivor needs that includes DV services, therapy, parenting classes, shelter, and sometimes a safety plan, with an emphasis on calling the police when an assault occurs and on obtaining a restraining order as a mechanism for safety. Any one of these options may be useful to a specific survivor, and collectively they may represent child welfare's *desire* to promote safety. However, this set menu for addressing survivor needs does not offer the most helpful, meaningful, safety-focused, or trauma-informed response when DV and child maltreatment co-exist in a family. For example, it is well documented that obtaining a restraining order can heighten risk, threat of harm, and retaliation to survivors.

The widely accepted conceptual framework for child protection – managing incidents of violence, child maltreatment, and risk of future harm – bifurcates the adults and children involved into categories of perpetrators and victims, thereby boxing solutions into limited pathways. This does not sufficiently account for the variation of DV *impacts* on survivor well-being and health, the rich and complex history of families' lives (individually and together) that has a direct influence on their behaviors and propensity for change, survivors' capacities and resilience, the root causes of violence, or systemic biases that contribute to disparities in outcomes by race, gender, and economic burden. Moreover, this framework will almost certainly yield the same dynamic of engagement and results – parents required to participate in services they may or may not find useful, children removed from the care of their parents and families, and people who use violence remaining unengaged or not held accountable for their actions. For adult survivors, this unfortunately means they are held responsible for violence perpetrated against them. For child welfare caseworkers, this framework too frequently leaves them with an over- or under-estimation of the potential for on-going harm to children.

In child welfare practice and decision-making, the Approach, now known as Bridges to Better, offers a foundational view of adult and child survivors' safety and well-being as inextricably linked, and centers adult survivors' resilience, strategies for coping, and often misunderstood or unseen efforts to keep themselves and their children safe. It compels us to find new ways to work in partnership with survivors; offers a framework and strategies for engaging people who use violence, holding them accountable, and supporting them to change; and obliges systems and community organizations to do much more to promote and sustain protective factors to complement and amplify survivor efforts.

Bridges to Better represents bold action to drive systems change across the DV landscape. The approach is based on more than 30 years of practice wisdom, lifts up survivor voices, and includes what we know from DV-specific research and implementation science. The QIC-DVCW attempted to shift DV related practice behaviors, program and intervention design and delivery, and local policy through direct cross-agency training of staff, monthly coaching of supervisors and their managers, intentional and responsive technical assistance, and by establishing collaborative Implementation Teams comprised of leaders and stakeholders from child welfare, the courts, and the DV service community. We imagined that

in this way, practice and policy changes could be codified, championed, and integrated into institutional ways of working. Throughout the initiative, Project teams worked in partnership locally and across the three states to make race and gender biases more visible and actionable, build research- and practice-based protective factors, acknowledge that what creates safety for one survivor may increase risk for another, engage in different kinds of helping relationships with people who use violence, and differentiate responses based on unique circumstances of each family.

This section explicates practice, policy, and research implications from the study and the lessons learned from FUTURES' experience overseeing the implementation via the QIC-DVCW. As such it builds on participant know how, priorities, and transformations from different points of view and offers actionable insights about potential pathways forward from the incredible work of the last five years.

CENTER LIVED EXPERIENCE OF SURVIVORS OF FAMILY VIOLENCE TO ADDRESS ADULT SURVIVOR WELL-BEING, DESIGN MEANINGFUL AND RELEVANT ACTION PLANS, AND ASSESS EFFORTS TO ELIMINATE DYNAMICS OF DV.

Child welfare practice is highly organized around monitoring and managing risk to children's safety in relation to maltreatment and violence exposure. In the context of domestic violence this limited point of view about a young person's status in the family pits their well-being against the well-being of their non-abusing parent, often the mother. Consequently, non-abusing mothers in DV-impacted families are often held accountable for the actions of the person using violence and the impact of those actions on her children, often with little to no consideration of the impact of that same violence on her own well-being. Results from this study about the well-being of adult survivors bore this out. Adult survivors served during the study period offered compelling testimony about their experiences with child welfare professionals, and specifically to this dynamic in particular.

Findings from the Implementation Study demonstrate that although child welfare staff found the Approach suitable to their work with DV-impacted families and of value *conceptually*, it proved more difficult to operationalize and was not highly feasible. Yet throughout the study period, there was uptake of the approach to practice and positive findings with respect to the adoption of both the protective factors (now Pathways to Healing) and relational and systemic accountability (now Pathways to Accountability) framework into practice with DV-impacted families.

