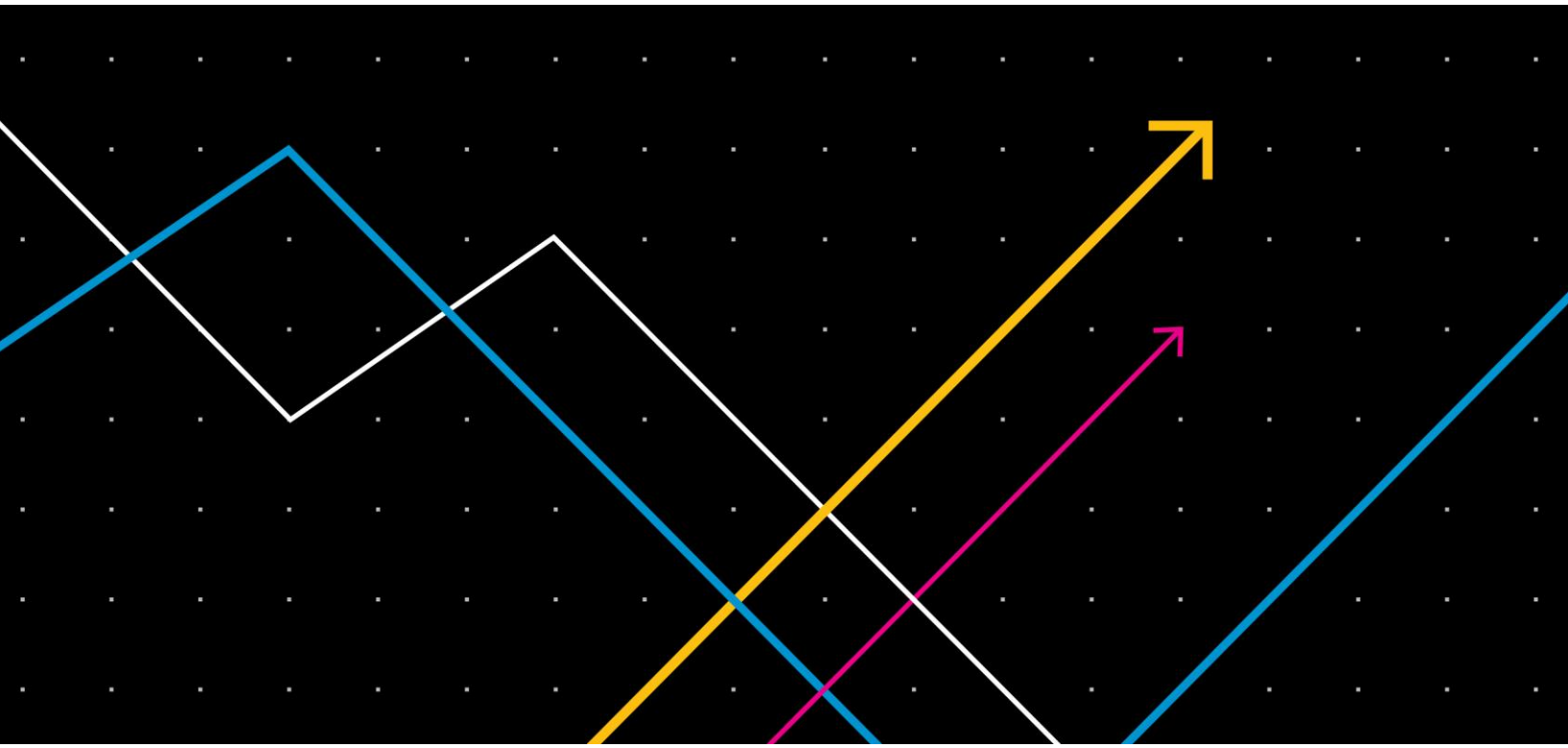

RESEARCH REPORT

FamilySafe Project Evaluation

Implementation and Outcomes of Family-Focused Counseling for Survivors of Gender-Based Violence

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Executive Summary

The FamilySafe Project (FSP) provides family-focused counseling and other services to survivors of gender-based violence and their children in New York City. The FSP is implemented by Sanctuary for Families (Sanctuary) and STEPS to End Family Violence (STEPS). The Urban Institute, in partnership with researchers Meredith Dank and Andrea Hughes, conducted an evaluation of the FSP from March 2019 to September 2022. The mixed-methods evaluation examined program implementation and model fidelity, client and family outcomes, and the performance of the FamilySafe Project Assessment Tool (FSPAT). The project and its evaluation were funded under the Manhattan District Attorney's Office's Criminal Justice Investment Initiative (CJII).

Findings

Sanctuary and STEPS successfully designed and continue to implement a trauma-focused model of programming that treats diverse families as a unit and facilitates communication and collaboration between the adult and child treatment staff. Overall, clinicians reported that the design and implementation of the FSP and FSPAT was successful. Clients generally report positive experiences with the FSP and other services provided by Sanctuary and STEPS. Furthermore, adults and children experienced significant reductions in post-traumatic stress disorder (PTSD) symptoms. Although Sanctuary and STEPS take slightly different implementation approaches, the organizations have largely adhered to the envisioned FSP model and made adaptations to the model to address challenges created by the COVID-19 pandemic. Additionally, even though CJII funding has ended, both organizations continue to implement the FSP model and the FSPAT in their counseling services with families.

This successful implementation resulted in several **positive outcomes** for adults, children, and the families overall. Adult clients reported that they experienced increased confidence, self-esteem, and understanding of their trauma. They also experienced significant reductions in their levels of PTSD symptoms, as measured through assessments. At the family level, many adult clients reported that they were better able to problem-solve, had improved communication, and had strengthened relationships with their children. Families also experienced increases in protective factors as measured through assessments. Parents reported that children's grades in school and their ability to manage emotions improved. Children also experienced significant reductions in PTSD symptoms, as reported by their parents.

Key **facilitators** to successful implementation include a shared vision of the FSP as a family-focused approach that is critical to clients; dedicated funding to support the program; training integrated with onboarding for clinicians; clinicians' ability to use the FSPAT to track clients' progress throughout services; the flexibility of the FSP and complementary case management, services, and resources offered by Sanctuary and STEPS; and the nonjudgmental understanding and support given to clients by clinicians.

The key **challenges** to implementation include: clinician turnover; challenges in communication between clients and staff; inconsistent training and supervision on the FSP and FSPAT, particularly during the COVID-19 pandemic; confusion on how to administer and use the FSPAT for treatment planning and provision; lack of fit or context with some components of the FSPAT for survivors of gender-based violence; and the prolonged length of intake and repeated intakes for some clients.

Recommendations

Based on the results of the evaluation, we offer several recommendations regarding staff capacity, service implementation and the assessment process, and further data collection and evaluation that could improve FSP operations and client experiences.

Regarding **staff capacity**, we recommend developing a clear and consistent onboarding and training process, identifying ways to recruit and retain more permanent clinicians, and providing regular supervision and support to clinicians.

To improve the **implementation** of the FSP, we offer several recommendations: share information about local resources and events with clients, improve communication between clients and clinicians, develop a clear framework for participation length and case closure while maintaining flexibility for client needs, offer classes for parents with older children, and continue to adapt and innovate the FSP model.

Regarding the **assessment** process, we make the following recommendations: implement clearer guidance for clinicians on how to use the FSPAT, conduct FSPAT reassessments more regularly and consistently, consider adapting the FSPAT to better fit client experiences and needs, improve consistency in FSPAT implementation, and build the full FSPAT into the data management system.

For future **data collection and evaluation**, we recommend requesting regular feedback from clients about their experiences, collecting more data related to clients' progress and outcomes, and conducting a further outcome evaluation that reaches a large proportion of clients.

Methods

The evaluation examined program implementation and model fidelity, client outcomes, and the performance of the FSPAT using a mixed-methods approach. The implementation evaluation drew on data from clinician and client interviews and a review of program administrative data to answer critical questions about the FSP's operations and the FSPAT's design and use. The outcome evaluation included a survey of adult program participants (parents) and analyses of program data and impacts reported in interviews with clients and clinicians. The FSPAT validation assessed the tool's ability to reliably identify PTSD symptoms and protective factors using assessment data and clinician perspectives. The evaluation's overall objectives were to assess FSP operations; whether FSP services are associated with improvements in well-being for parents, families, and children; and the efficacy of the FSPAT.

Introduction

The Urban Institute, in partnership with researchers Meredith Dank and Andrea Hughes, conducted an evaluation from March 2019 to September 2022 of the FamilySafe Project (FSP), an initiative of Sanctuary for Families (Sanctuary) and STEPS to End Family Violence (STEPS). The FSP provides family-focused counseling and other services to survivors of gender-based violence and their children in New York City. The project's development and implementation and this evaluation were funded under the Manhattan District Attorney's Office's Criminal Justice Investment Initiative (CJII).

Sanctuary provides clinical, legal, economic empowerment, shelter, and other services to survivors of domestic violence, sex trafficking, and related forms of gender-based violence and to their children. Sanctuary originally launched the FSP in its Manhattan office and has since implemented the project in its other offices throughout the metropolitan New York area. STEPS is a cadre of services within Rising Ground, a nonprofit human services organization in the greater New York City area. STEPS, which is based in East Harlem, provides community-based services and programming to survivors and their families.

This mixed-methods evaluation examines program implementation and model fidelity, client outcomes, and the performance of the FamilySafe Project Assessment Tool (FSPAT) in assessing parents' and children's post-traumatic stress disorder (PTSD) symptoms and family functioning. Specifically, the evaluation focuses on FSP operations, whether FSP services are associated with improved client outcomes, and the efficacy of the FSPAT. This report describes the methodology, findings, and implications of the process evaluation, outcome analysis, and assessment tool evaluation.

FamilySafe Project Background

The FSP takes a family-focused approach to providing evidence-based, trauma-informed counseling and support to survivors of gender-based violence and their families. Through the project, clinicians use the FSPAT to assess PTSD symptoms and family functioning of parents and children, and they provide services and programs that fit families' needs and goals. Both Sanctuary and STEPS use the FSP to serve families with counseling needs.

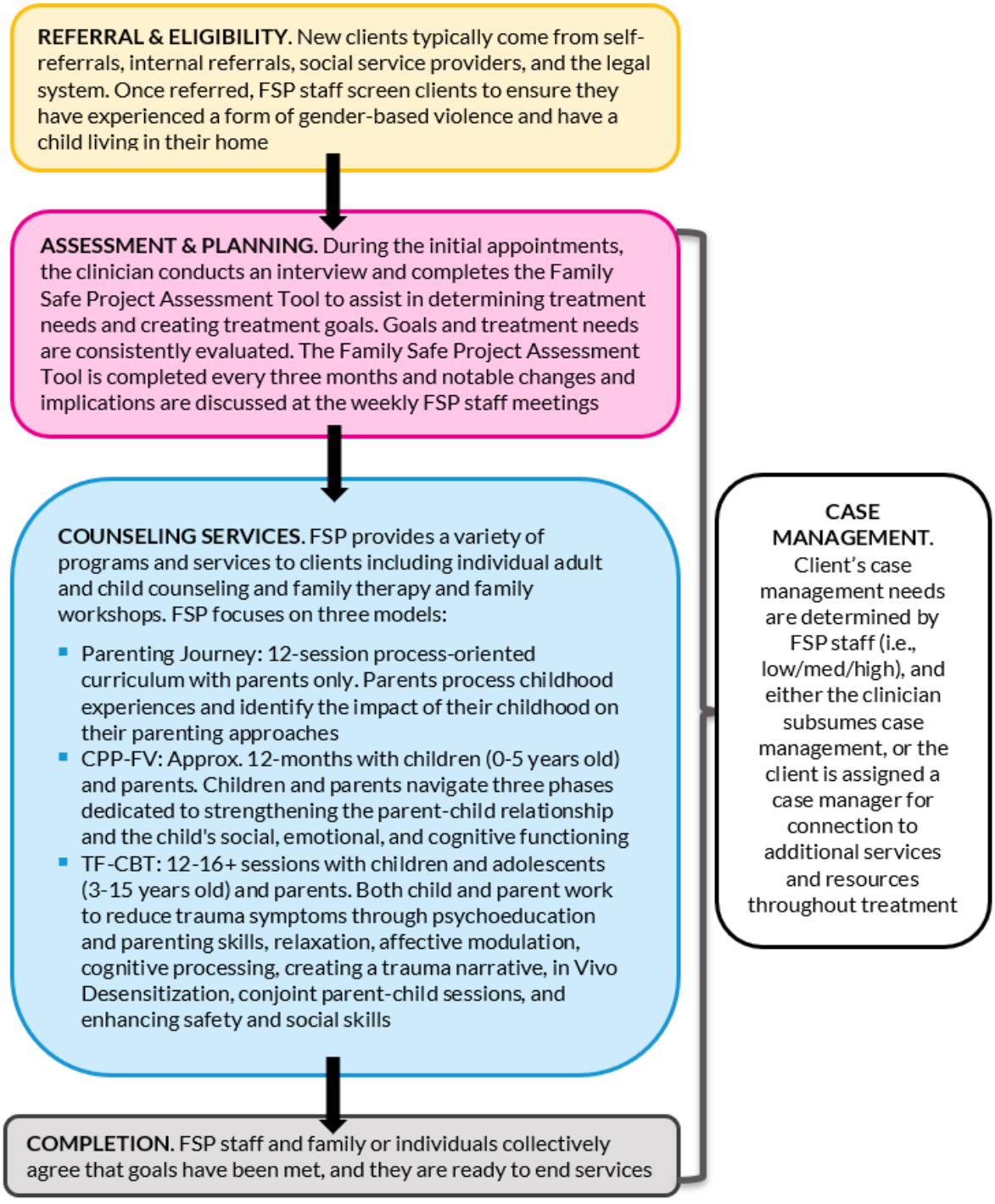
The FSP and the FSPAT emerged from a partnership formed in 2017 between Sanctuary and STEPS to develop and implement the project and assessment tool. To support the initiative, Sanctuary and STEPS applied for and received funding through the CJII. This partnership grew from a prior working relationship and provided an opportunity for Sanctuary to learn from STEPS, which already used a family-focused service model and some evidence-based assessment tools. Further, the collaboration permitted the two organizations to grow in key ways: for example, STEPS is located in East Harlem, a community that Sanctuary served but wanted to engage more directly. Through the FSP and FSPAT development and training processes, Sanctuary and STEPS began to work more closely together, and they continue to refer clients to and share knowledge with one another.

FSP Program Flow Overview

As part of the process evaluation, Urban developed and finalized an overview of the FSP program flow. The overview, provided below, details the program flow as of fall 2019 and as of early 2022, after the program had been adapted due to the COVID-19 pandemic. The evaluation of the FSP began in early 2019, allowing us to observe the program over time and describe FSP operations at these two different time points. Below we detail how Sanctuary and STEPS approached each stage of the FSP and describe differences in their approaches where relevant. The formal partnership between Sanctuary and STEPS that was funded through the CJII ended in June 2021. Accordingly, many of the noted COVID-19 modifications focus on Sanctuary. Figure 1 shows the program overview as a flowchart.

FIGURE 1

FamilySafe Project Program Flowchart



Source: Review of FSP materials and discussions and interviews with FSP clinicians in 2019 and 2022.
Notes: CPP-FV = Child-Parent Psychotherapy for Family Violence. FSP = FamilySafe Project. TF-CBT = Trauma-Focused Cognitive Behavioral Therapy.

Referral

Sanctuary for Families and STEPS receive referrals from several sources, including self-referrals, referrals from other clients, and referrals from the social service and justice systems. Key referral sources for Sanctuary include hotline calls (self-referrals), Sanctuary's legal and economic empowerment departments (internal referrals), New York City's Family Justice Centers, and community-based organizations. Key referral sources for STEPS are community-based organizations, other clients (word of mouth), and the Manhattan Family Justice Center.

Eligibility Criteria

When a client is referred to Sanctuary or STEPS, they are screened for eligibility for the FSP. Clients who have experienced intimate partner violence or another form of gender-based violence and have a child living in their home are eligible to participate.

Intake Appointments

During the intake appointments, a clinician administers the FSPAT. The FSPAT consists of the PTSD Checklist for DSM-5 (PCL-5) for adults, the Protective Factors Instrument (PFI) for families, and the Parent Report of Post-Traumatic Symptoms (PROPS) for children. Given the length of the assessment and the sensitivity of the questions (particularly for the PCL-5), administering the FSPAT typically takes two sessions, according to Sanctuary. Moreover, Sanctuary tries to ensure that the clinician who administers the FSPAT during the intake appointments continues to work with the client/family, but the organization also makes it clear to clients that this is not always possible, and the clinician may change depending on the results of the assessment and the services needed. At STEPS, the clinician who administers the FSPAT continues to work with the client/family.

At Sanctuary, the clinician administers a case management rapid assessment to determine whether to classify the client as low, medium, or high priority for in-house case management services. Once the FSPAT and rapid assessment are completed, the clinician fills out an intake form with key information and informs their supervisor that they have a case to present at Sanctuary's weekly FSP meeting, which is attended by all Sanctuary FSP clinicians. At STEPS, the clinician works with the client to develop flexible, individualized counseling goals based on the FSPAT. The STEPS clinician may also refer family members to additional services and programs, depending on the results of the assessment and the individuals' needs.

FSP Case Meeting / Roundtable

The Sanctuary clinician presents the case, including the FSPAT scores and treatment recommendations, at Sanctuary's weekly FSP meeting, also referred to as a roundtable. Though the clinician who administered the assessment takes the lead on the recommendations, all clinicians in the meeting ask questions and provide input. If the client is identified as high priority, they are assigned a case manager; if they are identified as medium priority, they are also assigned a case manager or placed on a list to be assigned a case manager and are assigned a clinician with more experience or case management skills. If the client is identified as low priority, the clinician addresses their case management needs without a case manager.

At STEPS, clinician assignment takes place prior to intake. The coordinator first refers a new FSP case to the STEPS supervisors, who meet and assign the case to a clinician, who then administers the FSPAT. If the client is high priority and the clinician cannot absorb the case management work, the client is also referred to an advocate and/or economic empowerment specialist at STEPS.

Beginning of Services

At Sanctuary, once the recommendations have been explained to the client and the client accepts or modifies the recommended services, the case is assigned to a clinician. The clinician then shares the results of the FSPAT with the client and administers a comprehensive assessment to gain a clearer picture of the client's experiences with intimate partner violence or other forms of gender-based violence; they also obtain demographic data, information about other providers and services the client has used, and other information. The clinician and client also develop counseling goals.

At STEPS, the clinician who administers the FSPAT continues serving the client. The clinician works with the client to develop flexible, individualized counseling goals and identify services and programs to advance those goals. Other team members who are assisting the family—adult counselors, children's counselors, and case managers—also meet to discuss goals for the family.

FSP Services and Programs

STEPS and Sanctuary provide a variety of programs and services to FSP clients, including individual adult and individual children's counseling, family therapy, and family workshops. Sanctuary and STEPS deliver three specific evidence-based therapy models for FSP clients: Parenting Journey (including Parenting in America), Child-Parent Psychotherapy for Family Violence (CPP-FV), and Trauma-Focused

Cognitive Behavioral Therapy (TF-CBT). Depending on their needs and availability, families can participate in multiple models.

Parenting Journey is a 12-session curriculum that takes parents on a "journey" through their childhood to see the ways in which their childhood affects their parenting. It provides a safe, judgment-free space with supportive limits where parents can express themselves and share their experiences. Each week has different focuses, agendas, and activities.

CPP-FV is an intervention model for children ages 0 to 5 who have experienced trauma and/or are experiencing mental health, attachment, or behavioral problems. Therapeutic sessions include the child and parent. The long-term treatment model has three phases—a foundational phase, a core intervention phase, and a termination phase—and can last more than a year from start to finish. The primary goal of the model is to strengthen the relationship between the child and the parent to improve the child's cognitive, behavioral, and social functioning.

TF-CBT is an evidence-based treatment model for children and adolescents who have experienced trauma and their parents. It addresses trauma symptoms from single, multiple, and complex trauma experiences. The clinician works with both the child and the parent to reduce trauma symptoms through psychoeducation and parenting skills, relaxation, affective modulation, cognitive processing, creating a trauma narrative, in vivo desensitization, conjoint parent-child sessions, and enhancing safety and social skills. The model can be completed in 12 to 16 sessions, but it typically takes longer because of the complexity of trauma experiences.

