RESEARCH REPORT

Evaluation of the Polyvictimization Initiative at the Queens Family Justice Center

Sara Bastomski *Alexandra Ricks* *Erica Henderson* *Jennifer Yahner*

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Executive Summary

From January 2018 to March 2019, the Urban Institute evaluated the Polyvictimization Initiative at the Queens Family Justice Center (QFJC) by request of the Mayor's Fund to Advance New York City (Mayor's Fund). The initiative aimed to improve service delivery for polyvictim clients as part of a demonstration grant from the US Department of Justice Office for Victims of Crime (OVC), called "A Pathway to Justice, Healing and Hope: Addressing Polyvictimization in a Family Justice Center Setting Demonstration Initiative." The nationwide initiative's goal was to develop a polyvictimization assessment tool (PAT) and service delivery model for Family Justice Centers (FJCs) or similar co-located victim services. As the program evolved, stakeholders also determined that a polyvictimization screening tool (PST) would be useful to improve service delivery and address polyvictims' needs.

The QFJC initiative was developed under the guidance of a local Polyvictimization Initiative consulting committee. Committee members included staff from the Mayor's Office to End Domestic and Gender-Based Violence (ENDGBV), QFJC, Safe Horizon, NYC Alliance Against Sexual Assault, Mount Sinai Sexual Assault and Violence Intervention Program (SAVI), Voces Latinas, and Sanctuary for Families. The purpose of the consulting committee was to come together and learn about the needs of polyvictim clients at the QFJC, and to discuss best practices for designing and implementing the assessment tool. The QFJC initiative's primary features were trauma-informed training and service delivery, client mapping, and the PST and PAT, all intended to inform and improve service delivery for clients who have experienced polyvictimization.

Urban conducted a mixed methods process evaluation of the PAT's development and implementation in the Queens Family Justice Center. A review of program materials, stakeholder interviews and surveys, observations of program operations, and analyses of PST/PAT and client data informed the evaluation, which assessed (1) the development of the PST/PAT, (2) the implementation of the PST/PAT, and (3) the validity of the PST/PAT.

In addition to an examination of how the PST and PAT were developed and implemented at QFJC, this report presents findings on the tools' impact on service providers and service provision for clients with complex, long-term needs for trauma-informed services owing to experiences of polyvictimization. Specifically, this report aims to provide readers (1) an overview of the literature on topics related to polyvictimization, victimization screening and intervention, and Family Justice Centers; (2) an in-depth examination of the development and implementation of the PST/PAT through the eyes of staff,

participants, and other key stakeholders; (3) evaluation findings that assess the validity of the PST/PAT; and (4) recommendations to promote best practices and address barriers to success.

This evaluation's **key findings** include the following:

- The Polyvictimization Initiative provided opportunities for QFJC and partner agency staff to receive training on providing trauma-informed services, and made tailored, intensive resources more available for QFJC clients who have experienced polyvictimization.
- Opportunities for collaboration and coordination—particularly working with polyvictim clients—improved relationships among staff participating in the initiative.
- The service delivery model improved for clients interested in specialized polyvictimization services; however, QFJC can continue making refinements to effectively identify such clients and route them appropriately.
- The Modified Polyvictimization Assessment Tool (PAT) could benefit from further refinement. Results indicate that although the majority of PAT questions are working as intended, some may not be as meaningful for QFJC clients.

Based on evaluation results, Urban proposes the following **six recommendations** to strengthen implementation of the Polyvictimization Initiative service delivery model at the Queens Family Justice Center:

- Ensure program operations continue supporting collaboration and coordination.
- Consider refinements to the Modified-PAT and PAT implementation process.
- Develop clear standards for training and supervision for staff who use the PST/PAT.
- Refine the plan for using the PST and build on strengths.
- Determine how to maintain, improve, and expand the reach of the Polyvictimization Initiative model at QFJC.
- Use PST/PAT data for long-term performance monitoring and strategic planning.

Introduction

From January 2018 to March 2019, Urban conducted a process evaluation of the Polyvictimization Initiative at the Queens Family Justice Center (QFJC) by request of the Mayor's Fund to Advance New York City (Mayor's Fund). The initiative aimed to improve service delivery for polyvictim clients as part of a demonstration grant from the US Department of Justice Office for Victims of Crime (OVC) called "A Pathway to Justice, Healing and Hope: Addressing Polyvictimization in a Family Justice Center Setting Demonstration Initiative." The initiative's goal was to develop a polyvictimization assessment tool (PAT) and service delivery model for Family Justice Centers (FJCs) or similar colocated victim services addressing polyvictimization. As the program evolved, stakeholders determined that in addition to the assessment tool, a polyvictimization screening tool (PST) would be useful for improving service delivery and addressing the needs of polyvictims. Box 1 defines key terms used throughout this report.

BOX 1

Key Terms

- **Polyvictimization screening tool:** this seven-question tool is an events-based screener to identify likely high-needs polyvictims. Urban and QFJC stakeholders collaborated to develop the PST.
- **Pilot polyvictimization assessment tool:** this long-form (61-question) tool was jointly designed by Alliance for HOPE International (AFH), the Center of Applied Research for Nonprofit Organizations (Center of Applied Research), and the six sites involved in OVC's national demonstration initiative. This version of the tool was used exclusively during the pilot phase, before it was revised and modified (the modified tool is available in appendix E).
- **Modified-PAT:** this long-form (44-question) tool is the revised version of the pilot PAT. It was revised by AFH, the Center of Applied Research, and the six sites involved in OVC's national demonstration initiative. Those six sites implemented the modified tool during the final implementation phase.
- **Pilot phase:** the pilot PAT was implemented and developed during this phase (June 2017 to May 2018). The polyvictimization service model was also developed and trauma-informed practices were instituted.
- **Final implementation phase:** during this phase (June 2018 to March 2019), the pilot PAT was revised and finalized as the Modified-PAT, then implemented. Stakeholders at QFJC also developed, piloted, and implemented the PST.

A local Polyvictimization Initiative consulting committee guided the development of the QFJC program. Committee members included staff from the Mayor's Office to End Domestic and Gender-Based Violence (ENDGBV), QFJC, Safe Horizon, NYC Alliance Against Sexual Assault, Mount Sinai Sexual Assault and Violence Intervention Program (SAVI), Voces Latinas, and Sanctuary for Families. The consulting committee's purpose was to convene stakeholders, learn about the needs of QFJC polyvictim clients, and discuss best practices for designing and implementing the assessment tool. The QFJC initiative's primary features included trauma-informed training and service delivery, client mapping, and the PST and PAT, all intended to inform and improve service delivery for clients who have experienced polyvictimization.

Urban conducted a mixed methods process evaluation of the PAT's development and implementation in the QFJC. A review of program materials, stakeholder interviews and surveys, observations of program operations, and analyses of PST/PAT and client data informed the evaluation, which assessed (1) the development of the PST/PAT, (2) the implementation of the PST/PAT, and (3) the validity of the PST/PAT.

This report examines the development and implementation of the polyvictimization assessment and polyvictimization screening tools at the Queens Family Justice Center, and presents findings of the tools' impact on service providers and service provision for clients with complex, long-term needs for trauma-informed services owing to polyvictimization experiences. Specifically, this report is meant to provide readers (1) an overview of the literature on polyvictimization, victimization screening and intervention, and family justice centers; (2) an in-depth examination of the development and implementation of the PST/PAT through the eyes of staff, participants, and other key stakeholders; (3) evaluation findings that assess the validity of the PST/PAT; and (4) recommendations to promote best practices and address barriers to success.

Literature Review

Polyvictimization

Polyvictimization—generally understood as the experiencing of multiple types of victimization—is increasingly recognized as a widespread problem, with consequences that can be far worse than those associated with repeated experiences of a single form of victimization. A recent nationally representative study showed that 17.8 percent of youth were polyvictims (Turner et al. 2017), and people who have experienced any victimization are particularly likely to have experienced multiple forms of it (Turner, Hamby, and Banyard 2013). Polyvictimization is also common among victimized elders (Ramsey-Klawsnik and Heisler 2014); one study found that nearly a third of mistreated elders experience multiple types of mistreatment (Wiglesworth et al. 2010). A polyvictim can experience more than fifteen types of victimization; some scholars designate those who have experienced four to six victimizations "low" polyvictims, and those who have experienced seven or more "high" polyvictims (Finkelhor, Ormrod, and Turner 2007).

The psychological consequences of polyvictimization can be deeply damaging. Polyvictims often experience negative outcomes—particular traumas—more severe than those associated with any single victimization, even one occurring repeatedly (Turner, Hamby, and Banyard 2013; Finkelhor, Ormrod, and Turner 2007; Sabina and Straus 2008). For example, Finkelhor, Ormrod, and Turner (2007) identified polyvictimization as a key predictor of trauma symptoms including clinical rage, clinical levels of anxiety, and depressive symptoms, thus significantly affecting and impacting survivors' mental health. Moreover, symptoms of trauma become more complex when people have been exposed to multiple types of trauma in childhood and adulthood (Briere, Kaltman, and Green 2008; Cloitre et al. 2009). Polyvictimization also has been found to independently predict delinquency in adolescents (Ford et al. 2010) and depressive symptoms among college women (Sabina and Straus 2008). Even physical health is implicated, as studies show links between experiencing multiple forms of violence, post-traumatic stress disorder, and physical health outcomes, such as pain symptoms (Campbell et al. 2008).

Moreover, the consequences of polyvictimization are long-lasting. One study finds that variability in psychological distress among college women can be accounted for by their experiences of polyvictimization in childhood (Richmond et al. 2009). People who experience childhood polyvictimization also face higher risk of being victimized as adults; for instance, women who experience multiple forms of violence and abuse as children are more likely to experience rape and intimate partner violence as adults (Aakvaag et al. 2016). Polyvictims may also lack support systems

because of the multifaceted forms of trauma they have experienced; healthy peer relationships are connected to mental well-being, and the cycle of violence polyvictims face may result in inadequate support systems (Turner et al. 2017).

Screening and Intervention

In light of the severe and negative impacts of polyvictimization, early screening and intervention are crucial. Studies show that people who have experienced one form of victimization are at increased risk of experiencing additional victimizations (Pilnik and Kendall 2012; Finkelhor et al. 2011). Traumatic experiences are often interconnected, and screening may reveal additional forms of trauma and victimization, presenting the opportunity to provide more comprehensive and integrated services. Moreover, given the aforementioned negative consequences of polyvictimization, intervention is imperative.

Early identification and intervention involving counseling and referrals to community resources have been shown to reduce domestic violence (DV) victimization (Kiely et al. 2010; Singh, Petersen and Singh 2014).[1] Though screening is only the first step, domestic-violence studies have shown that services such as shelters, advocacy organizations, support groups, and counseling improve victims' overall well-being (Allen, Bybee, and Sullivan 2004; Peled, Davidson-Arad, and Perel 2010; Sullivan 2018; Sullivan, Bybee, and Allen 2002). Shelters are safe environments for victims of DV and provide financial assistance and help accessing resources such as legal aid and social services (Chanmugam 2011; Few 2005). Shelters have also been found to lead to other positive outcomes for DV survivors, including increased hope and independence (Goodkind, Sullivan, and Bybee 2004; Sullivan and Virden 2017). Similarly, advocacy services and support groups have been shown to lead to a greater sense of well-being, decreased distress and violence, higher self-esteem, and a higher overall quality of life (Allen, Bybee, and Sullivan 2004; Bybee and Sullivan 2002; Constantino, Kim, and Crane 2005). Overall, victim services can promote long-term social and emotional well-being.

Research also emphasizes asking concrete questions using accessible language when screening DV victims, and not labeling victims as such. Respondents may not identify as victims and are unlikely to identify with stigmatizing labels such as "battered women" (Ellsberg et al. 2001; WHO 2001). Instead of directly asking victims whether they identify with certain labels, it is best to use behaviorally specific items. For example, when screening women for DV, experts recommend asking about specific behaviors—such as being slapped, beaten up, or having a weapon used against oneself—rather than asking broader questions such as, "Have you ever been abused?" (Ellsberg et al. 2001; Straus et al.