There are opportunities inherent in this knowledge to better address adult survivor well-being, strengthen the output of meaningful and relevant action plans and service referrals, and reduce burden on the non-abusing parent by placing accountability for harmful behaviors on the person using violence in the home. Involving survivors of domestic violence, particularly those who are most harmed by the design of the current system – Black, Native American, Alaskan Native and Latina/o survivors – in co-design of practice and policy and research is a viable step towards these actionable goals. Seeking and then making change based on meaningful and continuous input and feedback from people with lived experience of the system and the community providers who serve them should produce significantly better experiences and outcomes (Office on Child Abuse and Neglect, Children's Bureau, 2021/2022).

Adult survivors illuminated in their own words the potential for change that is possible by supporting them as 'impact experts' and leaders, using an intersectional lens. What's more, results from the collaboration survey showed that it is possible for professionals serving families impacted by both DV and child welfare to collaborate in a transformative way across sectors to shift away from 'business as usual' in service of more equitable and positive outcomes for children and their families. Ensuring that such partnerships

address power differentials, co-designing with those most impacted by the system, and sharing responsibility and resources for supporting families can help resolve tensions that different perspectives can generate when the stakes are high and the context of service is crisis-driven and trauma-saturated.

In conducting research, listening to people with lived experience requires attention to safety and facilitating their access to the research process. Developing new ways to include people with lived experience throughout the evaluation, from design to administration to analysis of results, similarly needs a holistic approach that includes sharing information and power, providing support, and acting on what survivors of the system bring to the table. Piloting the Adult Survivor Field Survey with a select group of adult survivors was a valuable strategy, as they shaped the survey protocol and the survey itself. Expanding efforts to center people's lived experience can only improve the meaningfulness and accuracy of evidence building in any demonstration project.

EMPOWER AND EMBOLDEN MIDDLE MANAGEMENT AND FRONTLINE STAFF AS LEADERS.

Rather than enacting more bureaucratic reforms, bold and visionary leaders can challenge 'business as usual' practices that have far too often failed to result in positive outcomes for children and families. Adult and child survivors of domestic violence and child maltreatment need leaders at the highest levels to understand their complex and multi-dimensional safety and well-being needs. Survivors require support from all state actors working together rather than remaining in silos. Using 21st century science and survivor-informed knowledge, leaders and policymakers can create safer and healthier families and communities by lessening the burdens that lead to stress in families (Weiner, et al., 2021). Relevant services and supports to reduce burdens and stress include investing in income and employment supports, public transportation, affordable housing, flexible childcare, education support, and mental health and wellness initiatives.

Throughout the initiative and particularly during the initial Covid-19 responses, QIC-DVCW program staff heard repeatedly from frontline and middle management that having more trust and freedom to make decisions based on their local and ground level view was not only critical to creative problem solving, but also important to more efficient relief of burden and stress to impacted families. This sentiment was also reflected by adult survivors and people who use violence. Many described caseworkers as consistently needing to check "up the chain of command," rather than make decisions in real time relevant to their pressing circumstances and needs.

At a local level, community leaders are critical and often under-valued drivers of systems change that actually works for the community. Their organizations and agencies can be incubators for innovation and their constituencies can provide critical data on what constitutes transformative help. These community leaders are well-positioned to guide the development of new, flexible pathways to safety and well-being for the survivors and families they serve, without the implicit threat of removal that comes with child welfare involvement. In hindsight, QIC-DVCW Project managers felt that community leaders could and should have played a larger role in the demonstrations – for example, in figuring out how to apply protective factors in practice, which could have then informed their adoption or adaptation in child welfare.

In future demonstration projects, child welfare leaders can amplify the leadership of community organizations who are connected to families and familiar with a community's resilience and challenges. Ingredients for success relative to amplifying community leadership involved use of clear and concrete strategies to position and support community leaders as project leaders – for example in funding applications, decision making, project design, resource allocation, communication planning, evaluation design, and so on. In addition, providing logistical and administrative support to smaller community-

connected organizations that may lack or need to develop their infrastructure to lead a project is also another tried and tested strategy for enabling and empowering community leadership.

KEEP EQUITY IN FOCUS

The murder of George Floyd in May 2020 galvanized the nation, and lent an urgency in QIC-DVCW coaching cohorts to tackling the figurative "choke holds" of the child welfare system on survivors and families of color. Supervisors in some coaching cohorts used the space to build their capacity for equity-focused reflective supervision through skill building and mock supervision on live case examples. Managers had difficult and authentic conversations about their own complicity with white supremacy culture and committed to take action. Project teams created new partnerships to advance learning and action plans. In these efforts, participants began or deepened conversations about the connections between child welfare and law enforcement, the root causes of race- and gender-based violence and the responsibility of publicly funded systems to eliminate disproportionality in child welfare, courts, and other systems.