Case Management

At Sanctuary and STEPS, clients can also receive in-house case management services. These services include assistance with completing grant applications, finding housing, scheduling medical appointments, and advocating for educational needs.

Reassessment

Clinicians reassess clients regularly, using the PCL-5 and PROPS every three months and the PFI after the first three months and then every six months thereafter. The reassessments allow the clinician to measure changes in clients' levels of PTSD symptoms and family functioning and then adapt counseling accordingly. If there is a notable change in the results of the FSPAT and a clinician intends to

recommend a change in services, they present the reassessment results at the weekly FSP case meeting for discussion.

End of Services

Services end when a client disengages from the program or when the client and clinician jointly decide the client has met their goals (recognizing that those goals can change). Participation in the FSP ends when the family disengages or when every family member completes their services. Though some families disengage or do not complete every service, many families and family members make progress toward their counseling goals and complete individual services and programs. Some clients may continue to receive other services from Sanctuary and STEPS, such as economic empowerment and legal support, after their involvement with the FSP ends.

FSP Program Flow during COVID-19

The COVID-19 pandemic and the resultant stay-at-home orders and other safety measures significantly impacted how Sanctuary provided programming. Sanctuary had to move to remote programming amid COVID-related staffing and capacity shortages; however, the organization quickly adjusted to remote service provision and continued to serve its clients. The following changes were made to the program flow during the pandemic.

Referral and Eligibility Criteria

During the pandemic, Sanctuary continued to receive referrals from the same internal and external sources as before. **Screening and assessment also continued largely unchanged.** However, with the advent of remote work, clinicians reported receiving their own referrals directly, and they assisted clients with accessing and using the technology necessary to receive services, as well as to plan their safety during calls.

Intake Appointments and FSP Case Meetings

During the intake appointments, clinicians continued to administer a case management rapid assessment and the FSPAT. Prior to COVID, two sessions were often required to administer the measures; however, during COVID, some clinicians found that the process took longer, as developing

rapport was more difficult and clients were sometimes only available for brief phone calls. One significant modification to the intake process was that the clinician who administered the FSPAT continued to work with the client/family and no longer needed to present the case at a weekly FSP meeting. Clinicians provided basic case management services and referred clients with high case management needs to a case manager.

FSP Services and Programs

During COVID, Sanctuary continued to provide individual adult counseling, individual children's counseling, and family therapy. The Parenting Journey programming was temporarily suspended because it could no longer be implemented in person. The CPP-FV and TF-CBT models were implemented remotely with clients. Most services were provided by phone or over Zoom or telehealth platforms.

Reassessment

Clinicians continued to reassess clients using the PCL-5, PROPS, and PFI as required; however, clinicians noted that they had to be a bit more flexible with scheduling due to COVID.

End of Services

Services continued to end for clients when they disengaged or completed their programs. COVID's impacts on Sanctuary clients led to an increase in the amount of time they engaged in services. Further, during the pandemic, many Sanctuary clinicians did not end services with clients but instead kept the cases open, as many clients had additional needs due to the pandemic.

Research Background

This section provides a review of prior research on gender-based violence and therapeutic approaches to addressing the effects of this violence on adults, children, and families. It includes information about the specific treatment modalities and assessment tools implemented as part of the FSP.

Gender-Based and Familial Violence

People around the world, of all demographic backgrounds, experience gender-based violence. According to the US Department of State, "any harmful threat or act directed at an individual or group based on actual or perceived biological sex, gender identity, and/or lack of adherence to varying socially constructed norms around masculinity and femininity"[1] constitutes gender-based violence. In the United States, an estimated 10 million people are affected by family and domestic violence each year (Huecker et al. 2022). Oftentimes, gender-based violence impacts intimate partner relationships and familial relationships. Before the pandemic, approximately 6.6 million women and 5.8 million men reported experiencing intimate partner violence in a year, and it was estimated that 1 in 4 women and 1 in 10 men would experience some form of intimate partner violence during their lifetimes (Smith et al. 2018).

The COVID-19 pandemic only exacerbated the problem. Economic instability, financial stress, and social inequality have always been contributing factors to gender-based violence; however, the pandemic aggravated all these factors, which has led to increased problems and a rise in gender-based violence (Rieger et al. 2022). According to a 2021 report by UN Women, 45 percent of women reported that they or a woman they knew had experienced a form of violence since the start of the pandemic; the rate was even higher for mothers, as half of women with children had experienced violence or knew a woman who had during the pandemic. Incidents of gender-based violence can result in a range of consequences. Most immediately, gender-based violence can result in serious injury or death; most women in abusive relationships sustain multiple types of injuries, and intimate partners represent the highest risk of homicide for women (Stöckl et al. 2013; World Health Organization 2013). Gender-based violence can also result in worsened sexual health, increased rates of depression and suicide attempts, and more frequent substance use and abuse (World Health Organization 2013).

While this type of violence clearly harms the individuals directly involved, gender-based violence can also impact the entire family unit, especially children. Households with violence are more likely to

have controlling dynamics, and children are often victims of coercive and abusive control (Callaghan et al. 2018). This situation can impact the relationships between parents and children; for example, children who have witnessed domestic violence have more negative perceptions of cohesion in the parental relationship and father-child relationship (Paul 2019). For any member of the family, exposure to violence can be an incredibly traumatic experience and cause the onset of numerous mental health issues. Oftentimes, family violence creates an environment of fear, anxiety, hopelessness, and anger; studies on the effects of family violence have associated witnessing family violence during childhood with lower levels of self-efficacy and social support in conjunction with higher levels of post-traumatic stress symptoms (Haj-Yahia et al. 2019; Haj-Yahia et al. 2021). Exposure to violence during childhood and the development of post-traumatic stress symptoms can also interfere with a child's education, resulting in learning barriers and disruptive behavior in school (Lloyd 2018).

The impact of witnessing gender-based violence can create long-term struggles as well. Children who witness domestic violence firsthand are at a higher risk for behavioral, emotional, social, cognitive, and physical maladaptation (Kolbo, Blakely, and Engleman 1996). Studies of children at battered women's shelters have shown that they are at a higher risk of developing aggressive, defiant, or antisocial behavior, and many children reach levels of conduct serious enough to need clinical attention (Ware et al. 2001). Exposure to domestic violence also places children at a substantially higher risk of becoming a victim or perpetrator of violence as an adult (Ehrensaft et al. 2003; Milaniak and Widom 2015; Whitfield et al. 2003), which can have long-term impacts on families across generations. Mothers who were exposed to violent families as children are more likely to develop trauma symptoms that last into adulthood, and the presence of these symptoms has been shown to be directly related to an increase in PTSD symptoms in their own children (Lünnemann et al. 2019). Women who have experienced interpersonal violence also exhibit symptoms of depression, which can result in decreased social competence and increased depression in their children (Levendosky and Graham-Berhmann 2001).

Due to the extensive impact of gender-based violence, practitioners have begun to focus attention on treating the entire family unit. The growth of Family Systems Theory (FST), which emphasizes the interconnectedness of the family unit, contributed heavily to this shift. Beginning with victims of sexual abuse, therapists started applying FST to different therapeutic interventions aimed at addressing symptoms related to trauma (Karakurt and Silber 2014). As professional organizations emphasized the importance of applying FST to early childhood settings, more forms of early childhood therapy began to include elements of FST (Christian 2006). Now, numerous therapeutic interventions for children focus on various aspects of childhood, including family dynamics. A comprehensive review of intervention

methods for children who have reported adverse childhood experiences found that multicomponent disciplinary interventions that include parental and pediatric support are the most effective in reducing the impacts of adverse childhood experiences and improving parent-child relationships (Marie-Mitchell and Kostolansky 2019). A study of children with externalizing disorders found that family interventions have proven an effective form of treatment, especially for children with conduct and substance abuse disorders (Diamond and Josephson 2005). Overall, intervention programs that involve the children and mother are generally more effective in addressing externalizing problems and perspectives on violence in children (Graham-Bermann et al. 2007).

Therapeutic Interventions

Therapeutic interventions can help support survivors of gender-based violence and their families. The therapeutic approach can include individual and family counseling, group programs, and specific therapeutic interventions. One approach to individual counseling that is frequently used in the FSP is Trauma-Focused Therapy, which aims to address the correlation between a traumatic experience and resulting emotional and behavioral responses.[2] While Trauma-Focused Therapy has various modalities, the Substance Abuse and Mental Health Services Administration has outlined six key principles for all trauma-informed interventions: safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment, and cultural/historical/gender issues (SAMHSA 2014). Trauma-Focused Therapy has proven especially effective in the treatment of survivors of gender-based violence. Effective Trauma-Focused Therapy interventions help empower women and teach skills such as coping, healthy communication, and strategies to boost self-esteem (Warshaw, Sullivan, and Rivera 2013). Trauma-informed group interventions for women who have experienced gender-based violence can result in improvements to participants' mental health and quality of life (Reid et al. 2021). Trauma-Focused Therapy can also support children who have witnessed or experienced gender-based violence. By focusing on skill building, psychoeducation, and cognitive processing, Trauma-Focused Cognitive Behavioral Therapy can foster improved functioning and improvement in PTSD symptoms in children impacted by trauma (Canale et al. 2021). Interventions incorporating a focus on trauma can result in positive growth and healing for participants, especially youth.[3] As a result, various therapeutic interventions have been developed that specifically target the family unit, and interventions involving Trauma-Focused Therapy are offered by a range of therapists and treatment facilities.

Beyond individual and family counseling, the FSP implements several specific therapeutic models, as noted above. Parenting Journey, a 12-session curriculum for parent improvement, was developed as

a form of therapeutic intervention for parents with negative parenting patterns and practices to help improve parental characteristics (Parenting Journey 2014). Drawing on validated scales of optimism, self-efficacy, and self-awareness, Parenting Journey measures effectiveness in promoting positive parenting practices throughout the program (Gratz and Roemer 2004; Scheier, Carver, and Bridges 1994; Schwarzer and Jerusalem 1995). In a quasi-experimental study with low-income and racially diverse parents, Parenting Journey was found to decrease parenting stress, improve understanding of parenting behaviors, increase access to social networks, and improve parent-reported outcomes (Kistin et al. 2020). Internal reviews have found that 86 percent of Parenting Journey participants report improvement in their relationships with their children as a result of the program (Parenting Journey 2014). Now, Parenting Journey is being replicated in more than 500 sites across the eastern United States to improve parent-child outcomes.

Child-Parent Psychotherapy for Family Violence, designed for children ages 0–5 provides attachment-based treatment for children who have been exposed to interpersonal violence, to improve parent-child relationships (National Child Traumatic Stress Network 2012). CPP-FV treatment is a long-term intervention provided by a licensed therapist that includes three phases of treatment: a foundational phase, a core intervention phase, and a recapitulation and termination phase (Hooker et al. 2019). Over time, the use of CPP has been proven to help improve mother-child relationship expectations and promote normative cognitive development during childhood (Cicchetti, Toth, and Rogosch 1999; Toth et al. 2002). A study of children who were exposed to domestic violence found that CPP-FV resulted in improvements in PTSD and depression symptoms and mother-child outcomes (Ghosh Ippen et al. 2011). While CPP in general has been proven to be an effective form of intervention, studies on CPP-FV are more limited, necessitating broader implementation and more extensive review of CPP-FV across the country.

Trauma-Focused Cognitive Behavioral Therapy was originally designed to be used with victims of sexual abuse; it was then adapted for use with traumatized adolescent children and nonoffending parents (Dowd and McGuire 2011). The clinician works with both the child and the parent to reduce trauma symptoms through psychoeducation and parenting skills, relaxation, affective modulation, cognitive processing, creating a trauma narrative, in vivo desensitization, conjoint parent-child sessions, and enhancing safety and social skills (Cohen and Mannarino 2008a). Studies on the implementation of TF-CBT have found improvement in children's PTSD symptoms, behavior problems, and outcomes following completion of treatment (Cary and McMillen 2012; Cohen and Mannarino 2008b). While TF-CBT has primarily been used in adolescents, a pilot trial of TF-CBT in individuals between 12 and 25

years old found it to be an acceptable and safe way to treat PTSD resulting from exposure to interpersonal trauma (Peters et al. 2021).

Case Management and Additional Services

Comprehensive care for individuals and families who have experienced gender-based violence extends beyond just therapeutic interventions. Given the range of impacts that gender-based violence can have, many organizations offer other forms of assistance, such as legal, housing, or employment services. Because such services can be extremely impactful, some clinicians have called for national standards on training and curriculums offered by domestic violence service providers (Stover and Lent 2014). A lack of national consistency has limited the research on the effectiveness of additional services; however, some studies have shown that programs that include counseling, advocacy/legal, and hotline services are beneficial to victims of interpersonal violence (Bennett et al. 2004; Dugan, Nagin, and Rosenfeld 1999). In a report published by the Centers for Disease Control and Prevention, 51.5 percent of female victims of interpersonal violence reported needing but not receiving housing services, 63.6 percent reported needing but not receiving legal services, and 44.9 percent reported needing but not receiving medical care, which demonstrates the importance of coordinating care services (Breiding, Chen, and Black 2014). Efforts by the government to support individuals experiencing gender-based violence have emphasized the importance of providing "the tools to establish economic self-sufficiency, short-term goal setting, and long-term planning for their futures."[4]

Assessment Tools

In their therapeutic approaches, clinicians may use several tools to assess a client's levels of symptoms, needs, and strengths. The FSP uses two specific tools to assess post-traumatic stress symptoms in adults and children—the PCL-5 and PROPS, respectively—along with the PFI to assess levels of family functioning. Here we describe the purpose of and previous research on each tool.

Post-Traumatic Stress Symptoms in Adults: PCL-5

Given the multitude of factors, including gender-based violence, that can lead to PTSD, multiple assessment tools that screen for trauma and related symptoms have been established, including the PTSD Checklist for DSM-5. The PCL-5 was developed as a self-reported assessment tool that screened

for 20 items correlated to 20 symptoms of PTSD, with its use concentrated in wealthier and Western countries (Verhey et al. 2018). The PCL-5 test has been most thoroughly validated in English with military populations (Bovin et al. 2016) and undergraduate populations in the United States (Ashbaugh et al. 2016). Studies have also validated the PCL-5 for use in less industrialized countries, specifically in screening people impacted by war in Syria and people with HIV in Zimbabwe (Ibrahim et al. 2018; Verhey et al. 2018). Recently, the PCL-5 was validated in several studies exclusively involving women. Studies conducted on female Filipino migrant workers, Greek women post-cesarean delivery, and Maltese women with perinatal PTSD have all validated the use of the PCL-5 (Buhagiar, Dimech, and Felice 2022; Hall et al. 2019; Orovou, Theodoropoulou, and Anoniou 2021). However, despite the expanded use of the PCL-5 to reach numerous other languages and cultures, its use in assessing victims of gender-based violence remains limited. A study of Indian women reporting gender-based violence demonstrated strong validity for the PCL-5, and the tool has since been used to measure PTSD in female sex workers (Patel, Newman, and Richardson 2022; Park et al. 2019), but additional validation for populations experiencing gender-based violence is still needed.

Post-Traumatic Stress Symptoms in Children: PROPS

Another common assessment tool, the Parent Report of Post-Traumatic Stress Symptoms, was also developed to assess a variety of PTSD symptoms, as well as changes in symptomology over time (Wu 2017). The PROPS tool is a self-reporting measure consisting of 32 items that participants rate on a number scale; the initial study conducted on PROPS showed internal consistency, content validity, construct validity, and criterion validity (Greenwald and Rubin 1999). Since its development, PROPS has been validated in a study of Korean children, as well as in numerous other languages and cultures (Greenwald et al. 2002; Lee et al. 2011). Since its development and validation, it has been used in many studies addressing PTSD in children and parents, including survivors of explosions and earthquakes (Hwang 2017; Roos et al. 2011). PROPS was used in a study of female victims of sexual violence in South Korea and demonstrated internal consistency (Chung et al. 2019), but the tool's use in measuring PTSD resulting from interpersonal violence remains limited.

Family Functioning: PFI

Another aspect of the relationship between parents and children involves familial protective factors. Multiple tools have been developed to screen for these factors, one of which is the Protective Factors Instrument, also referred to as the Protective Factors Assessment. The PFI is intended to measure a

parent's beliefs and behaviors, which are connected to indicators of five interrelated protective factors (Kiplinger and Browne 2014). Since its development, the PFI tool has been altered and adapted various times, but most studies have validated its use specifically in measuring protective factors as related to parent-child relationships (Counts et al. 2010; Kiplinger and Browne 2014). Following the development of the initial PFI, researchers developed and validated the Protective Factors Survey, 2nd Edition, which was intended to improve clarity and better support the needs of programs in measuring factors that are protective against child maltreatment (Sprague-Jones et al. 2019). Outside the United States, the PFI has been adapted and validated in Spanish and Portuguese (Augusto et al. 2014; Conrad-Hiebner et al. 2015). Other countries have also established versions of the PFI. In Australia and Indonesia, the Parenting and Family Adjustment Scale was adapted from the PFI to measure known risk and protective factors for parent-family relationships; its use validated initial studies (Sanders et al. 2013; Sumargi et al. 2018). The PFI and its variations have been consistently validated by use in programs addressing parent-child relationships.

Methodology

Our evaluation examined program implementation and model fidelity, client outcomes, and the performance of the FSPAT using a mixed-methods approach. The process evaluation drew on data from counselor and client interviews and a review of performance measures to answer critical questions about the FSP's operations and the FSPAT's design and use. The outcome evaluation included a survey of adult program participants (parents) and analyses of program data and reported impact taken from client and counselor interviews. The FSPAT validation assessed the tool's ability to identify PTSD symptoms and protective factors using assessment data and clinician perspectives.

The evaluation's objectives were to assess FSP operations; whether FSP services are associated with improvements in well-being for parents, families, and children; and the efficacy of the FSPAT. This section describes the study's research questions, methods, and data sources for the three evaluation components: the process evaluation, the assessment tool evaluation, and the outcome analysis.

Process Evaluation

The process evaluation objectives were to (1) document the development, implementation, and use of the FSPAT, including the resources and decisions that shaped the tool's design, client satisfaction with and staff perceptions of the FSPAT's performance, and factors that facilitated or impeded its use); (2) assess the role of the FSPAT in the development of client counseling goals development and the receipt of services; and (3) review the implementation and operations of the FSP as a whole.

Research Questions

Table 1 lists the process evaluation research questions.

TABLE 1

Process Evaluation Research Questions

Category	Questions
FSPAT design, implementation, and use	▪ What was the FSPAT design process? ▪ Who was involved (practitioners, therapists, FSP staff, clients) in the process? ▪ To what extent did the design process incorporate client input? ▪ How did the FSPAT differ from treatment as usual, and what weaknesses/gaps did the FSPAT address? ▪ What training do staff receive on the FSPAT? ▪ How do staff use and view the FSPAT in terms of strengths, weaknesses, relevance, reliability, utility, and sensitivity? Did use of the FSPAT differ by staff position or client?
Program operations	▪ How many clients (families, parents, and children) participated in the FSP, for how long, and how many services and sessions did they receive? ▪ How did FSP operations align with the program model regarding adherence to eligibility criteria, referrals, assessment processes, service receipt, and dosage (duration, intensity, delivery, completion); staffing; and data collection/reporting? ▪ What factors affected program implementation, operations, and use of counseling goals?
Client experiences	▪ What aspects of the FSPAT and FSP worked well for clients? ▪ How well did the FSP address clients' issues and needs? ▪ What barriers did clients face in accessing and participating in the program? ▪ How were these barriers mitigated?

Notes: FSP = FamilySafe Project; FSPAT = FamilySafe Project Assessment Tool.

Data and Methods

The process evaluation relied on the following data sources:

- program documents
- FSP Program Flow Overview, which serves as a logic model for the program and is summarized above
- program records (administrative data collected by Sanctuary and STEPS)
- semistructured interviews with clients (parents)
- interviews with program staff

PROGRAM DOCUMENTS

Urban received and reviewed a variety of program documents from Sanctuary and STEPS, including STEPS' Feedback Form, Children's Therapy Program Treatment Plan, and Counseling Goals, and Sanctuary's intake and assessment forms and Agency Wide Survey 2019, which examined how Sanctuary services affected clients' feelings of safety. Drawing on these materials and in consultation

with Sanctuary and STEPS, Urban developed and finalized the **FSP Program Flow Overview**, which serves as a logic model for the program (see the FamilySafe Project Background section on page 2). These program documents also informed the project's interview questions and survey questions.