1996). Yet, though behaviorally specific questions are best for screening for DV victimization, victims may not disclose key information if they do not identify with the behaviors being listed (Bonomi, Allen, and Holt 2006). Therefore, behaviorally specific questions should be combined with open-ended questions to elicit more accurate responses (Lindhorst, Meyers, and Casey 2008). Overall, these practices have been shown to be effective in screening for victimization.

Another factor to consider is how long a person has experienced polyvictimization; though it can be examined within different time frames, research suggests examining lifetime exposure to victimization (Finkelhor, Ormrod, and Turner 2007). Moreover, when operationalizing polyvictimization for research purposes, scholars typically include questions that are solely about experiences of victimization (most common), or questions about victimization and adverse life experiences (Adams et al. 2016; Finkelhor et al. 2011; Ford et al. 2010; Sabrina and Straus 2008; Turner et al. 2016). Studies have distinguished between questions about specific victimization incidents and questions about "other lifetime adversities," such as serious illnesses, accidents, homelessness, family conflict, and the death, unemployment, substance abuse, or incarceration of family members (Finkelhor et al. 2005b; Finkelhor et al. 2011). For example, Adams and coauthors (2016) included questions about adverse life experiences in their Trauma History Profile alongside questions about victimization, and used these questions about adverse life experiences in their operational definition of polyvictimization. Similarly, in their work to determine correlates of polyvictimization, Ford and coauthors (2010) included questions about adverse life experiences alongside questions about victimization in the trauma-exposure and post-traumatic stress disorder category.

By contrast, Finkelhor and Hamby's work considers indirect victimizations (e.g., witnessing or being exposed to violence), but does not incorporate adverse life experiences such as illness, accidents, substance use, and mental illness in its operational definition of polyvictimization (the authors examined these as correlates or control variables) (Finkelhor et al. 2011); they also used the Juvenile Victimization Questionnaire to create a short screener to identify polyvictims. The questionnaire consists of 34 simple, behaviorally specific questions in five domains: (1) conventional crime, (2) child maltreatment, (3) peer and sibling victimization, (4) sexual assault, and (5) witnessing/indirect witnessing (including witnessing domestic violence, witnessing the assault of family members, witnessing murder, living in a war zone, having your residence burgled, or having a family member murdered) (Finkelhor et al. 2005a). Their analysis found that polyvictimization—operationally defined as experiencing multiple victimizations or exposures to violence—was more important in predicting trauma symptoms than was a measure of other adversities that included serious illnesses, accidents, homelessness, family conflict, and the death, unemployment, substance abuse, or incarceration of

family members (Finkelhor et al. 2005b). This research shows it is important to consider how questions are asked and how polyvictimization is defined and operationalized.

Family Justice Centers

One-stop, multiservice, multiagency centers like Family Justice Centers are well-positioned to intervene to help polyvictims heal. The FJC model was created as a way to colocate staff members from a diversity of agencies under one roof to make it more convenient for victims to receive treatment and services (Gwinn and Strack 2010). Doing so helps end cycles of violence and protects vulnerable people by streamlining difficult systems through one-stop service provision (Gwinn and Strack 2010). Unlike traditional victim-service agencies (such as shelters), FJCs consolidate criminal justice processes and social services such as crisis intervention, advocacy, counseling, psychoeducation, case management, and housing specialists at one location (Simmons et al. 2016).

Thirty-six Family Justice Centers in the US serve an average of 329 victims a month (Abt Associates 2018), showing FJCs can serve many clients. Research has also shown FJCs are capable of meeting client needs, satisfying clients, reducing homicides, increasing victim safety, making victims more autonomous and empowered, reducing fear and anxiety among victims and their children, helping victims avoid recanting or minimizing their experiences, making service providers more efficient and collaborative, making offenders more likely to be prosecuted, and connecting victims and their children with support services (EMT Associates, Inc. 2013; Giacomazzi, Hannah, and Bostaph 2008; Gibson 2008; Hoyle and Palmer 2014; Kennedy 2013). For example, an evaluation of FJCs in California found that the centers increased service delivery, satisfied clients, and experienced few service barriers after clients enrolled (EMT Associates, Inc. 2013). An evaluation of an FJC in Idaho found providers felt a shared mission and similarly satisfied their clients (Giacomazzi, Hannah, and Bostaph 2008). These studies show that FJCs are uniquely situated to treat polyvictims' underlying vulnerabilities because the centers consolidate various services in one location.

Background on the QFJC Polyvictimization Initiative

In October 2016, the Mayor's Fund (in support of the Mayor's Office to End Domestic and Gender-Based Violence), ENDGBV and Queens Family Justice Center administrative staff, and community-based service provider partners (including Safe Horizon, New York City Alliance Against Sexual Assault, Voces Latinas, and Mount Sinai Sexual Assault and Violence Intervention Program) were selected as part of a demonstration grant from the US Department of Justice's Office for Victims of Crime called "A Pathway to Justice, Healing and Hope: Addressing Polyvictimization in a Family Justice Center Setting Demonstration Initiative." The project required that the Mayor's Fund and its project partners collaborate with the five other US jurisdictions that received the grant[2] to create and assess a model polyvictimization assessment tool that Family Justice Centers can implement nationwide. Alliance for HOPE International (a national technical assistance provider) and the Center of Applied Research for Nonprofit Organizations (a national evaluator) supported the project. In New York, the demonstration project was conducted at the Queens Family Justice Center, which ENDGBV operates.

Community Context

With an estimated 2,358,582 residents, Queens accounts for more than 27 percent of New York's population and is its second most populous borough. Queens residents are 40 percent white, 28 percent Hispanic or Latino, 27 percent Asian, and 20 percent African American; moreover, 47 percent of its population is foreign-born and 56 percent of families speak a language other than English at home. In 2017, nearly 14 percent of Queens families with children and 28 percent of families with a single female head of household with a child had incomes below the poverty level.[3]

Although rates of violent crime have decreased dramatically in New York since 1990, rates of domestic violence have remained high and have even increased in recent years (NYC Mayor's Office to Combat Domestic Violence 2017). In 2018 in Queens there were 24,577 intimate-partner domestic incidents, 1,105 intimate-partner felony assaults, and 115 intimate-partner rapes reported to police (ENDGBV 2018).

History of the Queens Family Justice Center

The Queens Family Justice Center was established in 2008 and is operated by the Mayor's Office to End Domestic and Gender-Based Violence. It is housed in a 16,000-square-foot stand-alone facility and includes 20 on-site and 25 off-site partner organizations, with 103 professionals working on site. Administrative staff from ENDGBV and QFJC are responsible for the center's daily operations, and community-based organizations provide clients services (we refer to these community-based organizations as "partner agencies"). Since 2008, it has provided comprehensive legal, counseling, and supportive services for survivors of intimate partner violence, elder abuse, and sex trafficking. However, in 2018 it expanded its focus to address all forms of gender-based violence, including sexual assault, human trafficking, family violence, stalking, and female genital mutilation.

The QFJC is a safe, caring environment that provides one-stop services and support to survivors of domestic and gender-based violence. Community, social, and civil legal services providers, key city agencies, and the Queens County District Attorney's Office are located on site to make it easier for survivors to get help. Services are free and confidential, and all are welcome regardless of their language, income, or immigration status. The QFJC takes a client-centered approach to service provision, providing clients information and options related to their needs before helping them determine which services to use (a list of services offered is shown in box 2 below). When a client first visits the center, they meet with a client screener employed by Safe Horizon, who (in consultation with the client) links them to an on-site case manager for safety planning and to create a service plan that includes referrals to the appropriate on-site social service providers and/or city agencies. The QFJC maintains an FJC application for each client that tracks their demographic, appointment, referral, and service information. This information is only collected in the aggregate and with clients' permission. From July 1, 2018, to December 31, 2018, the center served 2,639 unique clients through 5,387 client visits.

BOX 2

Services Offered by the Queens Family Justice Center

- Adult, child, and therapeutic counseling
- Case management
- Children's services
- Civil legal assistance (including family law, immigration and housing legal services)
- Computer classes
- District Attorney's office
- Economic Empowerment services
- Education program referrals
- Elder abuse services Financial assistance
- Help with public assistance case issues
- Housing and shelter advocacy
- Links to interfaith spiritual caregivers
- Links to job training
- Mental health services, including medication management
- Police services
- Safety planning/risk assessment
- Support groups
- Wellness services

Initial Demonstrative Goals

The Queens Family Justice Center had two goals for this demonstration grant: (1) develop a model for FJCs or similar colocated victim services to address polyvictimization, and (2) share lessons learned with the field. To develop a polyvictimization model, ENDGBV planned to help develop and implement a model assessment tool at the QFJC and identify new partners who could deliver the full range of services polyvictims need. To track and share lessons learned with the field, ENDGBV planned to collaborate with city agencies and community- and faith-based organizations, coordinate with OVC and a designated technical assistance provider during implementation, and partner with a research entity to conduct a site-specific project process evaluation. To accomplish these goals, QFJC brought together a consulting committee comprising a diverse group of service providers and key community stakeholders. The committee's purpose was to convene stakeholders to learn about the needs of QFJC polyvictim clients and discuss best practices for designing and implementing the polyvictimization assessment tool.

Urban was responsible for evaluating the development and implementation process and for evaluating the tool's effects during the pilot phase. The evaluation aimed to address three things: (1)

how implementing the tool affected QFJC systems and processes, (2) how the tool affected QFJC's staff dynamics and culture, and (3) how the tool affected service delivery. See appendix A for Urban's Process Evaluation Logic Model, which outlines the timeline Urban envisioned for the initiative.

The Polyvictimization Initiative Pilot and Final Implementation Phases

The Polyvictimization Initiative had two phases: (1) the Pilot Tool Development and Implementation Phase (pilot phase), and (2) the Final Tool Revision and Implementation Phase (final implementation phase). The six Polyvictimization Initiative sites, Alliance for HOPE, and the Center of Applied Research participated in both phases. During the pilot phase, these stakeholders aimed to understand the polyvictimization literature and review existing screening and assessment tools related to polyvictimization and complex trauma. The QFJC also mapped their client flow, identified needs related to training staff to address trauma, and set key goals for the initiative. Using this foundation, stakeholders from all six sites sought to collaboratively develop an assessment tool and related service model to be piloted at each site. During the pilot phase, the QFJC consulting committee decided that in addition to a long-form polyvictimization *assessment* tool, it would be helpful to develop a short-form *screening* tool. Although the PAT was shared across all six initiative sites, the PST was unique to QFJC; QFJC stakeholders worked with Urban to develop the PST at the end of the pilot phase, and continued testing it during the final implementation phase. For the final implementation phase, stakeholders sought to revise the pilot PAT and then implement the final version (the Modified-PAT). In both phases, QFJC sought to collaborate with partner agencies and improve trauma-informed practices.

Evaluation Methodology

Urban conducted a mixed methods process evaluation of the development and implementation of the PAT and PST at the Queens Family Justice Center from January 2018 through March 2019. Primary qualitative data were collected between February 2018 and February 2019. The research team used qualitative and quantitative research methods to document and assess (1) the tools' development at the QFJC, (2) their implementation, and (3) their validity.

Urban's evaluation aimed to address the following six core research questions:

- Development
  - (1) To what extent did QFJC project partners collaborate and strategically plan with each other and with national partners to develop the PAT/PST, and what were the key milestones of this process?
  - (2) How did project partners envision and implement changes to the QFJC's service provision to achieve PAT/PST goals?
- Implementation
  - (3) Were the PAT and PST implemented with fidelity at the QFJC, and what factors made implementation successful?
  - (4) What were the major barriers to successful implementation, and how were they addressed?
- Validity
  - (5) To what extent are the PAT and PST valid and reliable, and do they identify survivors of polyvictimization as intended?
  - (6) How does using the PAT and PST impact service delivery for clients who screen positively for polyvictimization?