Establishing clear racial equity goals is critical to any child welfare initiative, given the racial disparities and disproportionality that exist within the system. Examples of goals from QIC-DVCW Projects included increasing engagement of Black fathers and strengthening cross-agency leadership and capacity to apply an equity lens in practice, policy design, contracting, and administration. Over time, Project Implementation Teams evolved their thinking about what "collaboration" means, influenced by their use of the Centering Racial Equity in Collaboration Survey. This tool, developed by Latinos United for Peace and Equity, the University of Kansas School of Social Welfare and Futures Without Violence, measures constructs related to the collaboration domains, including resource sharing, dismantling structural oppression, cultural humility, and communication among partners. Significant improvements were observed in implementation team practices related to collaboration and racial equity in the following areas:

- people could describe ways the project worked to identify and alleviate race and gender equity,
- collaboration at the management level,
- team use of participatory methods for data gathering (storytelling, practice-based evidence, etc.), and
- teams had mechanisms in place to gather feedback from diverse community stakeholders and people served.

Other collaborative initiatives seeking to advance racial equity can benefit from using this survey and building evidence for its validity.

DV programs and coalitions, child welfare leaders at all levels, and many others have roles to play and a responsibility to re-design policies and practices that maintain or exacerbate racial and gender disparities in families' experiences, access to services and resources, and outcomes. These efforts must be informed by people with lived experience of the child welfare system, and include data-driven conversations about structural, institutional, and interpersonal biases experienced by those individuals and their families. Establishing measurable goals and action plans to both redress harm and prevent additional harm within or across partnering agencies and systems, and a commitment to continuous quality improvement are critical.

ESTABLISH INNOVATION AS A HABIT OF MIND AND CREATE SUSTAINABLE INFRASTRUCTURE FOR ITS ONGOING APPLICATION IN PRACTICE

Too often, evidence-building is less about creating long lasting, positive impacts for families and instead limited to "proving" something discrete in service of growth and spread often exacerbating or perpetuating the bureaucracy of child welfare and other systems. Efforts to secure expanded funding are focused on creating economies of

scale as opposed to ensuring a social return on investment for impacted people. Establishing a culture that fosters curiosity and values and supports innovation alongside continuous quality improvement commitments may lead to entirely new and successful ways of working, increased job satisfaction for professionals, breakthrough thinking and service design, and improved outcomes for survivors and families.

The Covid-19 public health crisis created an urgent need and a new spirit of experimentation that rapidly transformed some of the old ways of working in child welfare, courts and in DV programs. Rapid mobilization, shifts in practice, flexibility in policy, and other responses to Covid-19 demonstrated that the *system* has the capacity to change and adapt quickly, and many of the innovations developed by QIC-DVCW Project sites can be carried forward in service of increasing families' access to help, improving family engagement, and focusing on children's needs. Innovations to learn from enacted across the QIC-DVCW Project sites include but are not limited to:

- Child welfare agencies and domestic violence programs both shifted their work with families to address overall family stressors and the burdens of Covid-19. They delivered food, Personal Protective Equipment (PPE), and information about concrete community resources to people's homes. They also found avenues to expand access to technology, asked families directly what their needs were, and shared strategies for fun projects and activities to promote family well-being.
- Child welfare, courts, and DV programs began delivering services over videoconferencing platforms, increasing access to family meetings, court hearings, support groups, and intimate partner abuse programs. Because they recognized that it was not always possible to know who was in the home, professionals also began using new strategies like holding a card up to the screen with critical safety questions: "Can you talk privately?" "Do you want me to call your brother and ask him to drop by?" They also greatly expanded their use of text messaging and virtual strategies to check in with isolated family members to offer support.
- Staff of agencies connected with families in non-traditional spaces and ways that expanded their reach and impact on well-being. Child welfare workers went for walks with survivors, DV advocates wearing purple scarves connected with survivors in grocery aisles, and culturally specific organizations began offering homework help for children and youth to provide emotional as well as academic support.
- Programs for people who use violence spent significantly more group time focused on helping virtual participants with emotional regulation strategies, lessening the likelihood of violence.
- Overall, professionals became more dependent on, and tapped into, natural support systems of families in the system. Family members were the most likely to see the children and adults in the home, and many worked in partnership with child welfare and DV advocates to reduce stressors and provide a safety valve where violence might otherwise occur.

Survivors of domestic violence are in the best position to provide feedback on how these practice and policy shifts impacted their safety and well-being during Covid-19, and other shifts that can be helpful to them. Additional, critical information may be available from the children and youth who lived in homes with domestic violence during Covid-19 – including what/who helped them to feel and be safe, what resources they needed, and what/who they think helped their family the most.