PROGRAM DATA

Urban obtained administrative program data from Sanctuary and STEPS, which included aggregate data on FSP clients that were reported to the Institute for State and Local Governance (as a funding requirement) and individual-level client data from both organizations provided directly to Urban. Urban negotiated data-sharing agreements with each organization to receive deidentified client data. Urban received 12 quarters of STEPS program data, which covered the entirety of the period funded through CJII, from July 2017 to June 2021. The STEPS data were limited to only the FSP clients who were served by the clinician funded by CJII and therefore do not represent all FSP clients at STEPS. From Sanctuary, Urban received data on all FSP clients served by the provider's Manhattan office from April 2019 to June 2021, regardless of the clinician funding source. Sanctuary implemented a new, comprehensive data tracking method in April 2019, and data were not consistently recorded for clients who had ended services prior to this date. Therefore, the comprehensive Sanctuary data are not available for July 2017 to March 2019, but aggregate quarterly data were available for that period. We processed and standardized the individual-level data from STEPS and Sanctuary to make them as comparable as possible. However, any differences in data coverage, availability, and sources are noted throughout this section. The data include information on parents and children, including demographic characteristics, referral sources, services received, program participation, and assessment scores.

We performed descriptive analyses of the administrative program data to answer key questions. This process included summarizing core outputs and outcomes, such as the total number of clients enrolled and served (families, parents, and children); clients' average time in the program; the number that completed the FSP and individual FSP services; and the number of clients who were referred to, enrolled in, and completed Parenting Journey, CPP-FV, and TF-CBT. For the FSPAT, we measured how many people were assessed at intake and how many received reassessments. For all these descriptive analyses, we examined trends over time to determine whether client enrollment, program completion, and the number of assessments increased over time as the FSP was designed and implemented. We also analyzed the traumatic experiences reported in the PCL-5 assessments, which are described below in the assessment tool evaluation section.

STAFF INTERVIEWS

Urban conducted 13 semistructured individual interviews with key FSP staff members to inform the process evaluation: 12 with FSP clinicians from Sanctuary and 1 with a clinician from STEPS. The staff interviews occurred during in-person site visits in late 2019 and by Zoom in early 2022. This allowed us to gain an in-depth understanding of FSP operations before and during the COVID-19 pandemic. Prior to the staff interviews, Urban conducted several informal group interviews with multiple clinicians and administrators from Sanctuary and STEPS. These group discussions included various questions to help us understand the program and its history and informed the evaluation design and interview questions. From 2020 to early 2022, the research team held biweekly and then monthly calls with Sanctuary leadership from the clinical and data and evaluation teams to discuss progress on the data collection activities and to learn about FSP operations and adaptations made because of the COVID-19 pandemic.

Staff were invited to participate in the interviews via email. Upon completing our interviews with staff, we transcribed the recordings and used Microsoft Excel to process the data. We coded the data to categorize them into general themes related to the design and implementation of the FSP and FSPAT. Through the FSP staff interviews, we learned about the FSP's development and implementation at Sanctuary and STEPS, Sanctuary's counseling goals process and its shift to a family-focused service model, how Sanctuary and STEPS clinicians conduct the intake process (including FSPAT administration), training on the FSPAT tools, the FSP programs, and overall FSP processes and goals.

CLIENT INTERVIEWS

Urban conducted semistructured individual interviews with 25 adult FSP clients from Sanctuary (n = 17) and STEPS (n = 8). Because of the COVID-19 pandemic, interviews were conducted virtually by phone or web meeting. Interviews were conducted in English and Spanish, the two main languages spoken by FSP clients. Clients were asked about how they were referred to Sanctuary or STEPS; their initial goals; their experiences with the FSPAT and FSP services overall; barriers to accessing services; and the impacts of the FSP on themselves, their children, and their families.

Sanctuary and STEPS staff conducted direct outreach to clients to inform them about the interview opportunity. Sanctuary identified a diverse sample of clients who had received services for varied amounts of time and who had received counseling only or counseling in combination with other services (e.g., legal, residential, economic empowerment). Once a client expressed interest in the interview, staff completed an information release via Qualtrics. We received 49 information releases: 31 from Sanctuary and 18 from STEPS. After receiving the information on clients interested in participating in an interview about the FSP, research staff emailed and/or called them to schedule an interview time. We

conducted all interviews via Zoom or 8x8 phone[5] from September 2021 to April 2022. All interviewees received a $50 Amazon or Target electronic gift card to thank them for their participation.

We conducted 7 Sanctuary interviews in Spanish and 10 in English. We conducted 4 STEPS interviews in Spanish and 4 in English.

Upon completing our interviews with clients, we transcribed the interview recordings and processed them in NVivo, a qualitative data analysis software package. We coded the data according to general themes that were drawn from the research questions and related to the implementation of the FSP and FSPAT and client experiences. After coding the data, we exported and summarized them further to allow us to draw conclusions across staff and client interview data.

CLIENT INTERVIEW SAMPLE

The sample of clients who participated in the interviews included 17 Sanctuary clients and 8 STEPS clients. All but one client (a STEPS client) reported having children; most had at least two children, but the number ranged from one to five. Most children were infants or young children, with a few teenagers and young adults. Most clients reported that at least one of their children received therapy from Sanctuary or STEPS. It was more common for the children of Sanctuary clients to receive therapy than for the children of STEPS clients. A couple of STEPS clients reported that their children instead received therapy from other organizations.

Most clients we interviewed began receiving services between 2017 and 2019; however, some began as early as 2013 (at Sanctuary) or as late as 2020 (at STEPS). Clients generally reported that they received therapy and services lasting one to three years. One reported receiving various types of support from Sanctuary for nearly eight years. Most clients received in-person and virtual support. In-person services mostly occurred before the pandemic, and virtual services occurred both via video (e.g., Zoom, Doxy) and phone. STEPS clients who were interviewed received in-person services at the Brooklyn, Harlem, and East End locations. Sanctuary clients received in-person services at the Manhattan office.

Assessment Tool Evaluation

The FSPAT is a key component of FSP operations, and the evaluation included a specific examination of its implementation and validity. The assessment tool evaluation objectives were to assess the

effectiveness of the FSPAT in detecting PTSD symptoms in parents and children and protective factors in their relationships, and to determine how the FSPAT affected case planning and service provision.

Research Questions

The assessment tool evaluation aimed to answer the following questions:

- What were the psychometric properties associated with the FSPAT?
- Did the psychometric properties vary across subgroups of clients defined by race/ethnicity, immigrant versus nonimmigrant, level of English proficiency, or referral source?
- Did the FSPAT accurately and reliably identify PTSD symptoms and protective factors?
- Did the FSPAT demonstrate strong validity, according to staff perspectives and reports?
- How did the FSPAT, and its method of administration, affect case planning and service provision?

Data and Methods

The FSPAT evaluation relied on the following data sources:

- semistructured interviews of clinicians (conducted semiannually by phone or in person)
- program data (including administrative data and completed assessments)
- client surveys

STAFF INTERVIEWS

As outlined in the Process Evaluation section, Urban conducted **semistructured interviews with 13 FSP clinicians and administrators**. The staff interviews included questions about the FSPAT's design, use, and utility. To assess the construct validity, we interviewed clinicians about whether the tools measure what they are intended to measure—that is, whether the FSPAT captures all the components related to PTSD symptoms and family protective factors that are relevant to inform treatment and measure progress (from the clinician's perspective, and as compared with other tools). We also asked about the FSPAT's design process, its implementation, facilitators of and/or barriers to implementation, how staff are trained to use it, its role in forming clients' counseling goals and their receipt of services, differences

from treatment as usual, strengths and weaknesses, its alignment with professional judgment, modifications, and impacts.

DOCUMENT AND LITERATURE REVIEW

As part of Urban's document review, we also received and reviewed the "measures packet" (the FSPAT) from Sanctuary and STEPS in English and Spanish. Urban also conducted a scan of prior research (see the Research Background section above) on the three tools that make up the FSPAT: the PCL-5, the PFI, and PROPS. The three tools have been previously validated and are not being used for different purposes than originally intended.

ASSESSMENT DATA

Urban received electronic scans of the **intake PCL-5 and PFI assessments** and performed manual data entry of the scores for each item, as item-level data are not captured in Sanctuary's and STEPS' record management systems (which only record domain and total scores). Item-level data are required for the reliability and validity analyses. The PCL-5 contains 20 items, the PFI pretest 29 items, the PFI posttest 65 items, and the PROPS 32 items. The PROPS assessment is completed for each child in the family. During intake, clients receive the PCL-5, PFI pretest, and PROPS. At all reassessments, clients receive the PCL-5, PFI posttest, and PROPS. To be as precise as possible in defining the population for which the tools are validated, we focused on intake assessments only. Urban received 215 intake PCL-5 and PFI assessments from Sanctuary.

RELIABILITY AND VALIDITY ANALYSIS

With regard to the **reliability and validity analyses** of the FSPAT, though all three of the FSPAT tools have been previously validated and seem to be appropriate for the FSP, this evaluation focused on validating the PCL-5 and the PFI pretest. The PCL-5 has been successfully validated on many military and undergraduate populations (Blevins et al. 2015; Bovin et al. 2016), but not necessarily on populations that have experienced gender-based violence. Because the experiences of trauma in each of these populations may be different, a validation of the tool for this population would be a contribution to the field. The PFI has been validated on populations similar to those served by the FSP, but there have been few studies beyond those conducted by the tool developers (Kiplinger and Browne 2014). Because of the limited number of studies, we believe the validation of this tool would also be important. PROPS has been validated in various studies across multiple countries, including studies with socioeconomically disadvantaged populations, racially and ethnically diverse populations, and survivors of sexual abuse (Greenwald and Rubin 1999; Jaberghaderi et al. 2004; Saylor 2003); some of these

populations are similar to those served by Sanctuary. Because PROPS has supporting research on similar populations and manual entry of all item scores for every child in each family would have required expending significantly greater resources, we did not include it in our validation assessment.

We examined the FSPAT using three reliability and validity tests: internal consistency reliability, item discrimination, and convergent validity. Table 2 provides an overview of the validation analyses. We selected these three analysis types as they most succinctly and quantitatively assess the performance of the specific items and factors in the FSPAT. The specific analyses are described in detail below.

TABLE 2

Definitions of Common Reliability and Validity Analysis Types

Psychometric property	Question answered	Assessment method
Internal consistency reliability	Do the PCL-5 and PFI yield consistent scores across items within each domain?	Cronbach's alpha analysis (0.7 and higher) of each domain
Item discrimination	Do the PCL-5 and PFI items distinguish between clients with different levels of PTSD symptoms and family functioning?	Item response discrimination slope analysis (0.65 and higher)
Convergent validity	Are the PCL-5 and PFI individual domain scores highly correlated?	Correlation analysis of domain scores (0.3 and above)

Notes: PCL-5 = PTSD Checklist for DSM-5. PFI = Protective Factors Instrument. PTSD = post-traumatic stress disorder.

Examining Cronbach's alpha provides a measure of an instrument's internal consistency, or how closely related the set of items in a tool are as a group. Cronbach's alpha tests the intercorrelations among items, indicating how well they measure a single construct or concept. This measure helps indicate how well the PCL-5 and PFI yield consistent scores across items within each factor and across all factors. Cronbach's alpha coefficients (α) range from -1 to 1. A Cronbach's alpha of 0.7 or higher is considered acceptable (Nunnally 1978; Taber 2018). Values above 0.9 may suggest that some items are redundant and could be removed (Streiner 2003). A negative alpha indicates that one of the items in the factor may have an opposite scale from the others. For tests of Cronbach's alpha, a minimum sample size of 30 is recommended (Bujang, Omar, and Baharum 2018; Yurdugül 2008), a criterion that is satisfied with the more than 200 intake assessments available.

Item discrimination refers to the extent to which the PCL-5 and PFI items distinguish between people with different levels of post-traumatic stress symptoms and family functioning, respectively, as assessed through an item response discrimination slope analysis. Higher slope values indicate that an item is better at distinguishing between clients with different levels of symptoms or protective factors. Slope values greater than 0.65 are considered to indicate moderate or higher performance (Baker 2001;

Giguère and Lussier 2016), though a minimum of 0.2 may be acceptable (Jorion et al. 2013). The discrimination/slopes of items in each PCL-5 and PFI domain were calculated to reveal how well each item distinguished different levels of the latent factor it was purported to measure (e.g., reexperiencing in the PCL-5 and parental resilience in the PFI).

Convergent validity measures the correlations among the PCL-5's and PFI's individual factor scores, through Pearson correlation tests, to indicate the degree to which the PTSD symptoms and protective factors are related. Correlation coefficient values range from -1 to 1, where -1 indicates a perfect negative correlation between two variables, 1 indicates a perfect positive correlation, and 0 indicates that there is no linear relationship between the variables. Generally, a coefficient of 0.3 to 0.5 indicates a medium association between two variables, and 0.5 to 1 indicates a strong association. We also indicate whether the correlation is statistically significant.

We repeated these analyses for subgroups of clients when there was a sufficient sample size. In consultation with Sanctuary and STEPS, we determined that the characteristics of interest for comparative analyses were race/ethnicity, immigrant versus nonimmigrant, level of English proficiency, and referral source. Based on data availability and sample size, we compared tool performance by primary language, being born in or outside the United States, and race/ethnicity. Comparing performance across subgroups allows us to understand whether the PCL-5 and PFI are less or more reliable for certain groups than others. For example, the tools could be less valid for clients from other countries if some of the items are not culturally relevant or appropriate. Similarly, some items may not translate well for speakers of other languages. To compare performance across groups, we calculated 95 percent confidence intervals for the estimates of Cronbach's alpha through bootstrap sampling with replacement 1,000 times. We then compared the confidence intervals for each group to see whether they overlapped. The subgroup findings help indicate whether the FSPAT is less useful for certain groups or could benefit from adjustments to implementation.

CLIENT SURVEY

Finally, Urban conducted a client survey to inform the FSPAT evaluation and outcome evaluation. The client survey was conducted only with Sanctuary, not STEPS, clients because STEPS has significantly fewer FSP clients and less capacity for survey administration. Urban developed and finalized the client survey instrument in consultation with Sanctuary in fall 2019 and winter 2020. Because of the COVID-19 pandemic, Urban and Sanctuary were unable to launch the client survey at Sanctuary's Manhattan office in March 2020 as planned. Beginning in mid-March 2020, Urban began developing contingency plans for client survey administration in consultation with Sanctuary. In summer 2020, the research

team and Sanctuary finalized virtual survey administration plans after agreeing that the survey could not be postponed until in-person survey administration would be possible. The survey was launched on August 31, 2020, and remained open through December 2021. The survey was designed to be completed by new adult clients who had completed the intake process, and it was available in both English and Spanish. The client survey included questions from the FSPAT about PTSD symptoms in adults, protective factors in families, and PTSD symptoms in children, to compare results between the survey and the FSPAT scores. Clients received a $25 gift card for the baseline survey and a $40 gift card for the six-month follow-up survey to thank them for their participation.

The implementation of the client survey faced many challenges. Because the COVID-19 pandemic exacerbated the needs and concerns of survivors of intimate partner violence, Sanctuary clients remained on clinicians' caseloads for longer than before. As a result, Sanctuary had significantly fewer new clients than before the pandemic and therefore had fewer clients eligible to participate in the survey than anticipated. Prior to the COVID-19 pandemic, Sanctuary anticipated that 20 new English- or Spanish-speaking clients would be eligible to participate in the survey each month, which would have enabled us to reach our initial goal of more than 150 baseline surveys. To address these challenges, the research team worked closely with Sanctuary to ensure that the survey was accessible to clients and that Sanctuary clinicians were prepared to introduce the survey opportunity to new clients. Despite substantial troubleshooting and adaptation, it was difficult to recruit clients to participate in the survey. Although the survey remained open for 15 months, only 20 baseline and 10 follow-up surveys were completed. Because of the small sample size, we chose to report only a few overall findings from the survey.

Outcome Evaluation

This evaluation component analyzed FSP client data to clarify client trajectories and measure outcomes, specifically changes over time in family functioning and client well-being. It also assessed FSP participant outcomes overall and by various subgroups. We identified outcome measures of interest through discussions and interviews with Sanctuary and STEPS staff.

Research Questions

The outcome evaluation aimed to answer the following questions:

- Did program services improve (1) the quality of parent-child relationships/communication, (2) parenting skills, (3) emotional well-being, (4) physical well-being, (5) levels of PTSD symptoms, (6) social functioning (self-control, belonging) of children and parents, (7) parents' feelings of agency and power, and (8) parents' capacity to cope and problem-solve?
- Did program outcomes differ by subgroups of clients based on demographic characteristics or program participation?
- Did clients meet their counseling goals and address their individual needs?

Data and Methods

The outcome evaluation relied on the following data sources:

- client interviews
- client surveys
- administrative data

As discussed in the Process Evaluation section, we conducted 25 **client interviews**. During these interviews, clients were asked about their counseling goals; desired outcomes; progress; and impacts on themselves, their children, and their families overall. As outlined in the Assessment Tool Evaluation section, the **client survey** was designed to have a baseline and a six-month follow-up to measure changes over time. The client survey addressed several domains, including family relationships, parenting, self-esteem, self-efficacy, safety, and counseling goals. By comparing the baseline and follow-up scores on individual items and domains, we planned to assess client outcomes attributable to participation in the FSP. However, as described above, the survey had a low response rate, limiting our ability to conduct a baseline/follow-up analysis. With the small sample size, we were unable to reliably use the survey to describe client outcomes. Further information about the client survey results is available in the technical appendix.

With the individual-level **administrative data**, we measured how clients' FSPAT scores changed over time, as well as their program outcomes (i.e., completion of specific programs or services). Specifically, with the FSPAT, we examined how PTSD symptoms in parents and their children changed over time as well as changes in family protective factors. We then compared outcomes by subgroups to see whether any groups of clients tended to have better outcomes than others. One set of subgroups is based on demographic characteristics: race/ethnicity, immigrant versus nonimmigrant, level of English

proficiency, system involvement, and housing situation. Another set is based on service characteristics: referral source, whether the clients participated in any programs (Parenting Journey, CPP-FV, or TF-CBT), and the duration/dosage of services. Through this analysis, we mapped several common family trajectories, including the individual trajectories of parents and children. For all outcome measures, we conducted descriptive analyses and bivariate/multivariate statistical tests where feasible (e.g., chi-square test, *t*-test, regression).

Limitations

The evaluation has several data and methodological limitations.

First, due to data constraints, our evaluation offers a limited glimpse into FSP implementation at STEPS. Although the interviews included STEPS clients and staff, the administrative data cover only clients who were served by the one CJII-funded clinician. We denote findings for STEPS throughout the report.

Second, data collection was disrupted and challenged by the COVID-19 pandemic. All planned in-person activities (the client survey, client interviews, and staff interviews) had to be adapted to virtual administration. Further, engaging survivors of gender-based violence for these data collection activities was made even more difficult by the pandemic. Survivors seeking counseling are often in crisis or face many competing demands already (e.g., work, family, legal matters), which could have been exacerbated by the pandemic, lessening their ability to participate in interviews or a survey.

Lastly, by offering the client interviews and survey in English and Spanish only, we did not reach all clients. Sanctuary serves a diverse population of clients who speak many languages (e.g., Bengali, Chinese, Farsi, French, Tagalog, Urdu), and due to limited resources and capacity, the data collection activities could not occur in all languages. However, the vast majority of clients at both Sanctuary and STEPS are comfortable communicating in English or Spanish and were informed of survey and interview opportunities.

Findings

Between 2019 and 2022, Urban used quantitative and qualitative data from staff and clients to identify the treatment model of the FSP, document facilitators of and challenges to implementation, and measure initial outcomes for clients and families. Generally, the implementation and maintenance of the FSP model were successful, and the model was flexible enough to be adapted during the COVID-19 pandemic. FSP clients and families experienced significant improvements in their well-being, as measured by assessments and reported in interviews. The assessment tools also performed well with the clients served by the FSP.