To answer these questions, Urban analyzed qualitative and quantitative data, summarized in table 1.

TABLE 1

Evaluation Data Sources

Program materials	Review of program materials, including AFH and QFJC guides and implementation protocols, training materials, QFJC service information, and progress reports.
Stakeholder interviews	A total of 27 semi-structured, one-on-one or small-group interviews with 22 unique initiative stakeholders (some were interviewed multiple times). Interviewees included ENDGBV and QFJC leadership, leadership from partner agencies, QFJC frontline staff (including Client Screeners), case managers, and therapists.
Stakeholder surveys	Initial and follow-up web-based surveys of 32 initiative stakeholders.
Focus groups with survivors	Focus groups (held for both English and Spanish speakers) with 19 survivors who screened positively for polyvictimization.
Observations of program operations	Three observations of client screening (PST), assessment (PAT), and case management sessions.
PAT/PST data	Analysis of PAT/PST data from both the pilot and final implementation phases.
QFJC client administrative data	Analysis of clients' demographic data and service records.

Qualitative Data Sources

Urban completed three multiday site visits at the Queens Family Justice Center, two during the pilot phase and one during the final implementation phase. These three visits included the following evaluation activities: observations of polyvictimization screenings and/or assessments and any corresponding case management meetings (pilot and final implementation phases); one English-speaking and one Spanish-speaking focus group involving a total of 19 polyvictims who received services through the Polyvictimization Initiative (final implementation phase); and 27 interviews with 22 QFJC administrative and partner agency staff[4], including onsite and offsite staff (pilot and final implementation phases). Table 2 provides more detail about the QFJC administrative and partner agency staff whom Urban interviewed.

TABLE 2

Qualitative Data Respondents

	Number of unique respondents (*N*=22)
Respondent type	
Initiative core staff and service providers	
QFJC and partner agency leadership	5
Initiative key partner (grant-funded) leadership[a]	
QFJC and partner agency staff	
Case managers	3
Specialists/screeners	3
Therapists	2
Other	9

[a] "Leadership" refers to executive director or head of agency; to preserve respondent confidentiality, we do not report which agency leaders were interviewed. Managers were included in the "QFJC and partner agency staff" category.

Qualitative Data Analysis

The Urban research team took detailed notes when collecting qualitative data, and then cleaned and analyzed the notes for themes. Stakeholder interviews were coded for specific sets of themes, summarized in table 3.

TABLE 3

Themes Coded from Stakeholder Interviews

	Description
Theme	
Communication with AFH	Communication between QFJC and AFH technical assistance provider/evaluator on tool development, including how suggestions were made and how decisions and information were communicated.
QFJC internal collaboration	Internal collaboration, communication, and meetings (at the QFJC), including business as usual and changes related to the initiative.
Partner involvement	Includes information on different partners' involvement in the pilot PAT/PST development and implementation, including changes.
Tool development	Includes challenges and milestones pertaining to the Pilot PAT/ PST development,, as well as what consulting committee members initially wanted in the tool and how the tool ultimately was rolled out.
Pilot PAT and Modified-PAT	Includes information on the tools' content, structure, length, language, etc..

	Description
Tool implementation	Includes information on implementation plans, consulting committee expectations versus AFH final tool implementation plans; any similarities between or gaps in plans, including challenges and strengths, potential problems with clients, or potential conflicts with current practices; exact information on how the pilot and revised PATs were used in conjunction with preexisting screening, case management, and referrals.
Tool training	Includes information on training for tools, including AFH and QFJC trainings and education/training relevant to implementing and using the tool (e.g.,. staff without clinical training implementing the tool).
Services and referrals	Impact on changes to services/service referrals, including descriptions of business-as-usual practices and new systems.
Characteristics of Queens, QFJC, and QFJC clients	Information related to the context and clients of QFJC.

Quantitative Data Sources and Study Sample

Urban also used quantitative data to address the following three research questions:

- Do the PAT and PST correctly identify clients who have experienced polyvictimization?
- What were the demographic traits of the clients who the initiative served and who screened positively for polyvictimization?
- How does using the PAT/PST impact service delivery? More specifically, do clients who are routed to special Polyvictimization Initiative services receive different amounts and types of services compared with those who are not?

Quantitative Data

Urban's analysis relied on three quantitative data sources: (1) staff surveys, (2) data from the PST and the pilot and Modified-PAT, and (3) QFJC administrative records.

Urban fielded initial and follow-up stakeholder surveys with QFJC and partner agency staff in April 2018 and April 2019, respectively. Surveys were administered online using Qualtrics secure software. Urban sent the initial survey to 36 stakeholders; 11 responded, yielding a response rate of approximately 30.6 percent. The follow-up survey was sent to 36 stakeholders; 21 responded, yielding a response rate of approximately 58.3 percent.

Pilot Phase PST and PAT Data

Queens Family Justice Center staff used the PAT with 45 clients during the pilot phase between March 1 and May 31, 2018. In September 2018, Urban researchers worked with QFJC stakeholders to develop the PST, which was used with 30 clients in total.

Final Implementation Phase PST and PAT Data

Between December 1, 2018, and March 31, 2019, the Polyvictimization Initiative served 114 unique clients. These clients took the PST, the Modified-PAT, or both, depending on their circumstances. Appendix C illustrates the pathways into the program that were available to clients.

- *Eighty-four unique clients were screened with the polyvictimization screening tool and consented to participating in the study*. Although the PST was used to screen 89 clients for polyvictimization, five did not consent to be included in the study. This yielded a final sample of 84 PST clients.
- *The modified polyvictimization assessment tool was administered to 75 unique clients*. Seventy-five clients completed the Modified-PAT during this phase and consented to being in the study.
- Forty-one of the clients (about 49 percent) who completed a PST went on to complete a Modified-PAT during this phase. The remaining 43 *did not* go on to complete the Modified-PAT for various reasons. Some were not identified as high-needs polyvictims, and others chose not to receive the specialized services. Of the 75 clients who completed a Modified-PAT, 34 *were not* screened using the PST. Typically, this situation occurred when a client had already been working with a QFJC case manager or therapist who had identified the client as a polyvictim. Appendix C details these overlaps and how clients flowed through the program.

Quantitative Data Analysis

Urban researchers used Excel and Stata statistical software to analyze quantitative data, and imported survey data from Qualtrics to generate descriptive statistics and graphics. Administrative records from QFJC and data from the PST and PAT were submitted to Urban via Secure File Transfer Protocols, then analyzed to generate descriptive statistics and complete validity analyses.

Limitations

The main quantitative results presented in this report (i.e., results from the PST and Modified-PAT) have several important limitations. First, although the PST and Modified-PAT capture experiences of various forms of violence (as well as other types of adverse experiences), these tools do not record the perpetrators of such violence. This means we are unable to distinguish between a client who faced multiple forms of violence by the same person and a client who faced multiple forms of violence by different people. Second, the data analyzed is drawn from a convenience sample, rather than a randomly selected, representative sample of QFJC clients. Findings are therefore *not representative* of all clients served at the QFJC, nor of polyvictims at the QFJC or in New York more broadly. Third, there were a substantial amount of missing data for the Modified-PAT; specifically, per each of the Modified-PAT questions, the percent of missing observations ranged from zero to 42.7 percent. Missing data was primarily due to clients electing not to answer certain questions on the tool; this practice was permitted to ensure that clients always had the option to refuse to answer any questions that they did not wish to discuss. As such, the Urban research team conducted the main validity analysis on a subset of 43 clients who had completed the Modified-PAT and also had valid data available for all key variables (32 clients were missing data for key variables). For this reason, the results from our validity analysis are not necessarily representative of all clients served through the Polyvictimization Initiative.

Pilot Tool Development and Implementation

During the Polyvictimization Initiative's pilot phase, QFJC stakeholders participated in two key processes: **(1) developing the service model and pilot PAT, and (2) implementing the pilot PAT.** We describe both processes based on information from QFJC documentation, QFJC-specific and initiative-wide meetings, stakeholder interviews and surveys, client interviews, and observations.

Developing the Service Model and Pilot PAT

During the pilot phase, QFJC stakeholders participated in client-mapping activities to identify gaps in services, and subsequently implemented trauma-informed practices in their services and physical spaces. They also engaged with AFH, the Center of Applied Research, and other sites during this phase to develop the pilot version of the polyvictimization assessment tool.

Through the Client-Mapping Process, QFJC Administrative and Partner Agency Staff Identified Goals to Improve Intake and Service Delivery

One of the initiative's key components was client mapping. A process map is a planning and management tool that visually describes an organization's workflow by showing a series of events producing an end result.[5] Family Justice Centers can use process mapping to examine the client's path from intake to receipt of long-term services; to identify strengths, gaps in services, flows of collaboration, partners, or services that need to be included; and to identify strategies to improve service delivery. Process mapping requires teamwork and promotes understanding across an organization's functional areas (Southern Institute on Children & Families 2009). A modified version of the client flow analysis that the QFJC's mapping process resulted in is available in appendix B.

The QFJC's client-mapping process clarified how clients learned about the center, illustrated how clients progress, and showed how staff communicated and collected information about clients. As a result, the QFJC identified three key things. First, there was **a lack of specific information about clients being shared.** For example, clients had to recount incidents and histories of abuse multiple times during service provision. The client-tracking system also did not link to the individual case management systems operated by the partner agencies.[6] Second, the QFJC identified how **client volume impacted**

their service delivery; clients were not always able to meet with case managers on the same day as their intake date, and staff were often unable to provide a "warm handoff" when connecting the client to the next service provider. There was also no formal process for following up with clients after meetings, as each partner agency is independent and follows its own follow-up protocols. Lastly, QFJC was able to identify a **policy issue related to the role of case managers**. Case managers were usually a client's first point of contact after screening and remained their central point of contact. However, expectations about their responsibilities, including how to handle common concerns, properly complete referral forms, and engage in follow-up, needed to be clarified. In addition, part-time case managers struggled to keep up with QFJC operations. Staff at QFJC also identified the lack of multidisciplinary team meetings to review cases, the negative impact of staff turnover on collaboration and effective service delivery, and the community's lack of awareness of the QFJC's services as challenges.

Through the client-mapping process, **QFJC identified short- and long-term goals to improve intake and service delivery.** The four short-term goals were: (1) make screening more client-centered by deemphasizing data collection and emphasizing accessing client needs; (2) create a best-practices document and provide more training for case managers on QFJC policies and procedures; (3) create a mentoring program for part-time case managers; and (4) finalize new memoranda of understanding (MOUs) and an operations manual. The two long-term goals were: (1) redesign QFJC's client-tracking system so that questions about histories of victimization were only asked when necessary to determine service needs, and (2) create more partnerships with community-based programs so clients can receive services closer to their homes.[7]

QFJC Implemented Changes to Create a More Trauma-Informed Environment

One of the **Polyvictimization Initiative's primary components was a trauma-informed approach to service delivery**. Taking a trauma-informed approach ensures providers are accountable to survivors and their needs. According to the Substance Abuse and Mental Health Services Administration's definition, a trauma-informed approach "realizes the widespread impact of trauma and understanding potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeking to actively resist re-traumatization" (SAMHSA 2014, 9). A trauma-informed approach has the following six key principles (SAMHSA 2014):

- **Safety**. Family Justice Center staff and clients should feel physically and psychologically safe.

- **Trustworthiness and transparency**. Centers should operate (and decisions should be made) transparently and with the goal of building and maintaining trust among clients, families, staff, and others involved with the FJC.
- **Peer support**. Peer support is a key means of establishing safety and hope, building trust, enhancing collaboration, providing clients examples of recovery and healing, and maximizing a sense of empowerment.
- **Collaboration and mutuality**. Collaboration and mutuality are shown by leveling power differences between staff and clients and among staff, and by sharing power and decision-making.
- **Client empowerment.** To empower clients and provide them voice and choice, Family Justice Centers should recognize and build on clients' strengths and experiences and foster a belief in resilience. This ensures clients are supported in advocating for and empowering themselves.
- **Addressing cultural, historical, and gender issues**. Family Justice Centers should actively move past cultural stereotypes and biases, offer gender-responsive services, leverage traditional cultural connections, and recognize and address historical trauma.