CENTER THE POWER OF LANGUAGE AND RELATIONSHIPS

Small and significant changes occurred rapidly with the span of the QIC-DVCW, including the rejection of the use of language such as "batterer" or "perpetrator" in favor of the behaviorally focused "person using violence." "Victims" of domestic violence were referred to as "survivors" or "persons with lived experience of violence." Community partners and staff of systems in all three QIC-DVCW demonstration projects adopted this language early and enthusiastically, and provided feedback throughout implementation that the shift in language was powerful and opened space for new ways of thinking about families. Coaching focus group results reflected the impacts of shifting toward more person-centered language on their and their staff's mindsets or mental models as study participants noted changes in their orientation to people who use violence in particular. Shifting language may be a powerful initial/prerequisite step to changing underlying concepts and theories that can result in additional changes in practice.

Child welfare is not the answer to all risk or danger within families. We know from the adult survivors who shared their experiences that involvement in the child welfare system often creates additional risk, harm and long-term devastating results. Listening and learning from adult survivors' lived experiences must be taken up as the norm in practice if we are truly committed to improving the lives and well-being of children and youth impacted by violence. In addition, simple yet powerful questions, asked regularly with collaborating partners, can generate new ideas about how to help families, and who is best positioned to provide that help. Examples include:

- What are we actually dealing with? (risk, danger, bias, dominant points of view, lack of information?)
- What resources does the family say they need to provide for their children and reach their goals? What do they want to see happen?
- What is the impact we're trying to have, collectively? Who does the family want to see take the lead?
- What principles or values underlie or guide this decision?

Asking families and each other questions from a place of curiosity, seeking shared understanding and clarity about the issues at hand, and committing to meeting the real needs of survivors and families can help to avoid case drift and longer-than-necessary involvement in the system.

GO SLOW, BE INTENTIONAL, AND EXPECT AND ENGAGE PIVOTS, TO STEWARD TRULY TRANSFORMATIONAL SYSTEMS CHANGE

Be intentional and consistent about the iterative process of setting shared expectations as collaborative partners (at all levels) conducting a demonstration project. Setting shared expectations should span the entirety of the project's work and scope. Without the mechanism of shared expectations, critical decisions made during planning and implementation can derail processes and timelines. This is particularly important for alignment of principles for the Project overall and the evaluation specifically. For example, the QIC-DVCW project was designed initially as a quasi-experimental research design, which can come with assumed measurement expectations. However, after repeated challenges it became clear that the QIC-DVCW principles drove the evaluation to use a more participatory action research approach in all evaluation related efforts, including developing project-specific measures. At a minimum, demonstration project partners can consider whether a project will use standardized measures at the onset of the project, and establish norms and processes of how decisions are made with regards to the evaluation in line with the philosophical and practice values of the project. Practically speaking, if surveys will be project-developed, plan for that labor to take place earlier in the project, maximizing the time limited grant period, and factor in the additional analytical work in the data analysis phase of the project and the

potential loss of data due to measurement related issues.

The QIC-DVCW used Active Implementation Frameworks (AIF) of the National Implementation Resource Center (NIRN). Use of implementation frameworks is helpful to move through defined phases of work and develop or adapt tools to understand and advance progress. However, many professionals involved in the QIC-DVCW as participants on Project Implementation Teams, as providers of technical assistance, or in a project management capacity were unfamiliar with implementation science (IS) as a field and the specific elements and purpose of AIFs. While the QIC-DVCW produced resources and supporting materials to assist Projects to learn new vocabulary and skills at using the data provided each month by the Evaluation Team, the full utility of the implementation frameworks was not realized. For example, during key informant interviews no participant mentioned implementation science as an important facilitator of implementation. Using implementation frameworks effectively may require substantial time, active participation by implementation science experts and practical examples to develop shared language and shared commitment at the beginning of a project.

CONCLUSION

Staff of child welfare systems have the ability to provide real help – effective engagement of an abusive partner and services/supports for them to change; educational or community advocacy for children and youth who are struggling with the impacts of violence; provision of resources to meet concrete needs of survivors, like housing and childcare, that survivors might otherwise need from their abusive partner, and so on. Their ability to do so depends largely on the alignment of goals and mutuality of their relationships with community partners and courts, so investing in authentic collaboration is critical. However, the child welfare system was created to address the symptom of child maltreatment before we had a systematic understanding of the root causes of violence and before we could, in science, unpack the causal mechanisms inside the black box of child and human development. We know more now than we ever have that children can and do heal from trauma, as well as what types of relationships, experiences, and conditions are necessary for their positive growth and development over their life course. We therefore have an opportunity to draw from and build on our bold actions in this demonstration project to build systems that address trauma, repair past harm, and promote healing – on purpose and by design.

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