Implementation Evaluation

Through the implementation evaluation, we sought to clarify the FSP treatment model implemented by STEPS and Sanctuary and document the degree to which each organization implemented the FSP and FSPAT as intended, and to identify facilitators of and challenges to implementation. We also documented any temporary and permanent adaptations made to the treatment model and implementation as a result of COVID.

In this section, we describe the characteristics of the clients served by the FSP and the design and adoption of the FSP model and the FSPAT. We then describe each stage of the FSP: referral and eligibility, intake and assessment, case planning, service provision, and completion.

Client Characteristics and Incoming Needs

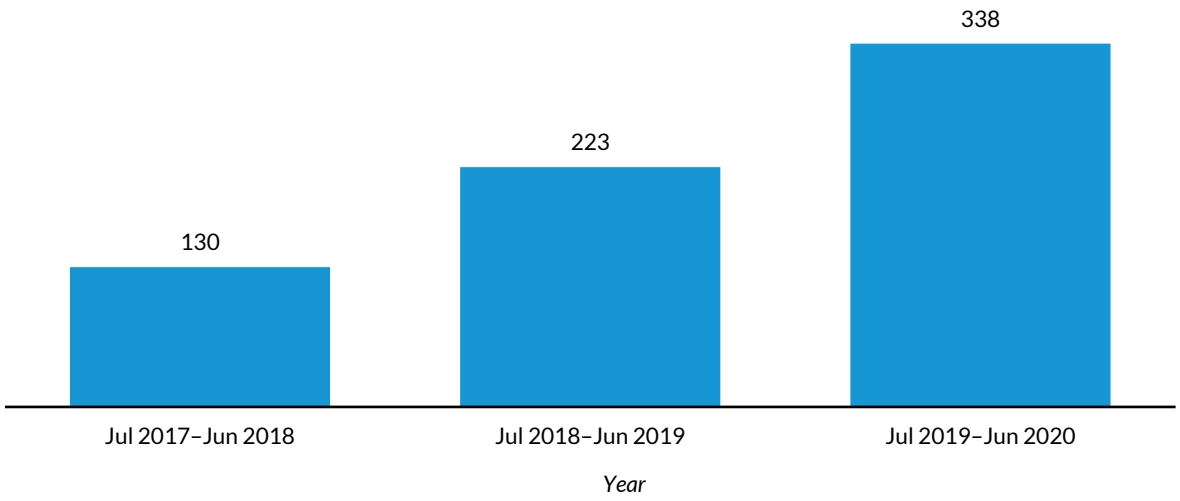
Sanctuary and STEPS serve families with diverse experiences and backgrounds. Adult clients in our data sample were a range of ages, came from all regions of the world, spoke many languages, and had experienced different and complex traumas. About half of adult clients also had children participating in the FSP, but all were parents. Many of the children had also been exposed to gender-based violence or experienced it directly.

Since beginning FSP implementation, STEPS and Sanctuary have served hundreds of clients each year. The number of new families served grew substantially in each year of the FSP from July 2017 to June 2020 (figure 2). As the FSP is designed to serve adults who have experienced gender-based violence and have children, most families (98 percent) had one parent participating in the FSP. Family size varied, with one-quarter of families having one child receiving FSP services, one-quarter of families

having two children receiving FSP services, and half of family units having no children receiving FSP services. The FSP is designed to serve families, but not all children may need, want, or be able to participate in the FSP.

FIGURE 2

Number of New Families Receiving FamilySafe Program Services at Sanctuary for Families and STEPS to End Family Violence by Program Year

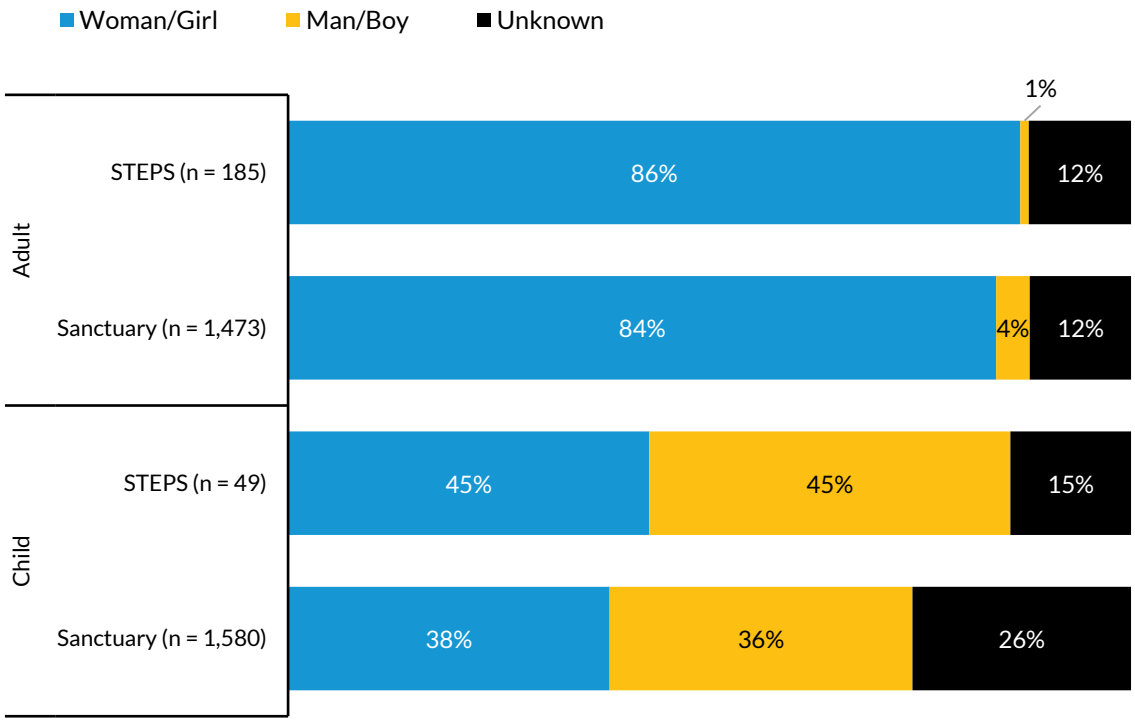


Source: Urban Institute analysis of quarterly FamilySafe Project progress reports submitted by Sanctuary for Families and STEPS to End Family Violence to the Institute for State and Local Governance.

The average age of adult clients was 36, with a range from 18 to 69. The average age for child clients was 8, with a range from younger than 1 to 17. Most adult clients were women, while child clients were roughly evenly split between boys and girls (figure 3). Gender is reported here as it was recorded in Sanctuary and STEPS' data systems.

FIGURE 3

FamilySafe Project Clients at Sanctuary for Families and STEPS to End Family Violence by Gender

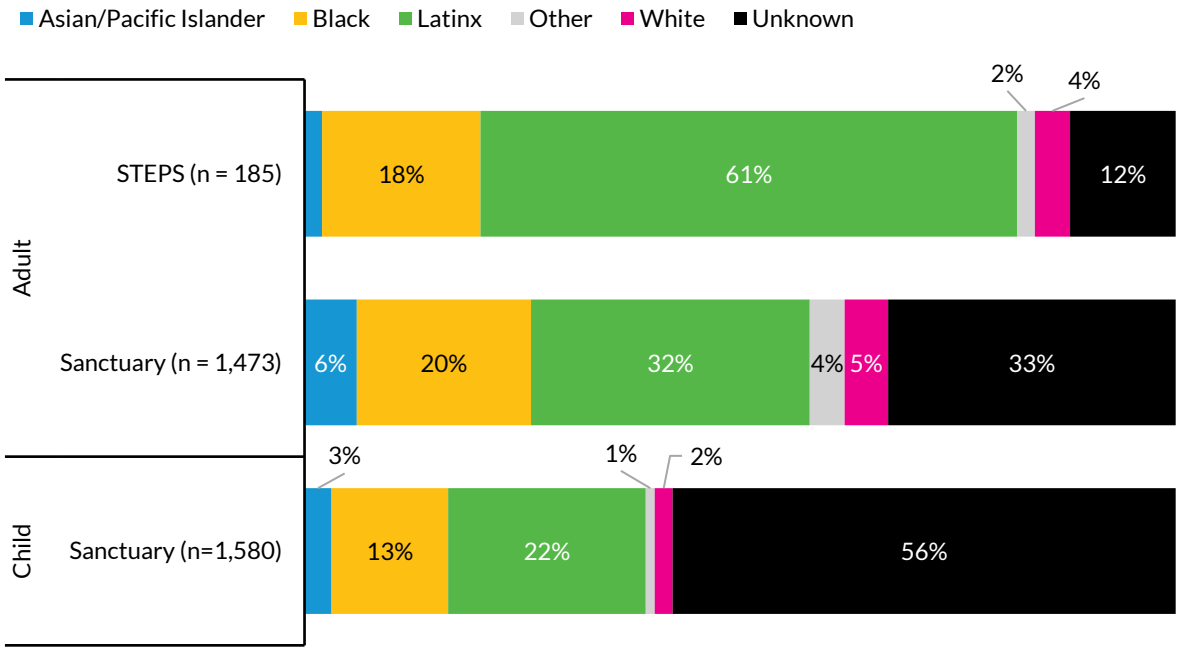


Source: Urban Institute analysis of Sanctuary for Families and STEPS to End Family Violence administrative data.

Most adult clients served by STEPS were Latinx (61 percent), followed by Black (18 percent) and white (4 percent) clients (figure 4). At Sanctuary, a third of adult clients were Latinx (32 percent), 20 percent were Black, 6 percent were Asian or Pacific Islander, and 5 percent were white. Nearly half of Sanctuary adult clients (46 percent) were born outside the United States, while 27 percent were born in the United States and 27 percent were missing information about birth country. STEPS did not report data on the race/ethnicity of child clients. At Sanctuary, information on race/ethnicity was missing for most child clients (56 percent). Twenty-two percent of children were Latinx, 13 percent were Black, and 3 percent were Asian or Pacific Islander.

FIGURE 4

FamilySafe Project Clients at Sanctuary for Families and STEPS to End Family Violence by Race/Ethnicity



Source: Urban Institute analysis of Sanctuary for Families and STEPS to End Family Violence administrative data.

In alignment with FSP program eligibility criteria, all clients reported during the intake process that they had experienced gender-based violence. We examined the traumatic experiences recorded by the clinicians in the intake PCL-5 assessment (*n* = 204). Many clients reported histories of gender-based violence, with experiences of child sexual abuse, familial abuse, witnessing domestic violence, and then domestic violence in adulthood. A few clients reported that they were abused by their in-laws in addition to their partner. Multiple clients said they experienced choking, strangulation, and physical abuse during pregnancy, all indicators of high risk for potential lethal abuse. Some clients shared that the incidents bothering them most at the time of intake were the verbal abuse, psychological abuse, or acts of humiliation perpetrated by their partner. As is common in domestic violence situations, many clients indicated that their partner used pregnancy and their children as tactics for control and escalating abuse. The majority of clients also described experiences in which their children witnessed domestic violence, were also abused, or had been abused by someone other than their partner.

Clients reported various needs and concerns when seeking help from Sanctuary and STEPS. Sanctuary and STEPS clients reported that dealing with their fear and anxiety was their greatest need when first starting FSP services. STEPS clients also reported needing assistance with housing and food.

In addition, Sanctuary and STEPS clients regularly mentioned needing help with emotional regulation, parenting, and psychological support. A few clients reported that they did not know their exact needs when they began services. One explained, "I was just showing up. I was like, I know that this is going to help me. I know that this is gonna be good for me. Just go." Adult clients reported that their children needed treatment because they were having trouble in school and focusing, getting along with others, navigating the effects of experienced abuse and violence, and adjusting to a recent move. In the survey taken by clients soon after intake (*n* = 20), a majority of respondents said they were interested in receiving counseling for themselves (75 percent), counseling for their children (55 percent), and legal or economic empowerment services (50 percent). A smaller share was interested in counseling for their family (30 percent), support groups (25 percent), and shelter (20 percent). (See table A.3 in the appendix for more information about the client survey.)

Traumatic Experiences from COVID-19

Although all clients had experienced gender-based violence, the incident that was bothering them the most at the time of intake sometimes reflected other losses or stressors, such as the death of a loved one. This was especially the case during the COVID-19 pandemic, when some clients reported on the PCL-5 that the most traumatic experience was a family member dying of COVID-19. When clients reported a death as the most pressing trauma, clinicians had to shift away from the FSP treatment model and implement grief counseling.

Design and Adoption of the FSP and FSPAT

Sanctuary and STEPS partnered in 2017 to develop and implement the FSP and the FSPAT, though the implementation by the two organizations differed. Sanctuary and STEPS pursued the partnership because they shared a desire to develop a family-focused treatment model informed by evidence-based assessments. Also, their organizations had an established working relationship and their staff members knew one another. Having never used a family-focused model, Sanctuary sought to learn from STEPS, which already used a family-focused service model and evidence-based assessment tools. **Both STEPS and Sanctuary clinicians agreed that the main reasons for designing and adopting the FSP and FSPAT were to adopt a trauma-focused model of programming that would treat families as a unit and facilitate communication and collaboration between the adult and child treatment staff.** Clients reported that the increased collaboration and communication between staff was beneficial and that the FSP approach of treating the entire family unit was critical to family healing.

Staff reported that having funding dedicated to the design and implementation of the FSP and FSPAT was critical to the project's success. Both programs were able to adopt existing evidence-based treatment curricula to meet the needs of the FSP treatment model. The curricula used in the FSP are the Parenting Journey and CPP-FV programs (which STEPS had used for years). Key staff members and leaders informed the design of the FSP, with some input from clients. For example, clients had shared that having separate intake processes for adults and children was traumatic and time-consuming. As a result, STEPS and Sanctuary designed an intake process that included assessments for the child and adult at the same time.

The funding was also critical for the development of the FSPAT. Originally, STEPS and Sanctuary staff intended to create new assessment tools for the FSPAT. However, STEPS was already using the PROPS and PFI (two evidenced-based tools) successfully, so the staff decided to adopt the PCL-5 and implement the three as the FSPAT across STEPS and Sanctuary. Adoption of the FSPAT was simpler for STEPS than for Sanctuary because the clinicians were already trained on and using the PROPS and PFI and only needed training and practice using the PCL-5. A consulting psychologist trained Sanctuary staff on all three tools. **The FSPAT has since been integrated into the onboarding process for new staff, which clinicians reported as being essential to the success of FSP implementation.**

Staff reported initial reluctance from clinicians about adopting the FSPAT because of fears about pathologizing clients or preventing clients from speaking freely. This reluctance was overcome by focusing on the shared vision to create the family-focused treatment model, and by using a well-known and trusted psychologist to train staff on the FSPAT tools. **Staff generally reported that the external psychologist—who acted as a consultant for the entire design and implementation process—was important to the success of the FSP and FSPAT.** However, during interviews, staff reported that clinicians received inconsistent training on the FSP and FSPAT, with some reporting that they received little training at all, especially those who began their employment during COVID. Sanctuary recently received additional funding to provide standardized and ongoing FSP and FSPAT training to everyone. The new training will provide a deeper dive into the clinical model, including trauma-informed care; race, culture, and ethnicity as they relate to trauma; how to use the assessment tools; and how to synthesize the results of the assessment tools and develop goals with clients.

Most clinicians who participated in the interviews considered the FSP a successful model and highly useful to them and to clients. Some clinicians reported that the FSP was **helpful for collaboration among staff to ensure that the entire family received complementary treatment.** Some also reported that as a result of the FSP and the FSPAT development and training processes, Sanctuary

and STEPS work more closely together and continue to refer clients and share knowledge with one another.

I think that the FamilySafe model has been helpful in understanding that there is a need for everybody in the household to get services if possible and enforcing collaboration between the adult program and the children program. —FSP clinician

Many clinicians said the trauma-informed, family-based treatment approach was beneficial for clients. They explained that the FSP was helpful to both clinicians and clients for learning about and understanding PTSD and the symptoms of trauma, and for providing a way to assess and identify client symptoms at intake. **Several clinicians said that through the FSP, they can confidently implement a trauma-informed model.**

Referral

The first stage of the FSP model is the referral. **Sanctuary and STEPS are well-known organizations and receive referrals from multiple sources, including self-referrals, internet searches, word of mouth, and the social service and justice systems.** New York City's Family Justice Centers[6] are Sanctuary's most common referral source, as documented in the administrative data, while the Manhattan Family Justice Center specifically, community-based organizations, and client referrals are STEPS' most common referral sources. Other key referral sources noted in the data, and by staff and clients, include hotline calls (self-referrals), internal referrals from Sanctuary's legal and economic empowerment departments, and community-based organizations (e.g., Safe Horizon). Once they receive the referrals, Sanctuary and STEPS screen adult clients for FSP treatment eligibility. Clients who have experienced intimate partner violence, or another form of gender-based violence, and have a child living in their home are eligible to participate.

All STEPS clients and most Sanctuary clients reported that the referral source gave them Sanctuary's or STEPS' contact information, and they called the organization to initiate services. Some Sanctuary clients reported that the referral source provided the client's information directly to Sanctuary; then Sanctuary called the client. Some clients also reported that either their shelter or another service provider had facilitated a warm handoff with Sanctuary. Some clients mentioned that

they were on a waiting list for several months, and a few clients expressed frustration about having to call multiple times without a response. However, this may partially reflect the impact COVID had on staffing capacity and access to services.

Intake and Initial Assessment

After referral, the next step is intake and initial assessment, which varies slightly by organization and by clinician. The intake for both Sanctuary and STEPS consists of a clinician administering the FSPAT and a case management rapid assessment (to determine the level of in-house case management needs). Clinicians may also complete a genogram, which is a diagram that shows the family members and their relationships. Given that many clients are in crisis, are experiencing trauma symptoms, and have large families for whom the measures need to be completed, and given the length of the assessments and the sensitivity of the questions (particularly for the PCL-5), **staff reported that the intake typically takes two sessions, sometimes longer, which can be frustrating to clients and delay treatment.** For large families in particular, the intake process can be protracted, as PROPS needs to be completed for each child.

All the clinicians we interviewed found the FSPAT useful and said it largely aligned with their professional judgment. **Clinicians reported that the primary strength of the FSPAT is progress tracking, because it provides a clear picture of how the clients' symptoms have changed, which they can share with clients.** One clinician explained that the FSPAT is "validating both for us and for the clients to see the numbers and, like, have a statistic to say, like, 'Look—this was happening before and this isn't happening now.'" Several clinicians shared that PROPS is helpful in that it provides insight into how parents view their children's functioning, which may be different from what the children are presenting.

However, clinicians reported that the questions might not always be inclusive of clients' true experiences. For example, definitions of family and friends might differ, as some clients have in-laws or extended family members who live with them. Or they may not have any friends if they are recent immigrants, but they could have neighbors who support them or who could be resources. Clinicians also reported that clients have a variety of reactions to completing the initial assessments, including strong trauma reactions in some cases, particularly to the PCL-5, which asks about traumatic experiences and potential trauma symptoms.

I have had parents who either become very overwhelmed by it [the PCL-5] and just can't continue, or I've had parents who are upset by being asked intrusive questions and they think it's like a gatekeeping method to services. I had a parent recently who said, "You know, I've already had to answer all of these questions to get services at intake and [am] on wait lists at other places and it's like it feels demeaning sometimes to be asked certain questions over and over again." How can we be as concise as possible in the questions we're asking? Because we're not the first person who's asked those questions. —FSP clinician

Sanctuary clinicians reported that they use their judgment to vary their approach to the intake and assessments based on the perceived needs of the client, including rewording questions, varying the order of questions, providing breaks, and providing redirection throughout the process. Clinicians found that using the measures as a tool for psychoeducation was beneficial to the clients. In going through PROPS, a clinician may explain how children often do not have the capacity or vocabulary to express their emotions, and that instead their behavior may be more telling. Some parents find this enlightening and see how their children are being affected.