The Queens Family Justice Center implemented four significant changes during the pilot phase to enhance customer service and create a more trauma-informed environment. First, it made its space more comfortable and welcoming. The center made physical changes to the security, reception, and waiting areas, including decorations with warm colors, artwork, lavender diffusers, plants, LGBTQ-affirming signs, and welcome signs in various languages. It also added a snack bar with a water cooler, snacks, and tea/coffee. Second, supervisors began observing staff monthly to assess (among other things) each staff member's customer service. Third, to increase staff's trauma-awareness, a Safe Horizon supervisor attended the AFH-sponsored Train the Trainer event on trauma, and subsequently trained security staff, civil legal staff, reception staff, and on-site police officers to increase their trauma-sensitivity. Additional trainings were offered for all staff, including LGBTQ-sensitivity training, Skills for Trauma Psychotherapy, Trauma-Informed Care and Cultural Considerations, and Grounding and De-Escalation. Fourth, the QFJC began holding quarterly events focused on staff wellness and self-care, including an event on mindfulness and grounding techniques using art.

Key QFJC Stakeholders Reviewed Tools and Literature on Polyvictimization

Queens Family Justice Center staff (and various other QFJC stakeholders) helped develop the Pilot PAT in addition to the service model. Led by Alliance for HOPE and in collaboration with other Polyvictimization Initiative sites, a core group of QFJC stakeholders helped review other tools, suggested features the Pilot PAT should have, and provided iterative feedback on drafts. the key grant-funded partners also helped develop the PAT: Safe Horizons, ENDGBV, Voces Latinas, NYC Alliance to Combat Sexual Assault, Sanctuary for Families, and the Mt. Sinai Sexual Assault and Violence Intervention Program. The QFJC consulting committee met bimonthly and included stakeholders from QFJC partner agencies with knowledge of the client population.

Alliance for HOPE began the process of developing the polyvictimization assessment tool by reviewing relevant literature and tools and selecting 30 "promising tools," sharing those tools with the six sites. Queens Family Justice Center stakeholders provided written feedback on the promising tools, including the tools' formatting and implementation practices. Alliance for HOPE then drafted the 61-question Pilot PAT and received multiple rounds of written and verbal feedback from the sites via several initiative-wide calls.

QFJC Stakeholders Requested Changes to the Pilot PAT and Its Implementation

Feedback from QFJC stakeholders flagged several issues with the Pilot PAT's structure and implementation plans. First, the consulting committee expressed that a two-tiered implementation approach was crucial to the Pilot PAT's success. In fact, there was almost universal agreement among stakeholders that the polyvictimization tool should be implemented in two-steps: (1) a short events-based screen conducted by the case manager to identify the presence of polyvictimization, and (2) an extensive symptomology-based screen conducted by the polyvictimization clinician. This feedback was ultimately incorporated into the Modified-PAT, though not during the initiative's pilot phase. After reviewing AFH's drafts of the Pilot PAT, QFJC stakeholders provided additional feedback on the topics and phrasing of the tool's questions as well as its implementation requirements. After receiving this feedback from the QFJC and other initiative sites, AFH finalized the Pilot PAT.

AFH Finalized the Pilot PAT and Provided Implementation Guidance to QFJC

The Pilot PAT that Queens Family Justice Center and the other five sites implemented included 61 questions about victimization events, other adverse life experiences, and trauma symptoms. It included 39 events-based questions; 20 focused on victimization events (such as strangulation or assault), and 19

focused on other adverse life experiences (such as homelessness and substance abuse). Events-based information (about events the client experienced or witnessed) was collected for the following periods: Child and Teen (ages 0 to 17), Adult (ages 18 and older), and In the Past Year.[8] The Pilot PAT also contained 22 questions about trauma symptoms, including pain, sadness, and avoidance. It also asked whether clients experienced trauma symptoms in any of the three periods mentioned above. The Pilot PAT was only available in English, and QFJC stakeholders administered a paper version to clients.

Queens Family Justice Center case managers implemented the Pilot PAT in accordance with AFH's guidelines for the tool's implementation timeline and the number and composition of clients with whom the tool should be used. Alliance for HOPE led an effort to establish several key agreements about how the six sites would use the Pilot PAT, and those agreements were shared at initiative-wide meetings. These included agreements to not simply use the tool as a checklist, to use the tool conversationally, and to use the tool to direct service delivery. The QFJC implemented the Pilot PAT between March 1 and May 31, 2018; it used the tool with 45 clients, 32 of whom were new, 9 of whom were returning clients, and 4 whose status was unknown.

Stakeholder Perspectives on Pilot PAT Development

This section discusses insights gleaned from stakeholder interviews and surveys, client interviews, and discussions between Polyvictimization Initiative participants at the local and initiative-wide levels. Stakeholders from QFJC identified several strengths, benefits, and challenges during the Pilot PAT's development stage.

Development at QFJC Benefited from Preexisting Collaborative Relationships

Queens Family Justice Center stakeholders uniformly reported that partner agencies' strong preexisting relationships improved internal collaboration during the development stage. Stakeholders noted that collaboration was rooted in a strong foundation, citing regular all-staff meetings and meetings for subsets of staff (e.g., case management and legal teams), as-needed communication, frequent referrals, and collaborative work. One interviewee noted the center's collaborative atmosphere, saying, "The local group, we play very well in the sandbox together; people talk well and express their opinions".[9]

Stakeholders Lacked Clarity about the Initiative's Key Definitions and Goals

Stakeholders faced several challenges during Pilot PAT development. First, some stakeholders lacked understanding of the tool's purpose. Staff wondered whether it would actually benefit clients by connecting them to services or whether it was simply being used to collect information for research or for strategic purposes. In a review of an early draft of the Pilot PAT, the consulting committee felt that the tool was more of a research instrument and less of a way to guide appropriate clients to polyvictimization services. For example, many committee members noted that focusing on polyvictimization symptoms exhibited by the client, rather than events, was more likely to identify clients who are currently in need of polyvictimization services. However, the tool is heavily skewed toward events. Given one of the goals identified during client mapping was to ensure the screening process prioritized clients' needs over data collection, stakeholders had reservations about creating a data collection tool.

Additionally, several stakeholders noted in interviews that they **had not received a clear definition of polyvictimization** during the development stage. Alliance for HOPE communications early in the development stage did include information about polyvictimization, but it did not specify how many victimizations a client needed to have experienced to be considered a polyvictim. By the end of the development stage, however, AFH shared an implementation guide with a working definition of polyvictimization: "While there is not a set number of 'yes' answers in the Tool to trigger a specific Center response, the Alliance recommends that any survivor who has experienced 4 or more victimizations, in the last year, be recommended for a multi-disciplinary team meeting" (AFH 2018).

Stakeholders Pushed for the Tool to Reflect Realities of QFJC, with Limited Success

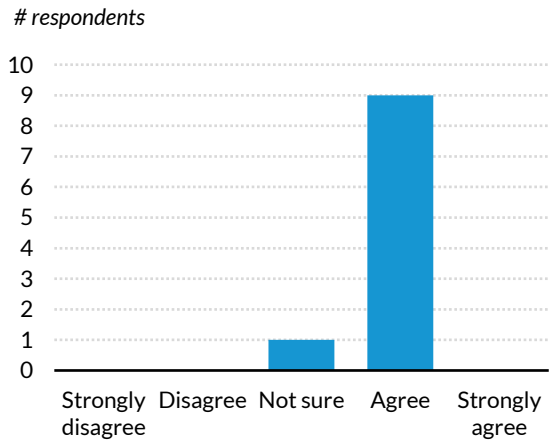
Queens Family Justice Center stakeholders saw QFJC as distinct from the other five sites, and considered this a challenge to developing a tool that could be applied to those sites' clients and contexts. One stakeholder emphasized that "the basic idea of what does polyvictimization mean for a victim coming into the FJC in Queens, which is a very diverse borough, in NYC, which, in comparison to the other sites, has more crime, more serious crime, and a higher volume of people coming through the doors, [is different]."[10] Stakeholders also felt that many of the Pilot PAT's events-based questions were not relevant to their clients' experiences. Stakeholders voiced this concern in several ways, including through the Pilot Phase Stakeholder Survey, where just 18 percent of respondents marked "been or lived in a military combat war zone" as relevant, and just 9 percent marked "exposed to dangerous chemicals or radioactivity that might threaten your health" as relevant.

For related reasons, **stakeholders were concerned the Pilot PAT was too long.** Multiple stakeholders shared that they would have preferred a specific focus on events; for example, one stakeholder said, "It could be a great tool…this one is very symptomological, and we want it to be more of a checklist."[11] Others believed it was more in-depth than necessary; one stakeholder stated, "It needed to be very short and it didn't need to be as specific as what emerged."[12] Relatedly, stakeholders identified redundancies in the draft tool; for instance, the consulting committee expressed that it was unnecessary to ask multiple questions about different perpetrators (for example, the Pilot PAT contained two questions about assault). As a result, almost every stakeholder interviewed agreed that the Pilot PAT was too long. Ultimately, most stakeholders felt they had a chance to provide feedback on the tool, but did not feel as strongly that their participation impacted the final version of the Pilot PAT (figure 1).

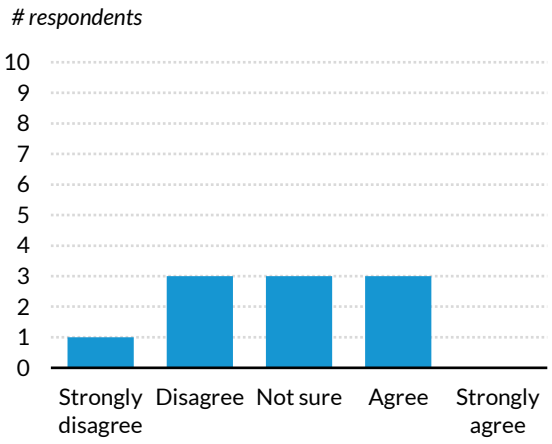
FIGURE 1

Stakeholder Perspectives

I had opportunities to provide feedback about the Pilot PAT



My feedback had an impact on the development of the Pilot PAT



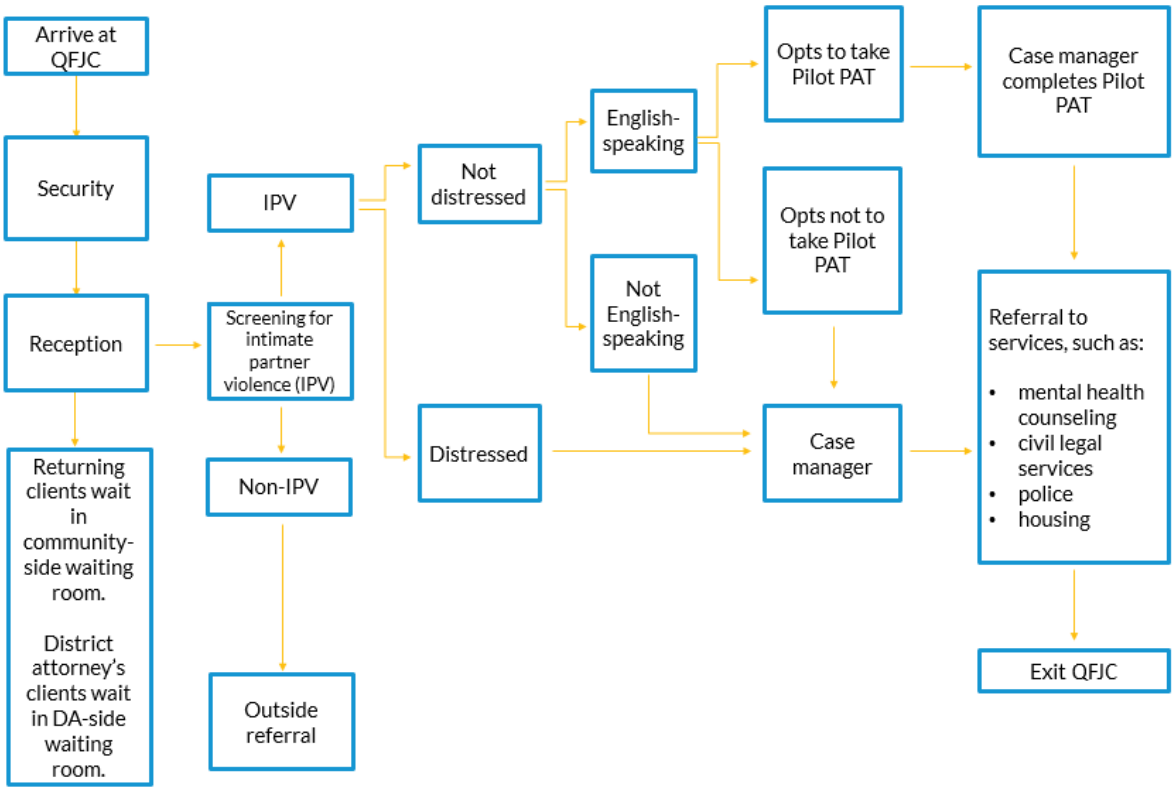
Source: 2018 Pilot Phase Stakeholder Survey.
Notes: *N* = 11.

Implementing the Pilot PAT

The QFJC implemented the Pilot PAT in three stages: (1) the center screened clients for eligibility, (2) client screeners introduced the tool to eligible clients, and (3) case managers began using the tool to assess clients. Figure 2 illustrates the client flow the QFJC designed for the pilot phase in its implementation guide. Through stakeholder interviews and observations in February and May 2018, **the Urban research team reviewed the implementation of the Pilot PAT.**

FIGURE 2

Pilot Phase Client Flow



Pilot Implementation Began with Business-as-Usual Practice by Reception, Client Screeners, and Case Managers, Supported by Their Supervisors

Safe Horizon managers provided supervisory support as client screeners and case managers at QFJC began the implementation process. In accordance with QFJC's usual operations, Safe Horizon managers met with case managers for biweekly supervision meetings, and occasionally observed their sessions with clients. Additionally, frontline staff were able to seek out their supervisors (who typically had open-door policies) to raise issues related to the Polyvictimization Initiative. Staff who responded to the Pilot Phase Stakeholder Survey generally considered the trainings and available supports during the pilot phase to be adequate, though some frontline desired additional training.

During Pilot PAT implementation, and in accordance with QFJC's business-as-usual practice, **front-desk staff collected initial information from all visitors** (these staff are called client services specialists). Clients passed the building's security entrance (which uses metal detectors) upon arrival.

They then checked in at the front desk; clients with appointments were diverted to the waiting room, and district attorney (DA) clients were diverted to the designated DA waiting area. If the client was new to QFJC, client receptionists and/or frontline advocates collected their name, date of birth, residential zip code, and precinct. They explained QFJC's services, gave an overview of the intake process, and estimated the wait time. Stakeholders estimated that this process typically took between three and five minutes.

Next, **two Safe Horizon client screeners introduced the Pilot PAT to the client, obtained their initial consent to participate in the research, and conducted QFJC's usual screening and intake process**. Specifically, after greeting the client in the waiting area and bringing them to the screening office, the client screeners provided an overview of the QFJC and the Polyvictimization Initiative. At this point, the screeners offered clients the chance to participate in a test of a new tool, explained the tool, and emphasized that participation was voluntary. (Although this informed-consent process was designed to help clients understand the initiative, some QFJC stakeholders indicated to Urban researchers that clients did not always understand the initiative at this stage.)

The opportunity to participate was (by design) only offered to English-speaking clients and to clients whom client screeners determined were not in emotional distress; staff estimated that approximately 30 to 60 percent of clients fell outside these categories and were not offered the opportunity to participate. Some clients who were invited to participate declined; though staff did not track these numbers, they reported that the most common reasons clients declined included being tired and being busy. Clients who agreed to participate signed consent forms for the Polyvictimization Initiative and for the usual QFJC services. After a client agreed to participate, a client screener held a short conversation to assess their needs and complete an intake form (per QFJC's business-as-usual practice). If during this conversation the client screener determined the client did not meet the center's eligibility requirements (i.e., they did not find the client to be a survivor of intimate partner violence, elder abuse, or sex trafficking), the screener connected them to an appropriate agency. If the client had experienced intimate partner violence, the screener informed the case managers that the client was ready as well as whether the client agreed to complete the Pilot PAT.

After the intake process, one of two Safe Horizon case managers administered the Pilot PAT. *Notably, case managers completed all business-as-usual case management activities before beginning the Pilot PAT.* In accordance with business-as-usual, the case manager began the case management process by meeting the client in the waiting room and bringing them to a private office. They then spent approximately one hour completing risk assessment and safety planning, connecting the client with services to address immediate needs (e.g., housing/shelter and lock changes), referring the client to

specialized services (e.g., mental health counseling, legal services, and public benefits administration), and scheduling follow-up meetings. Throughout this process, case managers took handwritten notes about clients' experiences or symptoms relevant to the Pilot PAT, that could then be logged in the electronic tool after their session concluded. After those activities, case managers again mentioned the Pilot PAT and confirmed whether the client was still interested in participating. According to the Pilot PAT implementation guide, case managers could have completed all Pilot PAT questions conversationally and then ended the session, but in practice, QFJC's case managers always had to ask for more detail regarding some portion of the questions on the Pilot PAT.

Case Managers Formally Asked Pilot PAT Questions after Typical Case Management Sessions

If a client still wanted to complete the Pilot PAT after the usual case management session, **the case manager began formally administering the tool**. During this process, case managers opened the paper tool, read the remaining questions (typically verbatim, in full or in part), and recorded answers directly in the tool. Although managers could glean some information during the case management session, they frequently had to raise various issues or events again to collect information about time frames (i.e., whether incidents occurred during childhood, adulthood, or in the past year). Case managers typically completed the tool in one session (80 percent of cases), though 9 percent of cases required two sessions and 2 percent (one tool) required three (for the remaining 9 percent of tools, data on the number of sessions need to complete the tool was missing). According to staff reports and researcher observations, the tools typically added between 15 and 90 minutes to the case management session.

Stakeholder Perspectives on Pilot Implementation

The Pilot PAT Benefited Some Staff and Clients

Implementing the Pilot PAT at the Queens Family Justice Center benefited staff and clients in several ways, including helping staff better understand and validate clients' experiences.

The Pilot PAT enabled case managers to learn things they would not otherwise have known about clients. One stakeholder described the benefits to the service provider: "It's an important step to understand all the experiences that are happening in people's lives…Maybe having more information about people's experiences can help us better reflect on what services we need to provide."[13]

Moreover, many **clients appreciated the opportunity to share their experiences** because it made them feel listened to and cared for. Staff reported that clients seemed to respond well to and feel relieved by being asked about their lives. Clients echoed this sentiment during Urban-led interviews, sharing that they felt listened to and comfortable answering the Pilot PAT questions. Additionally, some staff believed implementing the Pilot PAT provided a venue to help clients better understand their experiences of victimization. Many evidence-based models use this strategy, called **"psychoeducation,"** to empower clients and help them cope with their conditions and treatment (Lukens and McFarlane 2004). One stakeholder said it benefited clients "to know that this can be classified as a traumatic experience, because that can explain some of the symptoms or experiences [they are] having."[14]

Stakeholders Felt the Pilot PAT Clashed with Existing Service Models and Failed to Improve Client Services

Despite the strengths of QFJC's Pilot PAT implementation process, the tool presented several challenges. First, **the tool's length—coupled with its implementation structure—remained a constant challenge during implementation**. Some stakeholders believed the additional time needed to administer the Pilot PAT could inconvenience providers and their clients. Several stakeholders noted the QFJC's large number of clients had caused some clients to experience wait times of several hours. Stakeholders doubted whether many clients could take the time to complete the tool (recall those clients who declined to participate because they were too busy). Moreover, describing the constraints on staff time, another interviewee said, "When you have 50 clients a day, that [length is] just not feasible."[15]

Relatedly, **QFJC stakeholders did not consider the tool or its implementation to be client-centered**, something they and the Polyvictimization Initiative value. Safe Horizon (the service provider tasked with using the Pilot PAT) trains and requires their staff to engage in client-centered practices, meaning the client's needs and desires come first. Most clients enter the Queens Family Justice Center seeking services for their immediate safety (e.g., orders of protection for domestic violence or shelter housing). As such, before the Pilot PAT was implemented, stakeholders worried it would interfere with service delivery. As one QFJC stakeholder shared with AFH, "The information covered in the required questions [of the Pilot PAT] usually is not captured within the first few meetings with the client, and it is up to the client if and when to share this information" (QFJC 2017). In other words, for staff, asking clients to share those details did not accord with best practices for engaging in a client-centered approach.

Queens Family Justice Center stakeholders also had concerns about the tool's implementation, including that it was not shaping or changing the services provided to clients during the initiative's pilot phase. First, stakeholders noted that in accordance with the QFJC's client-centered approach, clients needed to receive the services they wanted; because most clients knew what they wanted when they arrived at the center, using the Pilot PAT did not shape the services they were offered. Second, because the QFJC had not yet hired specialized staff for the Polyvictimization Initiative, stakeholders were concerned clients were being asked deeply personal and possibly triggering questions despite the fact that the center had no new services to offer them (due either to a lack of specialized polyvictimization services or a lack of capacity). Stakeholders generally agreed that if staff were going to ask clients such deep, personal, and specific questions, there should be corresponding services to provide them. One interviewee stated, "I feel like if you're assessing something, there needs to be a reason for every question…For example, if someone indicates childhood emotional abuse, does that then mean that the [staff] will have received specialized training on working with childhood emotional abuse?"[16] According to stakeholders, these challenges were exacerbated by the limited availability of high-demand services such as mental health counseling. Additional capacity was not available among QFJC administrative and partner agency staff during the pilot phase, and some stakeholders doubted whether the PAT's many questions would add value to the QFJC's services.

The Phrasing of Pilot PAT Questions May Have Affected the Accuracy of Client Responses

The Pilot PAT's events-based questions were not phrased according to the research-recommended behaviorally specific framework, something that may have prevented clients from understanding the questions. The six initiative sites agreed that the Pilot PAT should be used conversationally, meaning it was not designed to be read verbatim. However, because of its length, the information about time periods that needed to be captured, the lack of connection between many of the questions, and a lack of comfort among staff, case managers had to read at least some of the PAT questions verbatim.

The questions, however, were not all phrased in a **behaviorally specific** way. Behaviorally specific questions are considered best practice in screening and assessment tools because they focus on specific actions rather than labels. Research shows they elicit more disclosures of victimization experiences, possibly because they reduce stigma and make it easier for clients to understand what is being asked (Ellsberg et al. 2001; Koss 1985; Krug et al. 2002; Lindhorst, Meyers, and Casey 2008). Few of the Pilot PAT's events-based questions were behaviorally specific, and frontline staff and researchers observed indications that clients may not have understood the questions sufficiently to provide valid responses.

Case managers shared that some clients needed certain words to be further explained. During observations, Urban researchers similarly noted that clients had trouble understanding some questions. For example, one client was asked if they had experienced "community violence," a term researchers and practitioners use to describe living in a community that experiences high levels of interpersonal violence. The client responded that they had not, but later contradicted themselves when they described frequently hearing gun violence in their neighborhood. This suggests the client may have misunderstood the question because it lacked behaviorally specific language. It is impossible to gauge to what extent this may have affected clients' responses to the Pilot PAT questions, but it was an important challenge that needed to be addressed in the Modified-PAT.