I do it collaboratively with them. And it's not a secret; I literally show them the score. We talk about PTSD, what it means. How does PTSD show up in children? What does PROPS really mean? … There's a lot of psychoeducation involved about trauma and domestic violence. —FSP clinician

Clients reported mixed views of the intake and assessment process. The client survey, which was completed by 20 clients within a few months of beginning FSP services, included several questions about the assessment process. Almost all respondents agreed that the assessment process was explained completely accurately to them over the phone (85 percent). The vast majority also said that the assessments were very helpful for understanding their symptoms (80 percent; see appendix table A.3). Conversely, most clients, especially Sanctuary clients, reported during interviews that they had difficulty remembering the intake process as a whole and were ambivalent about it. It is understandable

that some clients may not recall the assessment process, as it may have occurred months or years before the interview. Generally, clients recalled "answering a lot of questions" and completing paperwork. Several clients remembered the intake staff explaining the services at Sanctuary and STEPS during the intake process. Only two clients, both from Sanctuary, remembered their children undergoing the initial assessments during the intake process. They both reported that the assessments occurred within the first two months of their child's beginning therapy, and one client reported that the therapist had explained the process and purpose to them. Finally, a few clients reported frustration with the process because they were required to complete several intakes because of clinician turnover.

I mean, intakes are always long and, of course, many, many questions. It gets emotional, but this is important for the therapist to understand the story, the history, and the problems. It was painful. I was crying a lot, but of course I knew I have to go through this because she wants to help me. She has to know my situation. —FSP client

Intake and Assessment during COVID-19

During the COVID-19 pandemic, intake sessions remained the same, except that they were conducted virtually rather than in person. Some clinicians reported that it was more difficult to ask highly sensitive questions over the phone or on videoconference, as compared to when sessions were in person. Further, sometimes clients were only available for brief phone calls, as they were managing work, child care, or other disruptions due to COVID. The number of sessions required to complete the intakes increased as a result.

Service Planning

After intake, the next step is developing a plan of services. At STEPS, the same clinician who conducts the intake sessions is the treating clinician, and this clinician establishes a treatment plan. The clinician works with the client to develop flexible, individualized counseling goals based on the FSPAT. The STEPS clinician may also refer family members to additional services and programs, depending on the results of the assessment and the individuals' needs.

Sanctuary tries to keep the intake clinician and client together; however, sometimes the needs of the client require that a different clinician provide treatment. Sanctuary determines this by using weekly FSP team meetings. During these meetings, the clinician presents critical information from the intake sessions and their treatment recommendations to all FSP clinicians, and the group discusses the information and collectively determines an initial treatment plan. Staff reported that although these meetings were helpful for matching clients with appropriate care staff, the discussions about each client were lengthy, which sometimes prevented all cases from being addressed at each meeting, leading to service delays for some clients whose cases had not been discussed yet.

Treatment Planning during COVID-19

After the COVID-19 pandemic began, Sanctuary suspended the weekly case discussion meetings and instead followed STEPS' approach of keeping intake clinicians with clients throughout treatment. Some clinicians liked this change, as clients could begin services more quickly.

Clinicians from both Sanctuary and STEPS reported that it can be difficult to synthesize the information from the intake to create meaningful and operational counseling goals. Some clinicians reported that it was easier to develop treatment goals for higher scores than for lower scores. For example, high PCL-5 scores can map onto specific counseling goals related to reducing trauma symptoms. However, if the client had a low score, indicating low trauma, it was difficult to set corresponding goals. Some clinicians also reported confusion about counseling goals when the event listed on the PCL-5 was not the event causing the client most discomfort and dysfunction, or when there were multiple ongoing events impacting the client. Also, most of the interviewed clients reported that they did not recall setting goals with their clinician and/or did not revisit the goals during counseling. The challenges in setting and using counseling goals could stem from a lack of guidance on how to combine the various sources of information gathered during intake. Further, some of the assessments, particularly the PCL-5, may identify priorities different from the current priority related to gender-based violence. Lastly, each assessment has a different purpose which may not readily translate to counseling goals.

You take all these different pools of information that you're getting, whether it be the intake, which is a biopsychosocial [assessment], then you've got the assessments and you've got the case manager rapid assessment, and we also do a genogram, by the way, and we haven't tried to figure out how to synthesize all of that into the goals. —FSP clinician

Services and Programming

With a plan identified, the provision of services and programming begins. Depending on the needs of the clients, services may consist of counseling, reassessment using the FSPAT, group programs, case management, and other services. Both STEPS and Sanctuary provide multiple programs and services to FSP clients, including individual adult and individual children's counseling, family therapy, and family workshops. In addition to general counseling and other programs and workshops, Sanctuary and STEPS deliver three specific evidence-based therapy models for FSP clients: Parenting Journey (including Parenting in America), CCP-FV, and TF-CBT. Depending on their needs and availability, families can participate in multiple models and services at once.

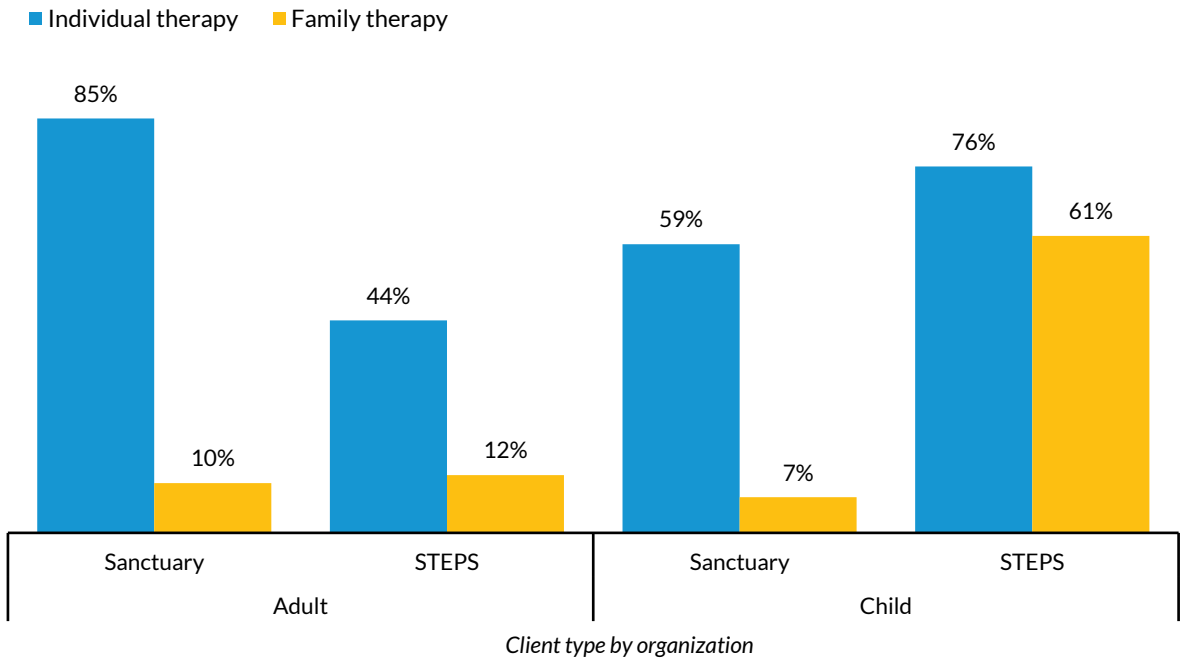
COUNSELING

Generally, clinicians reported positive experiences with FSP programming and providing services. They reported that the FSP's greatest strength was its flexibility, allowing clinicians and clients to create a family-focused and trauma-oriented plan that met the unique needs of each client. That is, even though there were challenges with the initial assessment and service planning process, the clinicians appreciated the FSP service model.

Individual counseling was the most common type of service that adult and child clients received (figure 5). At Sanctuary, 85 percent of adult clients and 59 percent of child clients received individual counseling. A much smaller share of adult and child clients received family therapy. At STEPS, 44 percent of adult clients and 76 percent of child clients received individual counseling. Family therapy was also common for child clients, but not adult clients at STEPS.

FIGURE 5

Shares of Adults and Children Receiving Individual and Family Therapy by Organization



Source: Urban Institute analysis of Sanctuary for Families and STEPS to End Family Violence administrative data.

Overall, clients reported positive experiences with FSP programs. **Clients overwhelming reported that the nonjudgmental understanding and support provided by clinicians was most beneficial to them.** Also, many clients, primarily those who spoke Spanish, reported that the ability to speak in their native language was key to their success in therapy. They stated that without the ability to speak in their native language they would not have been able to share or to express themselves as they needed to. Generally, clients expressed appreciation for clinicians who listened deeply to their needs and worked to find unique solutions even when those needs were challenging or outside the scope of psychotherapy. Clients also reported that they valued the clinicians who communicated well and often; clinicians who were present throughout treatment; and clinicians who explained programs, processes, and progress throughout treatment.

I would say [what was most helpful about the counseling was] making me feel comfortable and understanding that domestic violence is a lot more common than we'd like to think. I think I felt safe. I felt like I could be vulnerable because I think, just for myself, it was very hard for me to admit that I had been abused and that I was in this type of relationship. When I finally opened up to that, I felt that I had really surrendered and was able to heal. I would say I felt safe and understood. —FSP client

Clients reported a few challenges with receiving FSP services, particularly during COVID, which caused significant disruption to FSP processes. Abrupt case closures and clinician departures were the greatest challenges reported by clients. Most clients reported having more than one therapist throughout therapy, and they said that the transition between therapists was typically unplanned and resulted in large gaps of time between ending treatment with one therapist and beginning with another. To address staffing shortages, some supervisors took on the cases of clinicians who had departed. Many clients also reported having to call many times to contact staff, rarely having their calls returned, and having therapy sessions and other appointments canceled at the last minute. A few clients also reported inconsistent communication from staff.

I changed counselors and that hurt me a lot. I always say that shouldn't be done, because you suffer a lot. When you have a new counselor, you have to retell things you don't want to remember so she can learn about your problems.

It was just really unfortunate, the timing, when she ended. A lot had happened in my life. I felt like I wasn't done, and my case got wrapped up because they were short on therapists. —FSP clients

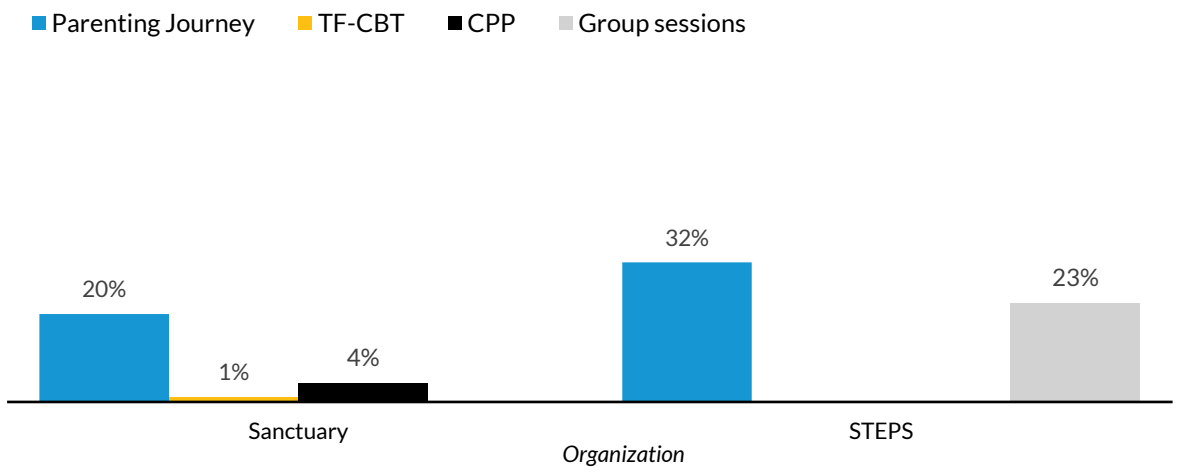
CLINICAL PROGRAMS

As part of the FSP, Sanctuary and STEPS also provide specific treatment modalities to clients. Specifically, Parenting Journey, TF-CBT, and CPP-FV may be provided based on the family's needs and

interests. At both Sanctuary and STEPS, Parenting Journey (including Parenting in America) was the program that adult clients participated in most frequently (figure 6). Small shares of clients at Sanctuary participated in TF-CBT (1 percent) and CPP-FV (4 percent). STEPS also frequently provided other group sessions to clients, such as Woman to Woman / Mujer a Mujer.[7] Many of the group-based programs were paused and then adapted due to the COVID-19 pandemic.

FIGURE 6

Shares of Adult FamilySafe Project Clients Participating in Treatment Modalities



Source: Urban Institute analysis of Sanctuary for Families and STEPS to End Family Violence administrative data.

REASSESSMENT

To track clients' treatment progress and program effectiveness, FSP clinicians are expected to administer the FSPAT to clients every three months. **Most clinicians reported that they use the FSPAT scores to understand clients' progression through treatment and discuss progress with clients.** They reported that scores can vary throughout services and are not linear, as clients' situations and needs may change. Though these variations in scores (both initially and over time) do not affect how clinicians use the FSPAT, they do shape how clinicians interpret FSPAT results. Clinicians reported that the FSPAT is particularly challenging to use when the scores do not change or if they increase, especially because the FSPAT does not measure all aspects of a client's experiences or progress. The clinicians explained that they collaborate with their clients and discuss the changes in scores, which serve as a measure of progress and allow clients to visualize changes.

Some clinicians found it difficult to discuss the results of the measures with clients when the numbers were not changing or were indicating an increase in symptoms. Given the population the FSP is serving—individuals who have experienced significant trauma and may still have contact with their

abuser—it is understandable that this particular challenge arises. **Several clinicians shared that they sometimes delay administration of the FSPAT measures because they do not provide nuance that reflects the specific circumstances a client may be experiencing at the time of administration.** For example, if a clinician believes the FSPAT scores will be particularly high one day due to circumstances such as the client having to appear in court, they will defer administration. Clinicians were concerned that a high score generated on a day when a client might be experiencing greater stress and an increase in trauma symptoms would not be reflective of how a client was doing overall and could cause the client to feel like they weren't progressing. Some clinicians reframe the scores by saying that maybe the client's symptoms haven't changed, but they may have had shifts in their thoughts and behaviors that are not captured by the FSPAT. This indicates that it is important to talk about progress and changes more globally and not be limited to what is measured by the FSPAT.

The frequency of reassessment varied but was close to the intended frequency, as reported by clinicians and as captured in Sanctuary's administrative data. On average, the first reassessment occurred approximately 4 months after the intake assessment (118 days for the PCL-5, 120 days for the PFI, and 125 days for PROPS; table 3). Additional reassessments on average occurred 3.3 to 5 months after the previous assessment (100 days for the PCL-5, 155 days for the PFI, and 103 days for PROPS). The amount of time between the last assessment and the reassessment varied greatly. Some clients had approximately a week between assessments, while others had a year or two between assessments. However, many clients were reassessed on the FSPAT close to the 3- and 6-month marks, as intended in the FSP model.

TABLE 3

Number of Days between Previous Assessment and Reassessment

Sanctuary for Families FamilySafe Project clients assessed from April 2018 to June 2021

	First reassessment			Additional reassessment		
	Median days	Minimum, maximum	*N*	Median days	Minimum, maximum	*N*
PCL-5	118	(5, 624)[a]	294	100	(1, 804)	485
PFI	120	(6, 965)	656	155	(17, 562)	564
PROPS	125	(3, 820)	303	103	(10, 450)	398

Source: Urban Institute analysis of Sanctuary administrative data.

Notes: PCL-5 = PTSD Checklist for DSM-5. PFI = Protective Factors Instrument. PROPS = Parent Report of Post-Traumatic Symptoms. First reassessment refers to the number of days between the intake assessment and the first reassessment. Additional reassessment refers to the number of days between any subsequent reassessments and the most recent reassessment.

[a] There is a large range of days for the follow-up assessment for each assessment type. The minimum days to follow-up assessment (5 to 7 days) reflects how some clients were assessed on a weekly basis. The maximum days to follow-up (approximately two years for some assessments) likely reflects how some clients may have disengaged from services for extended periods and then reengaged.

Generally, client reports varied in terms of the frequency at which they recalled receiving reassessments, with Sanctuary clients reporting reassessment every three to six months and STEPS clients reporting reassessment less consistently—from every month to every year. Many clients reported never receiving reassessments, and some did not remember whether they had been assessed at all. One of those who remembered the assessments recalled that staff "evaluated everything—me, my children, my needs, my traumas and those of my children, if my children needed special education, if they had suffered traumas or had any health conditions. All of this was evaluated at the beginning, before starting the sessions, and then they checked every three months." Some interviewees reported that staff reviewed the results of the assessments and used them to track treatment progress; others reported that staff never explained or referred to the assessment results during treatment. Those who remembered the assessments, and conversations about the results, said they helped them talk about their experiences in a "rational" way. One client explained, "It's helpful because it gives you a scale to understand and monitor where you're at in the process of coping with trauma. I think that's what it's mainly helpful for." Finally, few clients remembered reassessments for child clients, and those who did remember were ambivalent about their usefulness.

CASE MANAGEMENT AND ADDITIONAL SERVICES

Case management services are either delivered by a case manager employed by Sanctuary or STEPS, or, if the client is determined during intake to have low need, are provided by the FSP clinician. Clients also receive referrals to services within and outside the two organizations. Although most clients reported that they were satisfied with the referral process, a few mentioned that referrals were difficult at times because they would be referred to an internal service at Sanctuary or STEPS and never receive those services, or would be referred externally to inappropriate services. In addition, many clients reported receiving services beyond counseling, such as employment programming and financial and legal services. They also reported that the organizations provided them and their families with child care during therapy sessions, clothing, housing support (rent support and furniture), food (gift cards and pantry items), Christmas gifts, and baby supplies when needed. Both organizations also provided transportation support to clients when they could not afford to travel to their appointments. Most children participated in additional opportunities such as summer camps, reading programs, art activities, and Thanksgiving and Christmas parties and received school supplies. **Clients appreciated the variety of services and resources provided to them by Sanctuary and STEPS in addition to therapy, especially the events and activities tailored to both parents and children.**

FamilySafe Counseling and Services during COVID-19

During the COVID-19 pandemic, Sanctuary continued to provide individual adult and individual children's counseling, family therapy, and case management as normal; however, all services were offered virtually using various platforms. The Parenting Journey programming was suspended because it could not be implemented virtually, though it has since restarted. Clinicians supplemented Parenting Journey with a virtual parenting support group. CPP-FV and TF-CBT were provided remotely. Clinicians continued reassessing clients, as required; however, clinicians noted that they had to be slightly more flexible with scheduling.

Clinicians reported both positives and negatives to the treatment changes implemented due to COVID. One the one hand, virtual services offered greater convenience for clients who had busy schedules, who lived far from the office, who often forgot about appointments (during COVID-19, clinicians called clients), and who did not have child care for appointments. On the other hand, virtual services were difficult if clients did not have reliable technology, awareness of technology, or privacy for appointments. Remote service provision was also difficult for group treatment, especially with young children, and for children who needed play therapy.

Overall, clinicians reported that implementing the FSP and FSPAT took longer due to the shift to remote work and the need to navigate remote service delivery with clients. For example, clinicians reported that the assessments and service provision took longer because clients were sometimes busy or multitasking (e.g., at work, cooking, taking care of children) during their virtual appointments. The impacts of COVID also required an increase in case management services provided by clinicians, which sometimes impeded therapy services. **Clinicians also shared that staffing shortages since COVID have severely impeded program implementation.** Staffing shortages have included not only the actual open positions but also the limited capacity of staff who speak other languages. Further, some clinicians noted that they couldn't refer people on the wait list to other organizations, whose programs were also full.

Clients we interviewed said they found in-person and virtual service options beneficial depending on the services they were participating in. On the one hand, some clients preferred in-person services because they felt the human contact increased progress and feelings of connection. They also preferred activities such as yoga and family events in person. On the other hand, some clients preferred virtual service provision because it was more convenient and enabled them to attend therapy more consistently when balancing work and other commitments. They also reported that the trip to the organizations' locations could be "draining" and "scary" at times because of their experienced trauma.

FSP Completion

Participation in the FSP ends when the family disengages or when every family member completes their services, which is determined jointly by the client and clinician. Though some families disengage or do not complete every service, staff reported that many families and family members make progress toward their counseling goals and complete individual services and programs.

Clinicians reported that their clients remain in the FSP for varying lengths of time, depending on the intervention they are using and the challenges the clients are experiencing. One clinician said family counseling generally takes "eight months to a year," and their parenting work is "curriculum based, so it's only usually like three months, so we have a lot more turnover there." Another clinician said the short-term counseling they provide usually takes six to nine months. A few clinicians noted that one of the strengths of the FSP model is that it is very flexible, and clients can remain in programming as long as needed to meet their goals.

The administrative data reflected that the flexibility of the FSP results in a different quantity or dosage of certain counseling services delivered to each client. On average, adult clients at Sanctuary received 15 counseling sessions, with a range of 0 to 81 sessions,[8] and children received 132 sessions, with a range of 0 to 94 sessions (table 4). At STEPS, adult clients received an average of 10 counseling sessions, with a range of 0 to 62 sessions, and children received an average of 19 sessions, with a range of 0 to 71 sessions. The most common counseling type was individual counseling, but sessions could also include family and group therapy. The average length of time from case opening to closure for adult clients was 273 days at STEPS, with a range of 22 days to 2 years and 3 months, and 65 days at Sanctuary, with a range of 1 day to nearly 2 years. For children at Sanctuary, the average length of time from referral to case closure was 115 days, with a range of 1 day to more than 3 years. Several clients we interviewed also described receiving ongoing services for several years, indicating that the FSP allowed for meaningful, long-term engagement with the families.

TABLE 4

Duration and Quantity of Services for FamilySafe Project Clients

	Mean number of counseling sessions (minimum, maximum)	Mean days from referral to closure (minimum, maximum)
STEPS		
Adults	10 (0, 62)	273 (22, 824)
Children	19 (0, 71)	Not reported
Sanctuary		
Adults	15 (0, 81)	65 (1, 705)
Children	13 (0, 94)	115 (1, 1, 113)

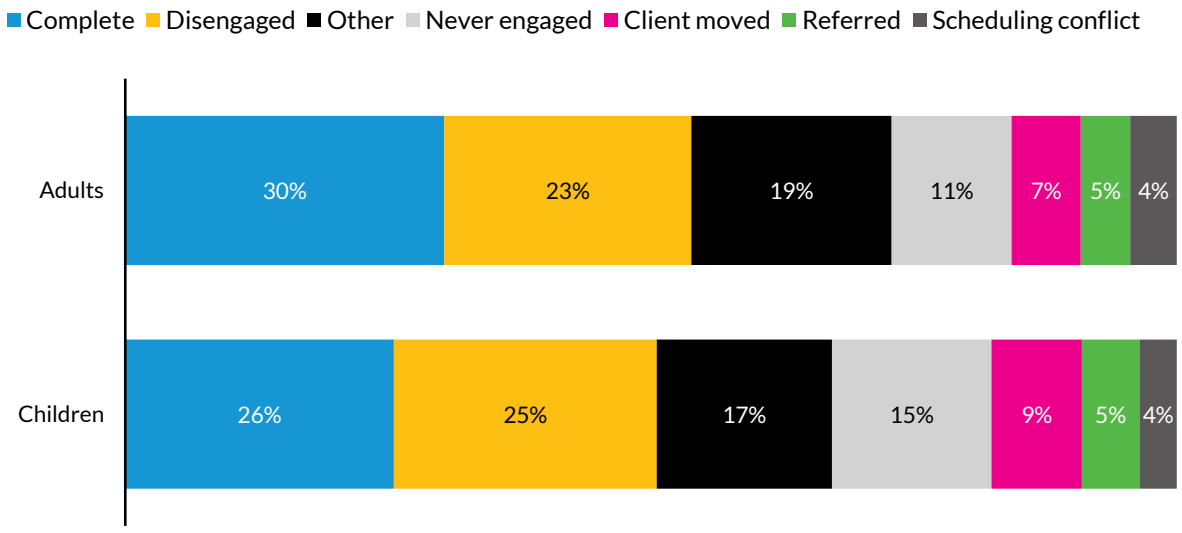
Source: Urban Institute analysis of Sanctuary for Families and STEPS to End Family Violence administrative data.
Notes: Clients with zero days from referral to case closure are excluded from the number-of-days calculations. STEPS did not report referral and case closure dates for children.

From July 2017 to June 2021, 235 adults and 192 children successfully completed the FSP across Sanctuary and STEPS. Of all the adult clients who ended FSP participation, 30 percent were successful completions (figure 7). The other most common case closure reasons were that the client disengaged (23 percent), never engaged after intake (11 percent), or moved (7 percent). Smaller shares of closures owed to the client being referred elsewhere (5 percent), scheduling conflicts (4 percent), staff capacity (1 percent), and rules (1 percent). Many adults and children continue to receive services and therefore are not reflected in figure 7.

FIGURE 7

Reasons for Case Closure for FamilySafe Project Clients

Adults (n = 745) and children (n = 732) at Sanctuary for Families



Source: Urban Institute analysis of Sanctuary for Families administrative data.
Note: Included in the "other" category are 1 percent of closures that owed to staff capacity and 1 percent that owed to rules.

Service Completion during COVID-19

Generally, during the COVID-19 pandemic, services ended as usual for clients—when they disengaged or reached their goals. COVID increased the length of time clients received services, as many clients experienced challenges and losses due to COVID and needed additional support. Sanctuary, specifically, did not end services with any clients during the early stages of COVID, as many clients had new needs.

Client and Family Outcomes

Receiving counseling through the FSP can contribute to many different outcomes for clients individually and for their families. For most clients and families, participation in the FSP contributed to meaningful changes in their lives. Adult clients reported that they experienced increased confidence, self-esteem, and understanding of their trauma. They also experienced reductions in their PTSD symptoms. At the family level, many adult clients reported that they were better able to solve problems, had improved communication, and had strengthened relationships with their children. For children, parents reported that their grades in school and their ability to manage emotions improved. Children also experienced reductions in PTSD symptoms.

Outcomes for Parents

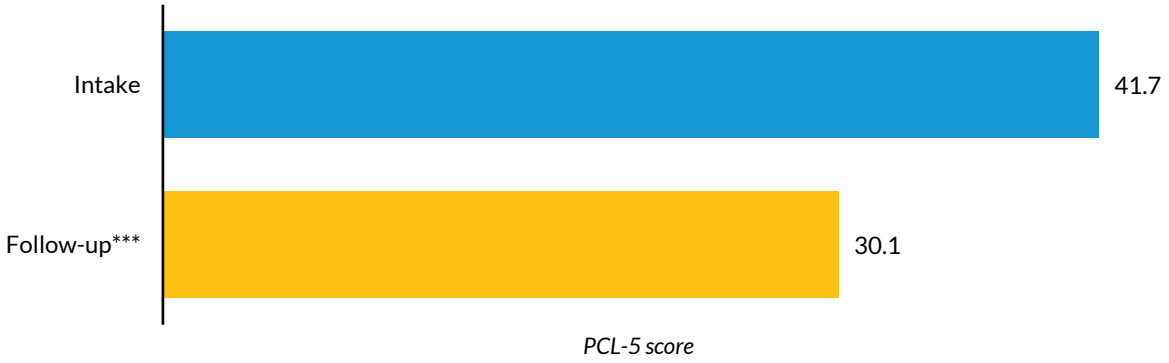
During our interviews, many adult clients reported positive outcomes for themselves. When asked about perceived impacts and outcomes, the most common benefits clients reported were **increased confidence and self-esteem, both as individuals and as parents**. Many clients also reported that therapy helped them **better understand abuse and trauma** and related triggers and thought patterns. A few Sanctuary clients and two STEPS clients reported that they have **more compassion and forgiveness toward themselves** and can give themselves "more credit." Increased patience, decreased fear, and increased emotional regulation were also mentioned by a few clients. Because of their experiences at Sanctuary or STEPS, many clients reported feeling like the staff and other clients "are now family"—so much so that a few clients reported that they refer others to Sanctuary and STEPS. However, a few clients from both Sanctuary and STEPS reported noticing no change in their confidence as individuals or as parents or in their ability to solve problems. One client reported that they were unable to meet any of their goals.

Adult clients generally also experienced reductions in PTSD symptoms. The FSP program calls for all adult clients to be assessed with the PCL-5 at intake and to be reassessed every three months. Through an analysis of PCL-5 assessment scores, we find that PTSD symptoms decreased as clients participated in the FSP. For adult clients at Sanctuary who had both an initial assessment and a follow-up assessment, the average initial PCL-5 score was 41.7 and the average final follow-up score was 30.1 (figure 8). In other words, the average client's score decreased by 11.6 points (28 percent), and their level of PTSD symptoms decreased from high to moderate. This decrease was statistically significant. The substantial decrease in scores on the PCL-5 provides evidence that receiving counseling and other services from the FSP may help reduce levels of PTSD symptoms. Given the variety of effects that symptoms of PTSD can have on everyday life, this likely represented a meaningful improvement for clients. The decrease in PTSD symptoms was also confirmed by clinicians, who reported that they observe these decreases as clients continue in the FSP. One potential limitation of this analysis is that clinicians reported that they may not administer the PCL-5 at the planned date if the client is having a bad day and is symptomatic, as the PCL-5 can be triggering. This may lead to follow-up scores being slightly lower, as only clients who are considered ready for the assessment receive it.

FIGURE 8

Average PCL-5 Score at Intake and Reassessment

Adult FamilySafe Project clients at Sanctuary for Families (n = 293)



Source: Urban Institute analysis of Sanctuary for Families data.
Notes: PCL-5 = PTSD Checklist for DSM-5. The minimum possible score is 0 and the maximum possible score is 80. *** Difference in intake and follow-up scores is significant at an alpha level of less than 0.001 using a paired *t*-test.

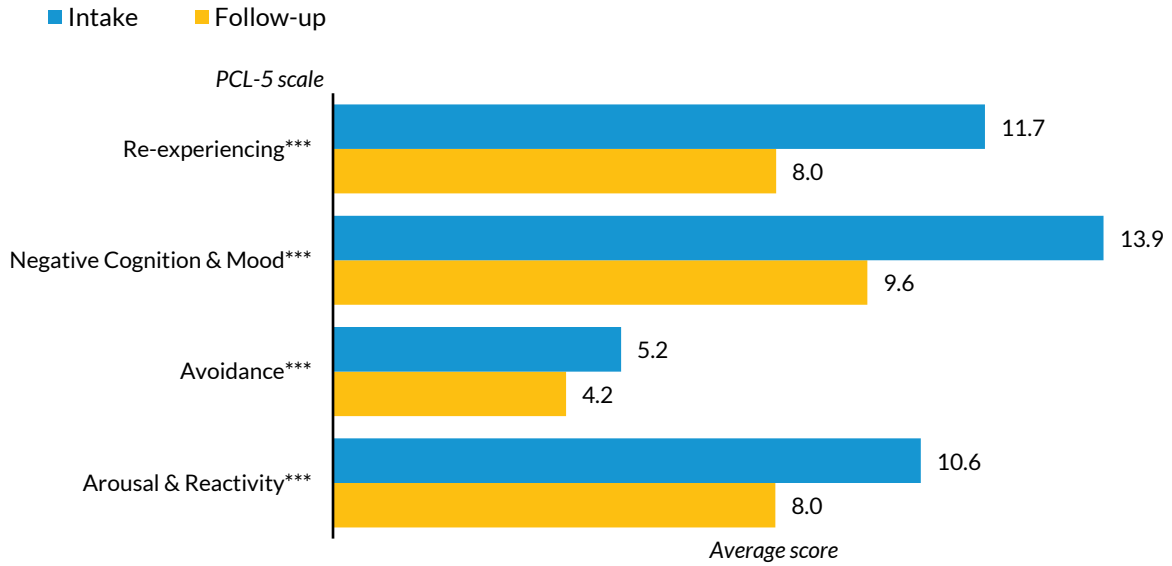
Clients also experienced substantial decreases in all the types of PTSD symptoms measured on the PCL-5. The PCL-5 has four subscales of different types of PTSD symptoms: reexperiencing, negative cognition and mood, avoidance, and arousal and reactivity. On average, the reexperiencing score decreased 32 percent, from 11.7 to 8.0 (figure 9). The negative cognition and mood score decreased 31

percent, from 13.9 to 9.6. The avoidance score decreased 19 percent, from 5.2 to 4.2. The arousal and reactivity score decreased 25 percent, from 10.6 to 8.0. All the decreases in the scores were statistically significant. The large decreases in all the types of symptoms indicate that participating in the FSP may help address PTSD symptoms broadly.

FIGURE 9

Average PCL-5 Scale Score at Intake and Reassessment

Adult FamilySafe Project clients at Sanctuary for Families (n = 296)



Source: Urban Institute analysis of Sanctuary for Families data.
Notes: PCL-5 = PTSD Checklist for DSM-5. *** Difference in intake and follow-up scores is significant at an alpha level of less than 0.001 using a paired *t*-test.

Outcomes for Families

Parents we interviewed reported many impacts for their families, including an **increased ability to solve problems and advocate for themselves and their children**, **strengthened relationships** with their children, and an **increased ability to understand and communicate with their children**. One client explained that "thanks to Sanctuary, we're now people who see reality as it is. We talk openly at home, we fix our problems together, we listen to each other. Counseling helped me a lot with my children." In contrast, when asked about changes in their relationship and communication with their children, a few clients (mostly those who spoke Spanish) reported no change. They typically explained that this was because their relationship and communication were strong before receiving therapy through the FSP.

In the FSP model, protective factors in the family are intended to be assessed at intake using the PFI and then every six months. The PFI is based on the parent's perceptions of their family. The PFI is scored on a positive scale, meaning that a higher score indicates higher levels of protective factors. For families with both an initial and second score, the average score increased by 0.7 points, from 15.1 to 15.8 (figure 10). The small increase, which was statistically significant, indicates that participation in the FSP may positively influence family protective factors as measured by the PFI. On average, parents reported moderate to strong levels of each protective factor at intake, so it may not be surprising that they reported only modest increases over time. In addition, the scoring of the PFI may make changes seem less pronounced because it averages across all the items in each subscale on a 1–5 scale and then adds the subscales together for the combined score (for a possible combined score of 4–20).

FIGURE 10

Average Combined PFI Score at Intake and Reassessment

Families at Sanctuary for Families (n = 629)

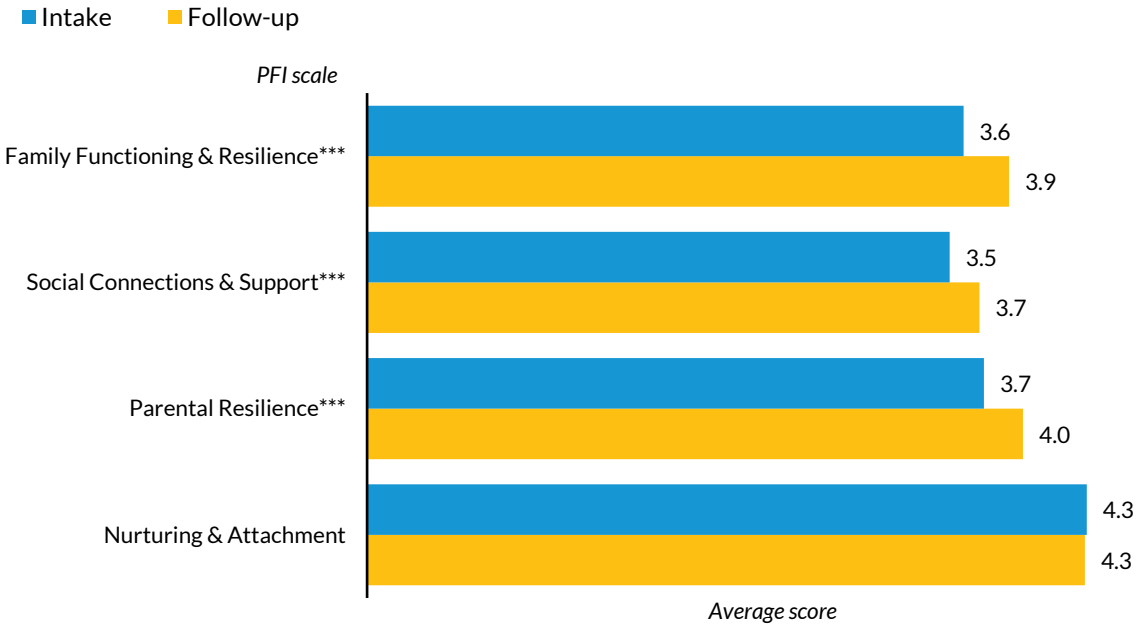
Source: Urban Institute analysis of Sanctuary for Families administrative data.
Notes: PFI = Protective Factors Instrument. The minimum possible combined score is 4 and the maximum possible score is 20. *** Difference in intake and follow-up scores is significant at an alpha level of 0.001 using a paired *t*-test.

Average scores on most of the scales of protective factors also increased significantly (figure 11). Notably, the average score on all PFI domains at baseline was between 3 and 4 (on a scale of 1 to 5), meaning that most clients are neutral or in agreement with the items when they begin the FSP. At follow-up, the average score indicates that they were still neutral or in agreement with the items. The average scores significantly increased on the family functioning and resilience, social connections and support, and parental resilience scales. The average nurturing and attachment score did not change from baseline to follow-up and was the highest of all the scales, at 4.3. The increase across multiple scales indicates that participating in the FSP may help build up protective factors within families.

FIGURE 11

Average PFI Subscale Score at Intake and Reassessment

Families at Sanctuary for Families (n = 636)



Source: Urban Institute analysis of Sanctuary administrative data.

Notes: PFI = Protective Factors Instrument. The minimum possible score is 1 and the maximum possible score is 5. *** Difference in intake and follow-up scores is marginally significant at an alpha level of 0.001 using a paired *t*-test.

Outcomes for Children

Parents reported improvements in their children's performance at school, emotions, and behavior. **Improved grades in school** were the most common outcome reported by clients of both Sanctuary and STEPS. **Improved relationships** and **the ability to manage emotions or behaviors** were also frequently mentioned. For instance, one client reported that their children had regularly fought with one another before therapy but had rarely fought since therapy. A few Sanctuary clients reported that their children experienced and displayed less fear and were more open and willing to participate in activities throughout the day. A few clients reported that their children demonstrated no changes.

Through the PROPS assessment tool, clinicians measure changes in levels of PTSD symptoms in children. PROPS measures a child's PTSD symptoms based on the parent's perceptions, as reported to the clinician. PROPS is scored at intake for all children. The average initial PROPS score was 21.6 and the average score at the final reassessment was 16.2 (figure 12), a statistically significant decrease of 25 percent. Considering the effects that PTSD symptoms can have on a child's development, associations

with family, and performance in school, this reduction likely was associated with meaningful improvements for the children. This substantial score reduction indicates that participation in the FSP may help reduce PTSD symptoms in children.

FIGURE 12

Average PROPS Score at Intake and Reassessment

Child FamilySafe Project clients at Sanctuary for Families (n = 307)

Source: Urban Institute analysis of Sanctuary for Families administrative data.
Notes: PROPS = Parent Report of Post-Traumatic Symptoms. *** Difference in intake and follow-up scores is significant at an alpha level of less than 0.001 using a paired *t*-test.

FSPAT Validation

Another purpose of the evaluation was to examine the performance of the tools used in the FSPAT. As part of the intake and reassessment process, FSP clinicians administer the PCL-5 and PFI to understand parents' levels of PTSD symptoms and levels of protective factors in the family. Both assessment tools have been validated in various populations and settings. However, this is the first examination of the reliability and validity of these tools for FSP clients. We found that both the PCL-5 and PFI perform well in terms of internal consistency, item discrimination, and convergent validity. The performance of both tools is similar to that seen in previous validation studies. We also found that the tools perform well for both English and non-English speakers, people born in and outside the United States, and people of different races and ethnicities.

This section reports the technical results of the validation analyses for each tool and subgroup of clients. The validation analyses were conducted on a sample of FSP clients from Sanctuary. The PCL-5 and PFI assessments were conducted as part of the intake process for this sample. Table 5 reports the descriptive statistics of the sample (*n* = 215).