Stakeholders Worried the Pilot PAT Could Trigger Clients

Concerns about nonclinical staff who lacked training implementing the Pilot PAT exacerbated fears that the tool could trigger or activate clients' traumas. Interviewees—including frontline and supervisory staff—repeatedly shared that they worried about case managers' ability to implement the tool because it was outside their area of expertise (as one interviewee stated, "That's not what they're trained to do").[17] One stakeholder noted the importance of "making sure they can recognize when someone may be dissociating and having some basic grounding skills to make sure that the person feels empowered not to screen them and send them into the real world with their skin turned inside out."[18] Although QFJC did not systematically track clients' feelings about the Pilot PAT, some stakeholders reported during interviews that some clients became upset after completing the tool.

Altogether, the pilot stage allowed QFJC stakeholders to identify strengths to build on and flaws to address in the Polyvictimization Initiative's implementation stage.

Final Tool Revision and Implementation

During the Polyvictimization Initiative's final implementation phase, Queens Family Justice Center staff participated in the development of the polyvictimization screening tool, the process of revising and modifying the polyvictimization assessment tool, and the implementation of both tools.

Developing the PST

QFJC Stakeholders Developed and Implemented a Short Screening Tool

During the pilot stage, most QFJC stakeholders hoped to see a short screening tool tested with clients before implementing the Modified-PAT. As such, in September 2018, stakeholders began taking steps to develop such a tool, with the support of Urban researchers. Through its OVC-funded capacity to provide technical assistance via the Center for Victim Research,[19] Urban led the development of the QFJC polyvictimization screening tool independently of the Polyvictimization Initiative. During the pilot phase, stakeholders emphasized their desire for a two-tiered screening process to prioritize use of the assessment tool with clients. Queens Family Justice Center stakeholders reported—and Pilot PAT data confirmed—that nearly all QFJC clients could be considered polyvictims, so staff needed a way to distinguish people with the highest needs to prioritize them for specialized services with limited availability. As noted above, staffed expressed a preference for a two-tiered process whereby a short events-based screener could be used before a clinician used a larger assessment tool over a longer period. Leadership from QFJC and the Mayor's Office to End Domestic and Gender-Based Violence proposed to develop and implement this shorter screening tool alongside the Modified-PAT, and QFJC stakeholders were glad when OVC, the Center of Applied Research, and the Alliance for HOPE agreed that QFJC and the other demonstration sites could develop and implement their own screening tools.

Urban, QFJC/ENDGBV, and QFJC Partner Staff Developed the PST Collaboratively

At the Queens Family Justice Center, **development of the screening tool began with Urban researchers analyzing Pilot PAT data.** Given the QFJC's preference for an events-based screener, Urban's team focused only on the events-based questions; in keeping with most polyvictimization research, the research team and QFJC stakeholders opted to focus more specifically on questions about

victimization. First, researchers examined the prevalence of each of the 13 types of victimization listed in the Pilot PAT, seeking to understand which victimization questions were most frequently reported and which yielded new information about clients' victimization experiences. Second, through further quantitative analysis, Urban determined that including just seven questions on different types of victimizations would be enough to help QFJC partner agency staff identify polyvictim clients with the highest needs. The seven types of victimization included assault, sexual abuse/assault, stalking, strangulation, robbery, cybercrime, and witnessing violence, and each question on PST was written using behaviorally specific language (see appendix D for the final version of the PST). Focusing on these seven victimization questions, Urban researchers used the Pilot PAT data to estimate the share of QFJC clients who would be identified as "high-needs polyvictims", using varying criteria (i.e., varying the total number of victimizations a client needed to report in order to be considered a high-needs polyvictim).

After the quantitative data analyses, QFJC stakeholders used their professional and practical knowledge to provide input. Urban researchers presented the draft tool and suggested screening criteria to the consulting committee at several meetings. Urban researchers initially proposed using two or more victimizations as the threshold for designating clients as high-needs polyvictims, which would have designated 62 percent of polyvictims as high-needs during the pilot phase. However, because QFJC partner agency staff intended to use the PST with a broader client population than the group that had been offered the Pilot PAT, they advised that a narrower set of criteria be developed. This would reduce the number of clients referred to the polyvictimization track, to ensure that specialized services would be available for all referred clients. For this reason, stakeholders decided to narrow the criteria for designating high-needs polyvictims to experiencing three or more of the seven victimizations. Stakeholders also emphasized the importance and lethality of three victimizations: strangulation, stalking, and sexual assault. They noted that victims of these crimes had particularly high needs, and requested to factor those needs into the criteria as well.

Ultimately, **the tool, dubbed the polyvictimization screening tool, consisted of seven questions about victimization events for clients and one validation question for the client screener.** As noted above, the victimization questions covered physical assault, sexual abuse and assault, stalking, strangulation, robbery, cybercrime, and witnessing violence across one's lifespan (appendix D). To allow for subsequent validation analyses, the client screener was asked whether and to what extent they felt their client had experienced polyvictimization. The official screening criteria stipulated that clients would be considered high-needs polyvictims if they reported three or more of the seven victimizations. Clients who reported two victimizations would also be considered high-needs polyvictims if one of those victimizations involved stalking, strangulation, or sexual assault.

The PST Was Piloted and Finalized for Implementation

The Queens Family Justice Center piloted the PST in September 2018. Client screeners implemented the tool, using it with all their clients during their usual screening sessions. Because the PAT was not being implemented during this period, clients proceeded to QFJC's usual case management and specialized services. Ultimately, 30 clients were screened with the tool during this period.

After the pilot phase, small changes were made to the tool and its implementation. First, one symptom-based question for the client was added as an additional validation question. The question asked clients whether they experienced physical pain, which QFJC stakeholders expected would be minimally distressing to clients (relative to asking about other potential trauma symptoms, e.g. intrusive thoughts). Second, the criteria for designating clients as high-needs polyvictims were narrowed because of the high number of clients who were screening as such during the pilot; stakeholders and researchers decided to consider polyvictims high-needs if they reported four or more victimizations *or* three victimizations that included stalking, strangulation, or sexual assault.

From Pilot PAT to Modified-PAT

In addition to the site-specific development of the PST, QFJC partner staff engaged in the initiative-wide process of revising the Pilot PAT into the Modified-PAT between June and November 2018.

Administrative Staff and Partner Agency Staff Participated in the Process of Modifying the PAT

The PAT revision process (like the development process) engaged core Queens Family Justice Center staff in a series of exercises led by Alliance for HOPE. During the Polyvictimization Initiative's pilot phase, QFJC frontline staff provided feedback on the Pilot PAT—and suggestions for the Modified-PAT and its implementation—during monthly calls with AFH. Urban researchers, QFJC stakeholders, and the other five initiative sites provided additional feedback on the PAT through the 2018 OVC Polyvictimization Screening Tool Feedback survey. The survey—which a total of nine QFJC stakeholders and Urban researchers responded to—asked whether each of the tool's questions should be kept and/or modified. Stakeholders also participated in initiative-wide meetings (primarily via video conference) during which the six sites and Alliance for HOPE made final decisions about the tool's content, structure, and implementation. At the sole in-person meeting, stakeholders decided sites could

develop and implement their own screening tools (in addition to the Modified-PAT) according to their own needs.

The Modified-PAT ultimately included 44 of the Pilot PAT's 61 questions. These 44 questions covered victimization events, other adverse life experiences, and symptoms over several time frames (appendix E). The tool was made available in English, Russian, and Spanish, and included 26 events-based questions, 14 focused on victimization and 12 focused on adverse life experiences. The remaining 18 questions focused on trauma symptoms. In addition to these, QFJC added an additional validation question asking staff to what extent they thought the client had experienced polyvictimization, on a scale from 1 to 10 (with 10 indicating the most severe experiences of polyvictimization). Queens Family Justice Center stakeholders considered the tool's biggest improvement was that it was shorter.

However, QFJC stakeholders still perceived some challenges during the PAT revision process. Though they appreciated that it had been shortened, stakeholders still felt the tool was too long, especially given the center's many clients and those clients' busy schedules. Stakeholders hoped some questions they considered triggering or irrelevant for most QFJC clients (e.g., experiences with natural disasters) would be excluded from the modified tool. Furthermore, some felt their suggestions were not considered. As one stakeholder said, "I did advocate for certain changes, but that didn't end up happening, some of them."[20] Other stakeholders did not believe that sharing their opinions would be fruitful. For example, one stakeholder stated: "It was to the point that when [the AFH] asked what we thought, we just agreed because we didn't want to bother going back and forth and fighting."[21]

Final Implementation of the PST and Modified-PAT

Queens Family Justice Center Hired Specialized Polyvictimization Staff to Complete the Final Implementation Phase

The QFJC implemented the polyvictimization screening tool and the Modified polyvictimization assessment tool between December 1, 2018, and March 31, 2019. During this period, staff used the PST with 89 adult clients and the Modified-PAT with 75. Between the pilot and final implementation phases, QFJC partner agencies hired specialized staff to work with the high-needs polyvictim clients: Safe Horizon hired an English-speaking intensive case manager to provide long-term case management; Voces Latinas hired a Spanish-speaking intensive case manager; and the Mt. Sinai Sexual Assault and Violence Intervention Program hired a polyvictimization clinician (a mental health counselor). These specialized staff formed the QFJC's polyvictimization track, designed exclusively to serve high-needs polyvictims. In addition to these staff, the initiative prompted the NYC Alliance Against Sexual Assault to hire a

polyvictimization specialist to provide training to QFJC partner agency staff, including training on topics like grounding and de-escalation techniques.

Figure 3 illustrates the polyvictimization track's typical client flow. Clients who screened as a likely high-needs polyvictim through the PST then received the Modified-PAT from an intensive case manager and/or polyvictimization clinician, though alternative referral pathways also existed.

High-Needs Polyvictims Were Typically Identified Through the PST

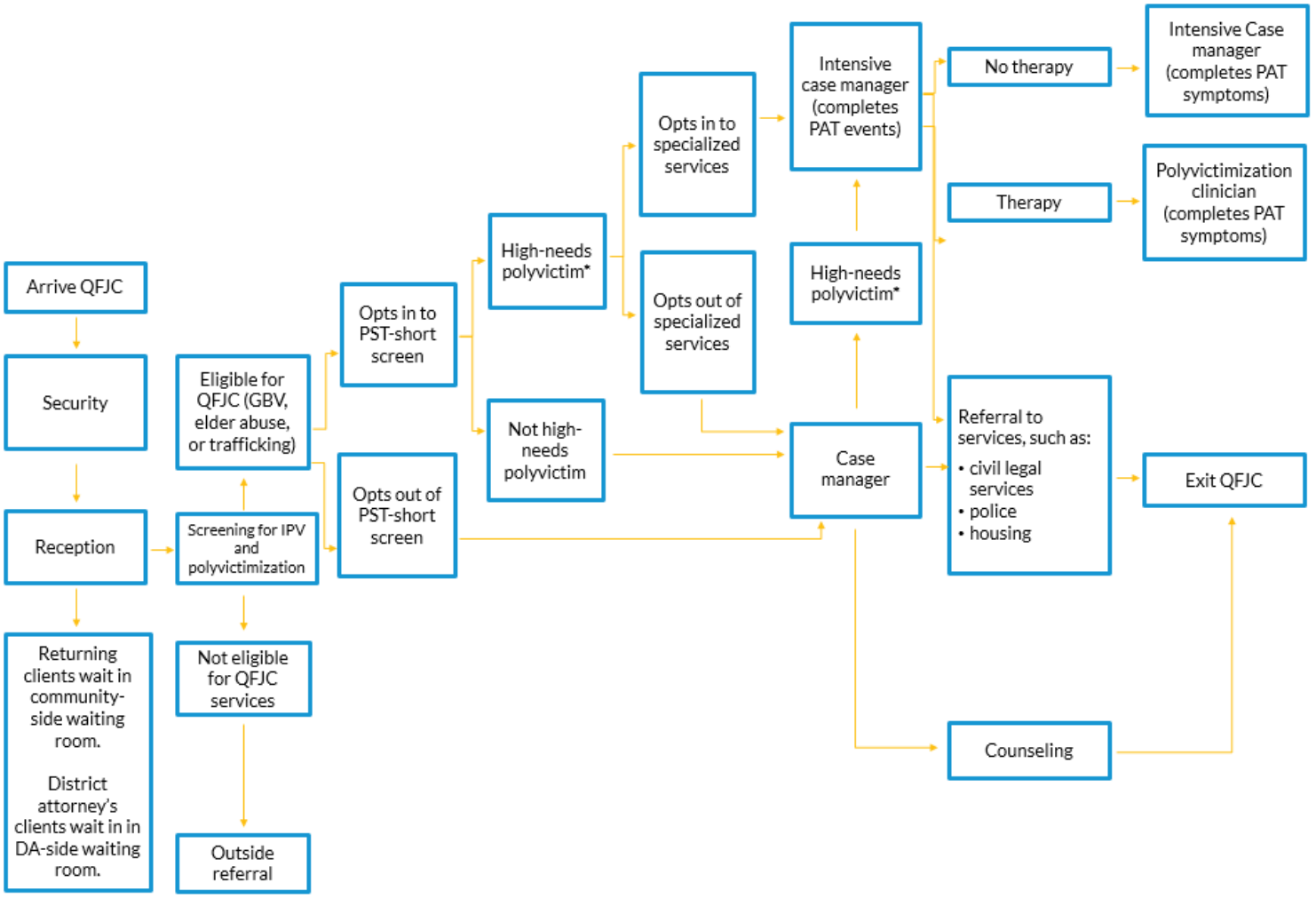
As in the initiative's pilot phase, clients began by **entering the Queens Family Justice Center through security and checking in at the reception desk**. After the client was checked in, a client screener conducted the QFJC's usual intake session, during which they described and received consent for services, assessed the client's eligibility, and obtained demographic and contact information. The screener then introduced the polyvictimization track by telling the client what services it offered (noting that the track was voluntary), and asking them to sign the consent form if interested; unlike the pilot phase, client screeners introduced nearly all clients to the initiative, including clients in distress.[22]