TABLE 5

Descriptive Statistics of Sample with PCL-5 and PFI Scores

	PCL-5		PFI	
	n/frequency	Mean/share	*n*/frequency	Mean/share
Characteristic				
Item score	215	2.07	215	3.90
Total score	215	41.15	215	109.91
Age at start of services	211	36	212	36
Woman	201	95%	202	95%
Primary language	**212**		**213**	
English	105	50%	104	49%
Spanish	77	36%	77	36%
Other	34	16%	36	17%
Birth country	**201**		**202**	
United States	57	28%	55	27%
Any other country	144	72%	147	73%
Race/ethnicity				
Asian / Pacific Islander	30	14%	30	14%
Black	46	22%	47	22%
Latinx	85	40%	85	40%
White	21	10%	21	10%

Source: Urban Institute analysis of Sanctuary for Families assessment data.

Notes: PCL-5 = PTSD Checklist for DSM-5. PFI = Protective Factors Instrument. Clients may report more than one primary language and/or race/ethnicity.

PCL-5

Overall, the PCL-5 performs well when examining the items and subscales collectively. For each item, table 6 reports the mean, standard deviation, skew, and item discrimination slope and the Cronbach's alpha value if that item were removed from the PCL-5. The overall Cronbach's alpha and inter-item correlation are also reported. The overall Cronbach's alpha value of the PCL-5 is 0.89 (table 6), indicating that all the items relate to each other well. Most item discrimination slopes are above 0.2 and many are above 0.65, indicating that they distinguish well between different levels of PTSD symptoms. All the items perform well, but the items with the lowest performance were items 8, 16, and 17.

Although not a primary focus for the validation and although a normal distribution of scores might not be expected, the skewness helps in understanding the distribution of the baseline item scores across the sample of clients (e.g., whether there were situations in which some clients received an exceptionally low or high item score that skewed the overall mean on that item). Generally, a skewness value above 1 (absolute value) is considered highly skewed, and a value between 0.5 and 1 is considered moderately skewed (Bulmer 1979). A negative value indicates that the item is left-skewed (has a long left tail) and the mean (average score) is to the left of (less than) the median (50th percentile score). A positive value indicates that the item is right-skewed (has a long right tail) and the mean is to the right of (greater than)

the median. Item 16 is highly skewed, and items 1, 4, 8, 11, 14, and 17 are moderately skewed (table 6). For example, most clients selected 0 ("not at all") for item 16, which caused it to be highly skewed.

TABLE 6

All PCL-5 Item Results

Item discrimination and Cronbach's alpha calculated for all items together

Item	In the past month, how much were you bothered by:	Mean	SD	Skew	Item discrim.	α if deleted
1	Repeated, disturbing, and unwanted memories of the stressful experience?	2.75	1.26	-0.62	0.66	0.88
2	Repeated, disturbing dreams of the stressful experience?	1.71	1.54	0.26	0.51	0.89
3	Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	2.07	1.49	-0.04	0.48	0.89
4	Feeling very upset when something reminded you of the stressful experience?	2.87	1.22	-0.92	0.54	0.89
5	Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	2.31	1.42	-0.29	0.57	0.89
6	Avoiding memories, thoughts, or feelings related to the stressful experience?	2.4	1.55	-0.43	0.44	0.89
7	Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	2.52	1.48	-0.48	0.45	0.89
8	Trouble remembering important parts of the stressful experience?	1.21	1.59	0.82	0.31	0.90
9	Having strong negative beliefs about yourself, other people, or the world?	2.02	1.53	-0.02	0.55	0.89
10	Blaming yourself or someone else for the stressful experience or what happened after it?	2.42	1.47	-0.49	0.56	0.89
11	Having strong negative feelings such as fear, horror, anger, guilt, or shame?	2.57	1.46	-0.6	0.68	0.88
12	Loss of interest in activities that you used to enjoy?	2.00	1.53	-0.06	0.63	0.88
13	Feeling distant or cut off from other people?	2.23	1.48	-0.28	0.55	0.89
14	Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	1.42	1.47	0.53	0.48	0.89
15	Irritable behavior, angry outbursts, or acting aggressively?	1.72	1.47	0.26	0.47	0.89
16	Taking too many risks or doing things that could cause you harm?	0.36	0.84	2.66	0.26	0.89
17	Being "superalert" or watchful or on guard?	2.52	1.50	-0.56	0.36	0.89
18	Feeling jumpy or easily startled?	1.77	1.52	0.18	0.57	0.89
19	Having difficulty concentrating?	2.07	1.40	-0.15	0.60	0.89
20	Having trouble falling or staying asleep?	2.39	1.53	-0.4	0.61	0.89

Source: Urban Institute analysis of Sanctuary for Families assessment data.

Notes: PCL-5 = PTSD Checklist for DSM-5. Item discrim. = item discrimination. SD = standard deviation. Mean inter-item correlation = 0.296. Overall Cronbach's α = 0.894. Possible values for each item range are on a 5-point scale from 0 (not at all) to 4 (extremely).

PCL-5 SUBSCALES

Here we examine each subscale of the PCL-5 separately. Because each subscale of the PCL-5 measures a different set of PTSD symptoms, it is important to see how well the items in the subscale load together or are a consistent measure of the concept. Table 7 reports the number of items in the subscale and the Cronbach's alpha for the subscale. All the subscales have a Cronbach's alpha above 0.7, indicating that the items are internally consistent, or relate to each other well. The strong internal consistency of the subscales is expected, given that the PCL-5 is a validated scale.

TABLE 7

PCL-5 Subscale-Level Analysis Results

Cronbach's alpha calculated for each subscale separately

	Items	Cronbach's alpha
Subscale		
Reexperiencing	5	0.79
Avoidance	2	0.72
Negative cognition and mood	7	0.79
Arousal and reactivity	6	0.71

Source: Urban Institute analysis of Sanctuary assessment data.
Note: PCL-5 = PTSD Checklist for DSM-5.

Given that each subscale of the PCL-5 measures a different set of PTSD symptoms, it is important to examine whether scores on one subscale are associated with scores on another subscale. Table 8 shows a correlation matrix of the subscale scores and overall PCL-5 score. The overall score is significantly correlated with all subscales. This is expected, given that each subscale feeds into the overall score. When looking at the individual subscales, all subscales are significantly correlated to the others. This indicates that clients tend to score similarly across all the subscales. That is, if a client scores highly on one subscale, they likely score highly on the other subscales. There are moderate positive correlations (0.3 to 0.5) between arousal and reactivity and avoidance, negative cognition and mood and avoidance, and avoidance and reexperiencing. There are strong positive correlations (greater than 0.5) for arousal and reactivity and negative cognition and mood, arousal and reactivity and reexperiencing, and negative cognition and mood and reexperiencing. The moderate and strong correlations between subscales indicate good performance of the PCL-5 for this sample of clients.

TABLE 8

PCL-5 Domain Correlation Results

Correlation matrix of subscales and total score

	Total	Reexperiencing	Avoidance	Negative cognition and mood
Subscale				
Reexperiencing	0.82***			
Avoidance	0.59***	0.41***		
Negative cognition and mood	0.89***	0.59***	0.41***	
Arousal and reactivity	0.86***	0.59***	0.39***	0.69***

Source: Urban Institute analysis of Sanctuary assessment data.

Notes: PCL-5 = PTSD Checklist for DSM-5. Pearson correlation, *** $p < 0.001$.

PFI

Overall, the PFI performs well when the items are examined collectively. For each item, table 9 reports the mean, standard deviation, skew, and item discrimination slope, and the Cronbach's alpha value if that item were removed from the PFI. The overall Cronbach's alpha and inter-item correlation are also reported. The overall Cronbach's alpha value of the PFI is 0.87 (table 9), indicating that all the items relate to each other well. Most item discrimination slopes are above 0.2, indicating that they distinguish well between different levels of family protective factors.

Although not a primary focus for the validation and although a normal distribution of scores might not be expected, the skewness helps in understanding the distribution of the baseline item scores across the sample of clients (e.g., whether there were situations in which some clients received an exceptionally low or high item score that skewed the overall mean on that item). Items 7, 15, 17, 20, 22, 23, 24, 25, 26, 27, 28, and 29 are highly negatively skewed (table 9). Most parents selected 5 (meaning "always" or "strongly agree") for all these items.

TABLE 9

All PFI Item Results

Item discrimination and Cronbach's alpha calculated for all items together

Item	Full item	Mean	SD	Skew	Item discrim.	α if deleted
1	In my family, we talk about our problems.	3.53	1.41	-0.47	0.39	0.86
2	When we argue, my family members listen to "both sides of the story."	3.29	1.45	-0.23	0.49	0.86
3	In my family, we take time to listen to each other.	3.55	1.35	-0.51	0.47	0.86
4	My family pulls together when things are stressful.	3.55	1.38	-0.49	0.52	0.86
5	My family is able to solve our problems.	3.29	1.31	-0.22	0.48	0.86
6	In my family, we support one another when something goes wrong.	3.88	1.31	-0.87	0.55	0.86
7	I am able to speak up for what my family and children need.	4.46	0.79	-1.6	0.32	0.86
8	I have people who will listen when I need to talk about my problems.	3.69	1.36	-0.77	0.42	0.86
9	I have friends I can talk to when I am lonely.	3.55	1.41	-0.59	0.36	0.86
10	I have someone I can trust to take care of my children when I need a break.	3.06	1.55	-0.07	0.32	0.86
11	I would know where to get help if my family needed food, clothing, or a place to live.	3.67	1.31	-0.74	0.35	0.86
12	I would know where to get help if I needed money to support my family.	3.40	1.49	-0.48	0.33	0.86
13	I would know where to get help if I needed a job.	3.47	1.41	-0.52	0.25	0.87
14	I have others I can talk to if there is a crisis.	3.45	1.34	-0.59	0.44	0.86
15	I know how to help my child learn.	4.13	1.01	-1.29	0.48	0.86
16	I understand why my child behaves the way he/she does.	3.94	1.06	-0.91	0.44	0.86
17	I know what behaviors and abilities are normal for my child's current developmental stage.	4.08	0.99	-1.06	0.27	0.86
18	I know how to obtain information on what to expect of my child as he/she grows and matures.	4.00	1.05	-0.94	0.53	0.86
19	I know where I can get information about parenting and taking care of children.	3.91	1.19	-0.94	0.50	0.86
20	I praise my child when he/she behaves well.	4.63	0.75	-2.26	0.32	0.86
21	I discipline my child without losing control.	4.10	0.98	-0.86	0.37	0.86
22	I am happy being with my child.	4.33	1.10	-1.66	0.20	0.87
23	My child and I are very close to each other.	4.46	0.90	-1.61	0.35	0.86
24	I am able to soothe my child when he/she is upset.	4.37	0.95	-1.63	0.45	0.86
25	I spend time with my child doing what he/she likes to do.	4.13	1.09	-1.09	0.47	0.86
26	I read to or with my child.	4.21	1.25	-1.47	0.34	0.86
27	My child has a routine for daily activities.	4.33	1.02	-1.52	0.37	0.86
28	I help my child figure out a task when he/she is having trouble.	4.43	0.84	-1.36	0.48	0.86
29	I provide activities for my child that will help him/her develop new skills.	4.25	1.05	-1.41	0.41	0.86

Source: Urban Institute analysis of Sanctuary for Families assessment data.

Notes: PFI = Protective Factors Instrument. Item dicrim. = item discrimination. SD = standard deviation. Mean inter-item correlation = 0.190. Overall Cronbach's α = 0.866. All items are on a 5-point scale ranging from 1 ("strongly disagree" or "never") to 5 ("strongly agree" or "always").

PFI SUBSCALES

Here we examine each subscale of the PFI separately. Because each subscale of the PFI measures a different protective factor, it is important to see how well the items in the subscale load together. Table 10 reports the number of items in the subscale and the overall Cronbach's alpha for the subscale. All the subscales have a Cronbach's alpha above 0.7, indicating that the items are internally consistent, or relate to each other well. Given that the PFI is a validated scale, the strong internal consistency of the subscales is expected.

TABLE 10

Subscale-Level Analysis Results

Cronbach's alpha calculated for each subscale separately

	Items	Cronbach's alpha
Subscale		
Family functioning and resilience	6	0.88
Social connections and support	8	0.76
Parental resilience	5	0.80
Nurturing and attachment	10	0.81

Source: Urban Institute analysis of Sanctuary for Families assessment data.

We also examine whether the subscales of the PFI are related to each other. Table 11 shows a correlation matrix of the subscale scores and overall PFI score. The overall score is significantly correlated with all subscales. This is expected, given that each subscale feeds into the overall score. When looking at the individual subscales, all subscales are significantly correlated to the others. However, some subscales have a weaker correlation (less than 0.3) with each other: family functioning and resilience with parental resilience, and social connections and support with nurturing and attachment. Given that the PFI measures a broad set of protective factors, it is more plausible that clients may not score consistently across the subscales. Nevertheless, the significant correlations between all the subscales indicate that the PFI performs well.

TABLE 11

PFI Subscale Correlation Results

Correlation matrix of domains and total score

Subscale	Total	Family functioning and resilience	Social connections and support	Parental resilience
Family functioning and resilience	0.69***			
Social connections and support	0.69***	0.30***		
Parental resilience	0.67***	0.21**	0.34***	
Nurturing and attachment	0.71***	0.29***	0.19**	0.52***

Source: Urban Institute analysis of Sanctuary for Families assessment data.

Notes: PFI = Protective Factors Instrument. Pearson correlation, ** $p < 0.01$, *** $p < 0.001$.

Performance by Subgroup

Sanctuary's clients are diverse in terms of primary language, country of birth, and race/ethnicity. It is important to examine whether the assessment tools perform well for all clients. Accordingly, here we show the performance of the PCL-5 and PFI by subgroups. **Both the PCL-5 and PFI are internally consistent for all subgroups of clients (primary language, birth country, and race/ethnicity).** Tables 12 and 13 show the overall Cronbach's alpha value for the PCL-5 and PFI for clients whose primary language is English, Spanish, or another language; who were born in the United States or any other country; and who are of different racial or ethnic backgrounds.

The **PCL-5 performs well for all the subgroups examined in the internal consistency analysis** (table 12). For all subgroups as defined by primary language, birth country, and race/ethnicity, the Cronbach's alpha value is 0.85 to 0.91, indicating strong internal consistency. The 95 percent confidence intervals for the Cronbach's alpha value for each subgroup overlap, indicating that any differences in the alpha are unlikely to be statistically significant. That is, the PCL-5 does not perform any better or worse for particular subgroups.

TABLE 12

PCL-5 Cronbach's Alpha by Subgroup

	n	Mean total score	Cronbach's alpha	Lower confidence interval	Upper confidence interval
Primary language					
English	105	41.60	0.90	0.87	0.93
Spanish	77	37.90[a]	0.89	0.85	0.92
Other	34	45.12	0.88	0.78	0.93
Birth country					
United States	57	41.14	0.91	0.86	0.94
Any other country	144	40.96	0.89	0.85	0.92
Race/ethnicity					
Asian / Pacific Islander	30	41.77	0.91	0.79	0.95
Black	46	43.33	0.93	0.88	0.95
Latinx	85	39.17	0.89	0.85	0.92
White	21	39.30	0.85	0.68	0.91

Source: Urban Institute analysis of Sanctuary for Families assessment data.

Notes: PCL-5 = PTSD Checklist for DSM-5. [a] Clients with a primary language of Spanish had a significantly lower score on the PCL-5 than non-Spanish speakers using a *t*-test.

Similarly, the **PFI performs well for all subgroups (primary language, birth country, and race/ethnicity)** (table 13). The Cronbach's alpha values for the subgroups range from 0.85 to 0.92, indicating strong internal consistency. The confidence intervals also overlap for each subgroup, indicating that the tool does not perform better or worse for any particular subgroup.

TABLE 13

PFI Cronbach's Alpha by Subgroup

	n	Mean of mean item score	Cronbach's alpha	Lower confidence interval	Upper confidence interval
Primary language					
English	104	3.93	0.86	0.80	0.89
Spanish	77	3.85	0.85	0.78	0.89
Other	36	3.93	0.90	0.81	0.94
Birth country					
United States	55	4.02	0.88	0.81	0.91
Any other country	147	3.87	0.86	0.82	0.89
Race/ethnicity					
Asian / Pacific Islander	30	3.86	0.92	0.85	0.95
Black	47	3.89	0.80	0.64	0.87
Latinx	85	3.88	0.86	0.80	0.90
White	21	3.91	0.90	0.71	0.95

Source: Urban Institute analysis of Sanctuary for Families assessment data.

Note: PFI = Protective Factors Instrument.

Conclusion

Sanctuary and STEPS successfully designed and continue to implement a trauma-focused model of programming that treats the family as a unit and facilitates communication and collaboration between the adult and child treatment staff and between Sanctuary and STEPS. Overall, staff and clinicians reported that the design and implementation of the FSP and FSPAT were successful. Clients generally reported positive experiences with the FSP and other services provided by Sanctuary and STEPS. Furthermore, adults and children experienced reductions in PTSD symptoms. Although Sanctuary and STEPS differ slightly in their implementation approaches, the organizations largely adhere to the envisioned FSP model, and any adaptations to the model were due to the COVID-19 pandemic. Additionally, even though CJII funding has ended, both organizations continue to implement the FSP model and the FSPAT in their counseling services with families.

This successful implementation resulted in the following **positive outcomes** for adults, families, and children:

- Adult clients reported that they experienced increased confidence, self-esteem, and understanding of their trauma. They also experienced significant reductions in their levels of PTSD symptoms.
- At the family level, many adult clients reported that they were better able to solve problems, had improved communication, and had strengthened relationships with their children. Families also experienced increases in protective factors as measured through the assessments.
- Children's grades in school improved, as did their ability to manage emotions, according to their parents. Children also experienced significant reductions in PTSD symptoms, as reported by their parents.

I remember going in person. I remember the building that I'd take my son to. It's nice. It was simple. Therapy with my son was awesome. We would go in and play with toys. I would read him books in the waiting room. The place is very clean. So pretty. I think that's beside the fact, the services. His therapist always had some type of activity mapped out for us that would be very meaningful and impactful, in person. Then when it went virtual, it was still awesome. We would all talk together and play games against each other virtually, interactively, online, while speaking. I found it interesting 'cause he learned how to keep my son engaged while having therapy and talking about things while they're still doing something else at the same time, to keep him engaged. I think it's also important to have a therapist that understands how to engage children in that manner, virtually, keep their attention. He definitely was able to do that. This whole time, even now. —FSP client

Key **facilitators** of successful implementation included the following:

- **A shared vision of what the FSP is and why it is critical to clients.** Staff largely understood the purpose and goals of the FSP and FSPAT and invested in the success of the model.
- **Funding dedicated to the program.** Sanctuary and STEPS were able to dedicate resources to design, training, implementation, and adaptations.
- **Consistent training integrated with onboarding.** Before the pandemic and the shift to virtual work, staff were aware of and trained on the FSP and FSPAT.
- **A known and trusted consultant who trained and supervised implementation.** The psychologist was trusted by staff and able to dedicate their time to creating buy-in and deep understanding and ensuring a standardized approach to the FSP and FSPAT.
- **Clinicians' ability to use the FSPAT to track client progress throughout services.** Staff reported that they were able to use the FSPAT to inform counseling and the service plan and discuss progress with clients collaboratively.
- **The flexibility of the FSP and complementary case management, services, and resources offered by Sanctuary and STEPS.** Staff reported that they were able to identify unique client needs beyond counseling and address them in collaboration with in-house staff to increase positive outcomes for clients and their families.

- **Nonjudgmental understanding and support given to clients by clinicians.** Clients found that clinicians provided a safe space with support that allowed them to heal and improve their well-being.

Key **challenges** to implementation included the following:

- **Clinician turnover during treatment.** Clients and staff reported that high staff turnover was extremely disruptive to client progress and well-being. Some clients also reported having to wait months before finding a new clinician and being required to complete a new intake each time they were assigned a new clinician, which was traumatic for them.
- **Clients' difficulty in communicating with staff.** Clients reported that getting in touch with clinicians could be difficult and frustrating. This was most likely due to staffing challenges, particularly during COVID.
- **Inconsistent training and supervision on the FSP and FSPAT.** During COVID and the shift to virtual work, clinicians reported that they received inconsistent onboarding and training on the FSP and FSPAT, making it difficult to implement the FSP or use the FSPAT effectively.
- **Confusion about how to administer and use the FSPAT for treatment planning and provision.** Clinicians reported a lack of guidance on how to synthesize the information from all sources in the intake process to create a service plan and provide effective counseling.
- **Lack of fit or context with the FSPAT.** Clinicians reported that some FSPAT questions did not fit all client experiences related to gender-based violence or provide context for all aspects of the client's background and needs.
- **The length of intake and repeated intakes.** Clinicians reported that intake appointments took several weeks and FSP case consultation meetings could take several more weeks, which delayed service provision for clients who needed support.

Recommendations

Based on the results of the evaluation, we offer a number of recommendations regarding staff capacity, implementation of the FSP model, the assessment process, and further data collection and evaluation that could improve FSP operations and client experiences.

Staff Capacity

Develop a clear and consistent onboarding and training process. The interviews with clinicians and the variations in client experiences revealed that onboarding and ongoing training could be improved. The COVID-19 pandemic understandably created disruptions in the onboarding and training of new staff. Going forward, clear and consistent training related to how to use the FSPAT, synthesize information to set counseling goals, and evaluate client progress could be most beneficial. Ongoing training for all clinicians also ensures that they are up to date on evolving practices. Sanctuary has already made adjustments to standardize onboarding and plans to develop additional training around developing and tracking counseling goals.

Identify ways to recruit and retain more permanent clinicians. As in many other professions, the pandemic led to challenges in staff recruitment and retention. Sanctuary and STEPS also have many clinicians who are students getting master's degrees in social work who are completing internships, who can augment the organizations' staffing capacity and their ability to provide services in multiple languages. Internships are important in developing the field of clinical providers, but most interns only stay in their positions for limited periods. The turnover in both full-time and temporary staff can lead to disruptions in services for clients. To reduce that disruption, we recommend that clients be assigned only one temporary clinician and that it be made clear early on during service provision that the clinician's position is temporary. There should be warm handoffs, where the client meets with the old and new clinicians; alternatively, when warm handoffs are not possible, supervisors could reach out to clients. While a new clinician is being identified, supervisors should also ensure that case management and participation in noncounseling services continue. During COVID, some clinical supervisors did take over cases as needed. Clear and consistent documentation of client progress and FSPAT scores could also help new clinicians continue services more seamlessly.

Provide regular supervision and support to clinicians. Although FSP clinicians have assigned supervisors, COVID created disruptions in mechanisms for discussing cases and having regular check-

ins with supervisors. These mechanisms should be restored or strengthened to ensure that all clinicians are receiving the supervision and support they need.

Service Implementation

Share information about local resources and events with clients. Clients suggested that it would be beneficial for FSP clinicians to be more aware of local referral options and free events. Clients reported that they spend a great deal of time searching for culturally appropriate and geographically convenient services and resources because those provided by Sanctuary and STEPS do not always fit well with what they may need or want. The solution could be a physical or digital centralized repository with information about local resources and events, especially those spanning different cultures and languages.

Consider increased flexibility in service duration. Many clients suggested longer counseling durations, especially when court and other cases are open and progressing. Some clients wanted longer individual sessions or more frequent sessions, while other clients suggested providing services for longer periods overall. Referrals to other organizations for maintenance counseling might also be beneficial for clients who want to continue services but have completed FSP programming.

Improve communication between clients and clinicians. Clients also expressed the need for improved communication, especially with their clinicians. Two clients recommended that clients be assigned a new therapist soon after their previous therapist leaves or is reassigned. Setting expectations about the types, reasons for, and frequency of communication at the outset of the FSP may help mitigate these challenges.

Develop a clear framework for participation length and case closure. Although individuals and families will have different needs and participate in different types of programming, there should be general guidelines for overall service length for counseling and specific programs. Sharing these average service lengths with clients would help with setting expectations. Relatedly, case closure reasons should be standardized. Ideal milestones should be shared with clients to further set expectations for service length and progress toward completion.

Offer classes for parents with older children. Some clients reported that it would be beneficial to have classes or events geared toward older children, not just younger children.

Continue to adapt and innovate the FSP model. Some staff at Sanctuary are looking into alternative paths of healing and Indigenous practices as a way to shift away from a medical model focused primarily on symptoms.

Assessment

Implement clearer guidance on how to use the FSPAT. Ongoing training and supervision on what the tools are, who they are appropriate for, how to administer them, and how to score them would be beneficial. In particular, guidance should detail how to use the FSPAT results in combination with other intake information to inform case planning and the development of counseling goals. There should also be guidance on and criteria for how changes in FSPAT scores should inform changes in services or case closure. Relatedly, the cut points for low/moderate/high scores on each tool within the FSPAT should be compared against the scores of the client population to see whether they are meaningfully distinguishing between clients with low, medium, or high levels of PTSD symptoms or family protective factors.

Conduct FSPAT reassessments more regularly and consistently. Although program guidelines call for reassessments every three or six months, these reassessments may not occur for a variety of reasons. For example, the client may have other pressing needs, may not be in a mental or emotional place suitable for reassessment, or may not have a session scheduled near the six-month mark. Reassessment reminders could be built into the data management system to help clinicians track and plan for reassessment. Reassessment should also be discussed during clinical supervision.

Consider adapting the FSPAT to better fit client experiences and needs. Although the PCL-5 and PFI showed strong reliability through the validation analyses, the clinician and client interviews revealed that these tools may not always be responsive to clients' cultures, languages, or needs. Sanctuary and STEPS could create standardized versions of each tool in the languages or dialects of the clients they serve so that clinicians are not translating while implementing the tool. Relatedly, Sanctuary and STEPS could develop alternate explanations and examples of items.

Improve consistency in FSPAT implementation. Any deviations from the tools to better fit client needs should be consistently implemented by all staff. For example, the implementation guidance should state whether clients are asked each item exactly as written and they verbally indicate their score, or whether the items are discussed and scored through general conversation. Lastly, the results should be shared with the client after each assessment.

Build the full FSPAT into the data management system. Clinicians vary in whether they administer the FSPAT in paper or electronic form. After administering the tool, all clinicians at Sanctuary then enter the scale and total scores in the electronic data system. To lessen errors in score totaling and data entry, each item should be individually scored in the data system and then subscale and total scores should be automatically calculated. Erroneous values could be immediately flagged. This may also help clinicians track progress and changes in client scores. Sanctuary has already begun digitizing the FSPAT into the data management system.

Further Data Collection and Evaluation

Request regular feedback from clients about their experiences. Sanctuary and STEPS have implemented various feedback mechanisms to learn from clients about what is working well and what could be improved. Client feedback could be garnered through occasional brief surveys during office visits or virtual sessions, additional questions during the FSPAT reassessment, or exit surveys when ending services. This information should then be collated and considered by leadership, supervisors, and staff. Sanctuary has launched an anonymous feedback survey that will be shared with clients when they end services.

Collect more data related to client progress and outcomes. The FSPAT allows for the measurement of changes related to PTSD symptoms and family protective factors. However, the FSP helps clients address a variety of goals and needs, such as those related to safety, emotional regulation, and children's performance in school. Additional assessments might be too burdensome and detract from sessions, but brief questions could be added as part of the aforementioned client feedback data collection. Other measures to consider include the General Well-Being Schedule (which has items about mental and general health) or the Outcome Questionnaire 45 (which has items about interpersonal relations and social roles). Sanctuary is considering developing a way to record and track progress toward counseling goals in the data management system.

Conduct further outcome evaluation that reaches more clients. Due to the COVID-19 pandemic and challenges obtaining client participation in the survey, the outcome evaluation was limited in terms of the data available and the types of outcomes examined. Sanctuary and STEPS could consider implementing elements of the client survey in the future to track changes in client progress and outcomes related to safety, self-esteem, and self-efficacy. Tracking other client outcomes would also generate data that could be used to examine program impact.

Appendix

This appendix provides additional details about the FSPAT validation analyses and the client survey results.

Validation Analyses

Tables A.1 and A.2 include additional information from the validation analyses, with more details on the performance of the subscales in each assessment tool. Because each subscale of the PCL-5 measures a different set of PTSD symptoms, it is important to see how well the items in the subscale load together and distinguish between different levels of the symptom. For each item on the four subscales, table A.1 reports the item discrimination slope and the Cronbach's alpha value if that item were removed from the subscale. The overall Cronbach's alpha for the subscale is also reported.

All the subscales have Cronbach's alphas above 0.7, indicating that the items are internally consistent, or relate to each other well. The Cronbach's alpha value of the subscale if an item were to be deleted helps in identifying which items are inconsistent with the other items in the subscale. If the item's alpha value is higher than the overall alpha value, it demonstrates that removing the item would make the subscale more internally consistent. Conversely, if the alpha value is lower, removing the item would make the factor less consistent. The only item whose removal would slightly improve the consistency of its respective subscale is item 8. The strong internal consistency of the subscales is expected, given that the PCL-5 is a validated scale. The results of the item discrimination analysis also show generally strong performance across the subscales. All items are in the acceptable range, above 0.2. The items with the lowest values are 8 and 16, indicating that they do not distinguish between clients with different levels of the PTSD symptom as well as the other items.

TABLE A.1

PCL-5 Subscale-Level Analysis Results

Item discrimination and Cronbach's alpha calculated for each subscale separately

	Item	Item discrimination	α if deleted
Subscale			
Reexperiencing (Overall subscale α: 0.79)	1	0.66	0.73
	2	0.54	0.76
	3	0.58	0.75
	4	0.48	0.78
	5	0.60	0.74
Avoidance (Overall subscale α: 0.72)	6	N/A	N/A
	7	N/A	N/A
Negative cognition and mood (Overall subscale α: 0.79)	8	0.27	0.81
	9	0.60	0.74
	10	0.54	0.75
	11	0.63	0.74
	12	0.55	0.75
	13	0.50	0.76
	14	0.52	0.76
Arousal and reactivity (Overall subscale α: 0.71)	15	0.40	0.68
	16	0.25	0.71
	17	0.35	0.70
	18	0.57	0.62
	19	0.50	0.64
	20	0.56	0.62

Source. Urban Institute analysis of Sanctuary for Families assessment data.

Notes: PCL-5 = PTSD Checklist for DSM-5. N/A = not applicable; item discrimination and Cronbach's alpha cannot be calculated for constructs with fewer than three items.

Because each subscale of the PFI measures a different protective factor, it is important to see how well the items in the subscale load together and distinguish between different levels of protective factors. For each item on the four subscales, table A.2 reports the item discrimination slope and Cronbach's alpha value if that item were removed from the subscale. The overall Cronbach's alpha for the subscale is also reported.

All the subscales have Cronbach's alphas above 0.7, indicating that the items are internally consistent, or relate to each other well. The Cronbach's alpha value of the subscale if an item were to be deleted helps in identifying which items are inconsistent with the other items in the subscale. The only item whose removal would slightly improve the consistency of its respective subscale is item 7. Given that the PFI is a validated scale, the strong internal consistency of the subscales is expected. The results of the item discrimination analysis also show generally strong performance across the subscales. All items are in the acceptable range, above 0.2. The items with the lowest values are 7 and 22, indicating that they do not distinguish between clients with different levels of the relevant protective factor as well as the other items.

TABLE A.2

PFI Subscale-Level Analysis Results

Item discrimination and Cronbach's alpha calculated for each subscale separately

	Item	Item discrimination	α if deleted
Subscale			
Family Functioning and resilience (Overall subscale α: 0.88)	1	0.53	0.88
	2	0.70	0.85
	3	0.76	0.84
	4	0.70	0.85
	5	0.68	0.85
	6	0.71	0.85
Social connections and support (Overall subscale α: 0.76)	7	0.20	0.77
	8	0.52	0.73
	9	0.39	0.75
	10	0.45	0.74
	11	0.46	0.74
	12	0.54	0.72
	13	0.49	0.73
	14	0.61	0.71
Parental resilience (Overall subscale α: 0.80)	15	0.47	0.79
	16	0.53	0.77
	17	0.62	0.75
	18	0.74	0.71
	19	0.56	0.77
Nurturing and attachment (Overall subscale α: 0.81)	20	0.45	0.79
	21	0.45	0.79
	22	0.28	0.81
	23	0.46	0.79
	24	0.57	0.78
	25	0.62	0.77
	26	0.48	0.79
	27	0.48	0.79
	28	0.58	0.78
	29	0.50	0.79

Source: Urban Institute analysis of Sanctuary for Families assessment data.

Note: PFI = Protective Factors Instrument.

Client Survey Results

Here we report the results of the client survey administered to FSP clients at Sanctuary. The baseline survey launched in August 2020 and closed in December 2021. The follow-up survey opened in March 2021 and closed in January 2022. The survey was designed for new adult FSP clients who had recently completed the intake process. The follow-up survey was designed to be administered approximately six months later. Due to the COVID-19 pandemic and the shift to virtual administration, client participation rates were lower than anticipated. In total, 20 clients completed the baseline survey and 10 completed the follow-up survey. On average, the follow-up survey was completed 7.6 months after the baseline survey. We have included the results in this appendix rather than in the main outcome

findings section because the sample size was not large enough to meaningfully measure any changes from baseline to follow-up.

Table A.3 shows the average scores on the baseline survey for all respondents, and on the baseline and follow-up surveys for those who completed both. A majority (60 percent) of respondents completed the survey in Spanish, and 40 percent completed it in English. All the respondents identified as women and had children. Nearly all (95 percent) of the respondents were born outside the United States. At baseline, a majority of respondents were interested in receiving counseling for themselves (75 percent), counseling for their children (55 percent), and legal or economic empowerment services (50 percent).

To inform the FSPAT validation, several survey items addressed the assessment process. Almost all respondents agreed at baseline that the assessment process was explained completely accurately to them over the phone (85 percent). The vast majority also said that the assessments were very helpful in understanding their symptoms (80 percent). Of those who completed the follow-up survey, the share reporting that the assessments were very helpful in understanding their symptoms dropped from 90 percent at baseline to 50 percent at follow-up. Lastly, clients were asked about their level of investment in participation in services at Sanctuary, and a majority of respondents said at baseline that they were very invested (65 percent).

TABLE A.3

Average Scores on Baseline and Follow-Up Survey

	Baseline (*n* = 20)	Baseline of subsample who have follow-up (*n* = 10)	Follow-up (*n* = 10)
Survey item			
Survey language			
English	40%	40%	40%
Spanish	60%	60%	60%
Demographics			
Woman	100%	100%	100%
Has children	100%	100%	100%
Born in United States	5%	0%	0%
PFI scale scores (1–5 scale)			
Family functioning	3.85	3.51	4.18
Social supports	3.56	3.78	3.88
Parental resilience	4.05	4.12	4.16
Nurturing and attachment	4.56	4.58	4.64
Other scale scores (1–5 scale)			
Self-esteem	3.58	3.61	3.62
Self-efficacy	3.89	3.94	3.77
Safety	3.89	3.93	3.85
What services are you looking for at Sanctuary?			
Counseling for myself	75%	60%	30%
Counseling for my child	55%	30%	30%
Counseling for my family	30%	50%	30%
Shelter	20%	30%	0%
Case management	45%	30%	20%
Support groups	25%	20%	10%
Events	10%	0%	10%
Legal or economic empowerment	50%	40%	40%
How accurately was the assessment process explained to you on the phone?			
Completely	85%	90%	--
Somewhat	5%	0%	--
Not at all	5%	0%	--
How helpful were the assessment measures in understanding your symptoms?			
Very	80%	90%	50%
Somewhat	20%	10%	0%
Not at all	0%	0%	20%
What is your level of investment in your and your family's participation in services at Sanctuary?			
Very	65%	60%	50%
Somewhat	30%	30%	10%
Not at all	0%	0%	0%

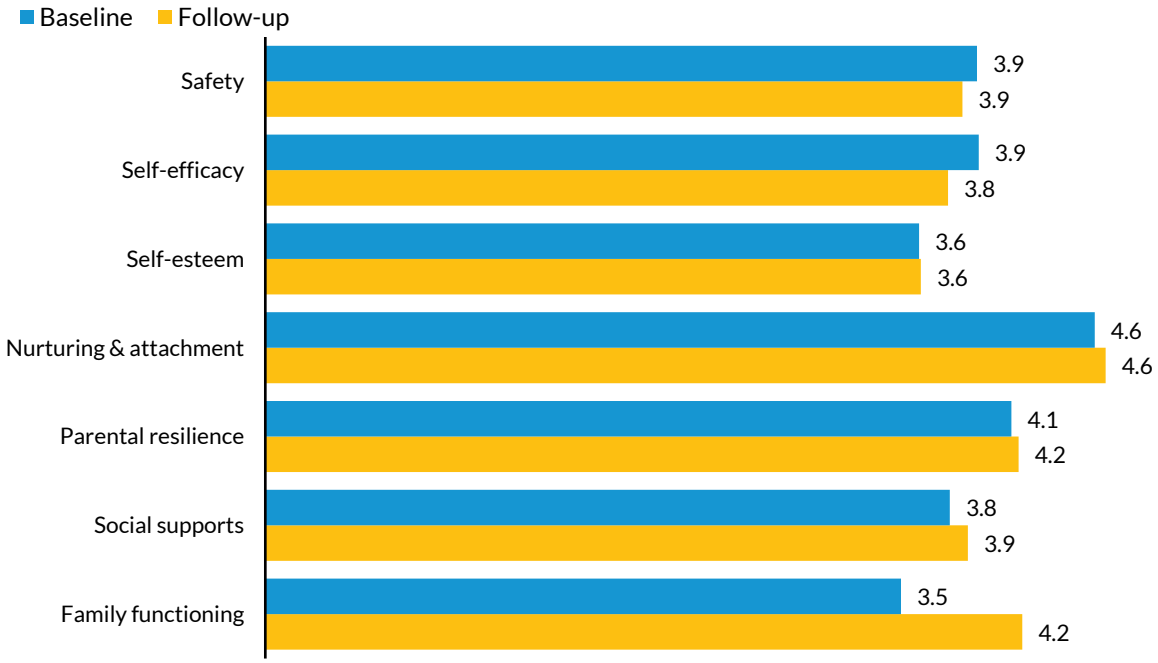
Source: Urban Institute survey of FamilySafe Project clients at Sanctuary for Families.

Notes: PFI = Protective Factors Instrument. The average follow-up survey was completed 7.6 months after baseline survey (with a range of 6 to 12 months). Some items may not total to 100 percent if respondents did not answer those items.

We conducted paired *t*-tests to examine whether there were any significant differences between participant responses on the scales related to protective factors, self-esteem, self-efficacy, and safety between baseline and follow-up. Ideally, these scores would increase as clients continue in the FSP. The average scores at baseline and follow-up were very similar. Likely due to the very small sample size (*n* = 10), there were no significant differences between baseline and follow-up scores on the various scales. Figure A.1 shows the average scores on each survey scale for respondents who completed both the baseline and follow-up surveys.

FIGURE A.1

Average Scores on the Baseline and Follow-Up Scales (*n* = 10)



Source: Urban Institute survey of FamilySafe Project clients at Sanctuary for Families.

Notes

[1] "Gender and Gender-Based Violence," US Department of State, accessed July 12, 2022, https://www.state.gov/other-policy-issues/gender-and-gender-based-violence/.

[2] "What Is Trauma-Focused Therapy?" Center for Child Trauma Assessment, Services and Interventions, accessed August 26, 2022, https://cctasi.northwestern.edu/trauma-focused-therapy/.

[3] "What Is Trauma-Focused Therapy?" Center for Child Trauma Assessment..

[4] Laura Rogers, "Transitional Housing Programs and Empowering Survivors of Domestic Violence," US Department of Justice, Office on Violence Against Women, November 1, 2019, https://www.justice.gov/archives/ovw/blog/transitional-housing-programs-and-empowering-survivors-domestic-violence.

[5] 8x8 is a business phone system that allows for conference calls and recording.

[6] The New York City Family Justice Centers are located in each borough and connect survivors of gender-based violence and their children to organizations that provide a variety of services. They provide free and confidential criminal and civil legal services and social services. For more information, see https://www.nyc.gov/site/ocdv/programs/family-justice-centers.page.

[7] Woman to Woman / Mujer a Mujer is an ongoing support group for women who have experienced intimate partner violence. It provides a safe and supportive environment in which women learn about available resources, family violence, and relationship abuse. It adopted virtual meetings during the pandemic.

[8] A client may receive 0 sessions if they start the intake process but do not continue in the FSP to receive counseling services.

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