If the client agreed to participate, the client screener administered the PST and recorded the client's responses.[23] The screener then determined the client's eligibility for the QFJC's polyvictimization track. Recall, a client was considered a high-needs polyvictim if they reported experiencing four or more victimizations *or* three victimizations that included stalking, strangulation, or sexual assault (it is important to note that the Urban research team could not confirm whether client screeners applied the criteria uniformly as intended—for example, four clients whom screeners had not identified as high-needs polyvictims later completed a PAT, indicating they had been routed to specialized services). After determining a client was a high-needs polyvictim, the client screener checked whether an intensive case manager was available. If so, the case manager met the client in the QFJC waiting room. If not, the client was offered the choice to wait, schedule an appointment, or meet with a non-polyvictimization-track case manager. Clients who chose the latter could still be referred to an intensive case manager.

Although many high-needs polyvictims were identified during the initial screening, **some high-needs polyvictim clients were identified through alternative referral pathways**. Some clients who declined to take the PST were identified as high-needs polyvictims by other case managers or service providers, who could then refer them to an intensive case manager. Other times, clients who had taken the PST misunderstood a PST question, chose not to divulge certain experiences, or had other victimization experiences the PST did not cover. In those cases, a service provider could refer the client directly to an intensive case manager.

FIGURE 3

QFJC Client Flow during Final Implementation Phase



*High-needs polyvictim: (of seven possible victimizations) 4+ victimizations or 3+ victimizations including at least one of strangulation, sexual assault, or stalking.

Intensive Case Managers and Polyvictimization Clinicians Used the Modified-PAT with High-Needs Polyvictims and Provided Ongoing Services

High-needs polyvictim clients then met with an intensive case manager, who completed the Modified-PAT (in whole or in part) and forwarded it to the polyvictimization clinician (who provided clients mental health counseling). This process changed during final implementation phase's first few weeks; key stakeholders decided between having the clinician complete the entire tool and having intensive case managers and the clinician administer the events- and symptoms-based questions separately.

Ultimately, the final implementation plan called for the intensive case manager to complete the tool's events-based questions and then to offer the client mental health counseling (stakeholders decided that the clinician was better equipped to work through the symptom-based questions). If the client accepted this counseling, the intensive case manager would forward the Modified-PAT to the polyvictimization clinician, who would complete the tool's symptoms-based portion with the client. If the client declined the counseling, the intensive case manager would complete the symptoms-based portion. On rare occasions, the clinician received a direct referral from her agency (SAVI). In those cases, the client completed the PST with a client screener and then went directly to the clinician, who completed both the Events and Symptoms sections.

Staff at QFJC implemented the Modified-PAT much as they did the Pilot PAT (though implementation sometimes varied among staff). First, the intensive case manager completed a business-as-usual case management session, listening for events and symptoms covered in the Modified-PAT. After completing all relevant referrals—including to the polyvictimization clinician—the intensive case manager reintroduced, received written consent for, and administered the Modified-PAT. Some case managers (typically those with more experience) used a conversational style when asking the tool's questions, whereas others read the questions verbatim. According to QFJC stakeholders, intensive case managers typically completed the Modified-PAT in one session lasting two to three hours, and the polyvictimization clinician typically completed it in two or three sessions (the symptom-based portion took one or two sessions).

Clients on the polyvictimization track were eligible for ongoing services with the intensive case managers and the polyvictimization clinician. Consistent, long-term case management was new to QFJC, addressing a service gap identified during client mapping. Increased capacity for providing mental health services also a much-needed addition to the center.

Frontline Staff Received Training and Supports for Implementing the Modified-PAT

Lastly, **throughout the final implementation phase, frontline staff—intensive case managers and the polyvictimization clinician—received supports in the form of continued wellness events, supervision sessions, group trainings, and individual consultations.** Staff wellness events continued after the pilot phase and included a dance class, yoga classes, and meetings with a therapy dog. During supervision sessions, frontline staff members' supervisors observed interactions with clients and offered supports as needed. In addition to these supports, the agencies central to the PAT implementation process—Safe Horizon, Voces Latinas, and SAVI—held joint biweekly meetings that included the intensive case managers and the polyvictimization clinician, their three immediate supervisors, and the QFJC's executive director. At these meetings, they discussed individual cases, issues, and potential responses.

The NYC Alliance Against Sexual Assault's polyvictimization specialist and staff from other partner agencies also offered frontline staff trainings and consultations. In assessment meetings with the specialist, frontline staff identified resources they needed in order to better assist high-needs polyvictims. Staff could also attend such trainings as Creative Interventions for Trauma Survivors, Working with Angry Traumatized Clients, Trauma and Child Sexual Abuse, and Administering the PAT. Some staff took advantage of one-time or ongoing biweekly consultations with the specialist to discuss cases and receive suggestions. Although the trainings' impact may have been limited by low attendance (most training sessions reportedly had only three to five attendees), those who participated in the trainings and the one-on-one consultations considered them invaluable. Overall, the majority of frontline staff and supervisors who responded to the Final Implementation Phase Stakeholder Survey considered the available staff supports to have adequately supported Modified-PAT implementation.

The Initiative Had Several Benefits at QFJC during Final Implementation

By the final implementation phase, QFJC stakeholders felt they understood polyvictimization and the needs of polyvictims better. During this phase, the Polyvictimization Initiative's resources allowed QFJC to hire more staff to serve high-needs polyvictim clients, and the Modified-PAT allowed those new staff to better identify clients' experiences and needs, all of which were clear steps toward serving polyvictims better. The Modified-PAT also improved service delivery by building relationships, enabling staff to better share information, and allowing staff to provide clients psychoeducation.

The Initiative Helped Stakeholders Understand Polyvictimization Better

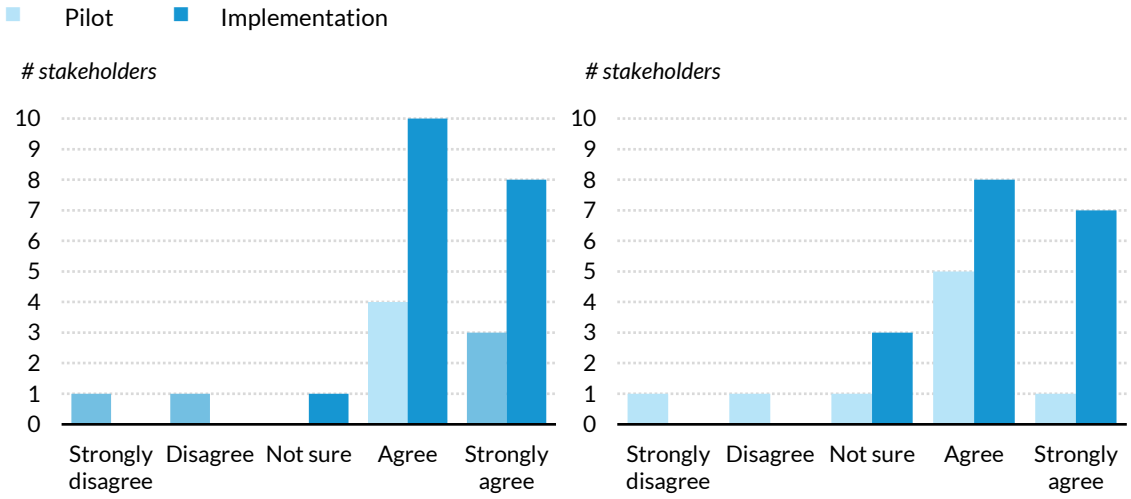
One of the Polyvictimization Initiative's key benefits was the knowledge stakeholders gained about polyvictimization and about the needs of polyvictims. Although stakeholders defined polyvictimization inconsistently (e.g., differing in the numbers of victimizations they thought constituted a polyvictim), many shared a common understanding of the concept's importance. Furthermore, surveys administered after the pilot and final implementation phases indicate that stakeholders gained knowledge about polyvictimization and the needs of polyvictims between the two phases (figure 4). On a scale of 1 to 5, stakeholders' agreement that the initiative increased their knowledge of polyvictimization increased from 3.8 to 4.4. Stakeholders' agreement that the initiative increased their awareness of how QFJC could meet polyvictims' needs increased from 3.4 to 4.2. Some stakeholders perceived gains in knowledge during the pilot phase, and that knowledge continued to grow throughout the rest of the initiative.

FIGURE 4

Stakeholder Perspectives:

The initiative increased my knowledge of polyvictimization

The initiative increased my knowledge of how QFJC can meet the needs of polyvictims



Source: 2018 Pilot Phase Stakeholder Survey and 2019 Final Implementation Phase Stakeholder Survey.
Notes: Pilot Phase *N*=11; Final Implementation Phase *N*=21.

Changes to QFJC Staffing Structures during the Final Implementation Phase Improved Services for High-Needs Polyvictims

The Polyvictimization Initiative drove several changes in the Queens Family Justice Center's staffing structure that QFJC stakeholders considered improvements. First, because of the initiative's added

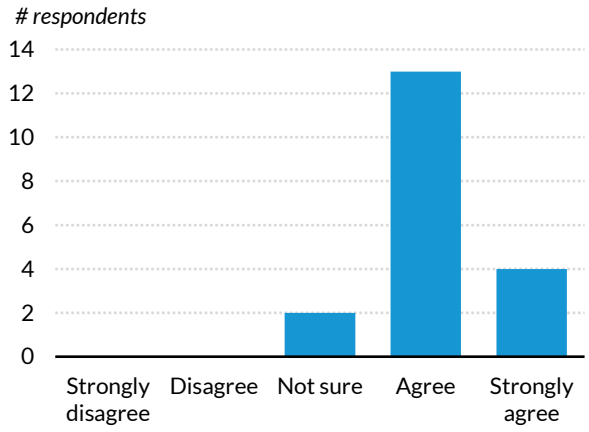
resources, **QFJC partner agencies could hire staff with the specific training and backgrounds to work with high-needs polyvictims**. Stakeholders considered this an asset because these specialized staff were hired for the initiative, meaning those staff felt an ownership over the work and had the specialized skills to work with high-needs clients. During focus groups, clients who had screened as high-needs polyvictims expressed that these new specialized staff made them feel supported and heard. One client shared, "I like the trust you build with the case worker and therapist. You have someone who isn't just judging and saying, 'I understand.' They're not just sympathetic. They really give you good advice."[24]

Relatedly, **having staff devoted to long-term case management and a clinician created more resources the QFJC could offer clients**. This was a step toward addressing stakeholder fears about a lack of sufficient support services during the pilot stage. Previously, QFJC did offer consistent, long-term case management services, and having a specialized clinician meant that high-demand mental health services were available for clients in the polyvictimization track. As described in this report's findings section, clients in the polyvictimization track *did* receive more services and complete more return visits to the QFJC, compared to typical QFJC clients. High-needs polyvictims who participated in the Polyvictimization Initiative focus groups reported accessing a range of services, including psychiatry, therapy, legal services, connections to the district attorney's office, long-term case management, and medical services. They also reported positive experiences with these services.

Overall, clients felt supported by the team of new staff. One stakeholder said, "I think the strength is that whenever a survivor has a cohesive team behind them, it's validating and empowering."[25] Lastly, implementing the PAT across multiple partner agencies – particularly, Safe Horizon, SAVI, and Voces Latinas - built relationships between those agencies. Stakeholders stated that sharing a tool and clients required building **closer, more collaborative relationships** than they previously had (figure 5). Stakeholders also considered the biweekly initiative-focused meetings important because they facilitated and strengthened these relationships.

FIGURE 5

Stakeholder Perspectives: The Polyvictimization Initiative Has Increased Communication and Collaboration among Local Partner Agencies



Source: 2019 Final Implementation Phase Stakeholder Survey.
Notes: *N*=21

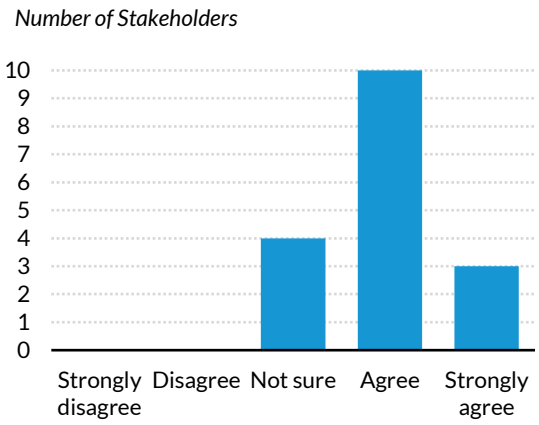
Stakeholders Reported the Modified-PAT Helped Them Recognize Polyvictims and Identify Relevant Services

Stakeholders noted the Modified-PAT was useful for identifying high-needs polyvictims—by uncovering experiences and symptoms they might otherwise not have noticed—**and for recognizing services the client may need**. According to stakeholders, asking pointed questions brought up issues or symptoms a client may not otherwise have divulged which in turn helped them identify the appropriate services to connect clients to. On the Final Implementation Phase Stakeholder Survey (figure 6), many stakeholders agreed or strongly agreed that the tool was well-designed to identify polyvictims, and an even greater share agreed or strongly agreed that the tool helped identify polyvictims connect them with services.

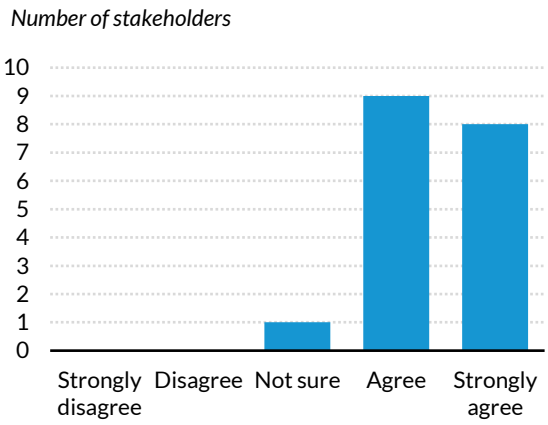
FIGURE 6

Stakeholder Perspectives

The current, final version of the PAT is designed well to identify/detect polyvictims within the QFJC population



The PAT supports the goal of detecting and identifying polyvictims and linking them to appropriate services



Source: 2019 Final Implementation Phase Stakeholder Survey.
Notes: *N*=11.

She said it was a relief for her. She was like, throughout my life, I didn't know there was a word, 'polyvictimization,' for it. She was relieved that there were more services she could seek out. She wanted to…she could maybe put a name to her situation. It hadn't just been one incident, it had been multiple incidents.
—QFJC stakeholder

The PST and Modified-PAT helped staff share information, guide conversations with clients to learn more about their experiences, and provide psychoeducation to clients. The tools also benefited stakeholders during service provision. Across the board, stakeholders at the Queens Family Justice Center considered the polyvictimization screening tool a valuable mechanism for sharing information among partner agencies. The PST was shared with some partner agencies during final implementation (albeit inconsistently), and they used it to prioritize clients based on the victimizations they reported (e.g., clients with high-lethality victimizations, like strangulation, could be seen first). Stakeholders also reported that sharing the PST with additional partner agencies in the future could address the problem of clients being asked to recount their experiences multiple times to different service providers.

Stakeholders also valued the Modified-PAT as a conversation guide and a form of psychoeducation. Stakeholders noted the polyvictimization assessment tool was a useful conversation guide (particularly for staff with less experience), as it provided structure and discussion topics. Moreover, as with the Pilot PAT, stakeholders considered psychoeducation a benefit of the Modified-PAT. One stakeholder described the relief a client felt after understanding her situation and available supports: "She said it was a relief for her. She was like, throughout my life, I didn't know there was a word, 'polyvictimization,' for it. She was relieved that there were more services she could seek out. She wanted to…she could maybe put a name to her situation. It hadn't just been one incident, it had been multiple incidents."[26]

Stakeholders Still Faced Challenges during Final Implementation

Queens Family Justice Center stakeholders continued to face challenges during the final implementation phase, and improvements and expansions to QFJC services were limited to a subset of clients. Though clients in the polyvictimization track received new and more services, stakeholders knew—and data confirmed—that most QFJC clients are polyvictims, and that restraints on resources (among other challenges) limited the center's ability to serve them.

Changes between the Initiative's Two Phases Created Additional Challenges during Final Implementation

Despite the benefits of implementing the PST and Modified-PAT at QFJC, several challenges remained. **Importantly, the pilot implementation and final implementation processes varied in their steps and the staff who participated, meaning some kinks had to be worked out during final implementation.** The center's staffing structure underwent several changes between the two phases. During the pilot phase, the grant-funded partner agencies had not yet hired initiative-specific staff. This meant (1) that Voces Latinas and SAVI had not gotten experienced with the implementation process because the pilot tool was implemented solely by Safe Horizon, and (2) that the newly hired staff had not practiced implementing the tool during the initiative's pilot phase. Other changes pertained to the initiative's implementation structure. First, because the specialized staff had not yet been hired, the QFJC lacked specialized polyvictimization services to offer clients during the pilot phase, meaning the process of referring clients to services and handing clients off between long-term case management and mental health counseling had not been ironed out by final implementation. Second, the absence of a short

screener (i.e., the polyvictimization screening tool) during the pilot phase meant client screeners were unable to practice screening clients into the polyvictimization track.

Possibly because of the changes in staffing between the pilot and final implementation phases, **some stakeholders perceived challenges in the new relationships** between the agencies (particularly Voces Latinas, Safe Horizon, SAVI, and QFJC leadership) participating in the Polyvictimization Initiative at QFJC. Stakeholders felt relationships between these organizations evolved during the final implementation phase, as partners learned each other's personal and organizational communication styles, workstyles, and boundaries. Stakeholders emphasized that there were differences in these traits by organization that had to be navigated by the partners as they worked together more closely than they had previously. The agencies had more shared clients as a result of the initiative (e.g., clients receiving intensive case management and mental health services simultaneously), meaning agencies had to communicate about the client and coordinate service provision to best meet their needs. Stakeholders considered this work time-consuming (especially as it prompted the biweekly meetings and other ad hoc conversations), and noted it created new ground for conflict. For example, with shared clients, staff sometimes felt their role was being assumed by another person. Overall, stakeholders wished there had been more team-building activities before the final implementation phase, especially to get leadership on the same page.

QFJC Was Still Not Fully Able to Respond to Distress Triggered by the Modified-PAT

As with the Pilot PAT, stakeholders thought the final PST and PAT could be triggering or challenging for some clients, and although therapy was more available during the final implementation phase, not all clients were able to access immediate support for trauma responses. Stakeholders noted that the Modified-PAT (and even the PST) could activate trauma reactions by reminding or asking clients about their experiences. Several factors exacerbated this possibility. First, client screeners and intensive case managers (the people responsible for completing the tools) **typically lacked the clinical experience and formal training needed to ground triggered clients after a screening or assessment section.** Second, stakeholders noted that although some clients received mental health counseling, most did not receive it immediately, and others—in accordance with the center's client-centered practice model—opted not to receive it at all.

Frontline staff also faced challenges managing their own reactions in addition to those of their clients. Some stakeholders had concerns that the Modified-PAT was leading services providers to

experience vicarious trauma. One stakeholder said, "Vicarious trauma is huge. People are in the field because they feel called to do it, but if they don't receive enough support, they burn out…They really care about their clients—they give 200 percent of themselves. And that has an impact. Especially when working with people who've been identified as polyvictims. They receive phone calls on the weekends. It's really hard on them. They need that support."[27] Training on vicarious trauma was available to staff during the final implementation phase, and the QFJC should continue providing such trainings and possibly increase their availability.

Stakeholders Felt Improved Services Had Limited Reach

The Polyvictimization Initiative had several positive impacts on QFJC's client services First, staff generally agreed that the Modified-PAT successfully identified clients who had experienced polyvictimization. Second, the initiative increased the availability of long-term case management and mental health services at the QFJC. Third, administrative records (see the following section) show that on average, clients in the polyvictimization track returned to QFJC for services more than other clients.

Despite these improvements, stakeholders still believed the initiative's impact on service provision ultimately had several limitations. First, stakeholders noted that QFJC already offered nearly the entire spectrum of services (excluding consistent, long-term case management and mental health services) before the Polyvictimization Initiative (see this report's Pilot Tool Development and Implementation section). This meant the initiative did not greatly increase the QFJC's array of service options. Second, service referrals are always optional for QFJC clients (in accordance with the client-centered approach). Stakeholders believed some clients arrived at QFJC knowing what services they wanted, and that clients would sometimes decline the specialized services (i.e., long-term case management and/or therapy) resulting from the Polyvictimization Initiative. As one stakeholder noted, "It's up to the client. A lot of them really need counseling, but some decline it because it's not a priority for them—they need housing and legal services."[28] Third, stakeholders emphasized that many services—like affordable housing placements—are simply in limited supply, even for high-needs polyvictims. And, though services like long-term case management and mental health counseling became more available to clients in the polyvictimization track, stakeholders generally believe that all or nearly all QFJC clients are polyvictims. The services were therefore still limited because they were only offered to the highest-need polyvictims. Unfortunately, constraints on resources limited the QFJC's ability to provide specialized services to all of its polyvictim clients.

Overall, stakeholders' perceptions of the Polyvictimization Initiative became more positive after the pilot phase, despite the persistent challenges preventing all polyvictim clients from accessing services.

Findings from Quantitative Analyses of PST, Modified-PAT, and Client Service Records

During the initiative's final implementation phase, QFJC partner agency staff used the PST to screen 89 clients and route those identified as high-needs polyvictims to polyvictimization services, and completed 75 Modified-PATs to assess clients' past polyvictimization experiences. This section presents quantitative findings including (1) descriptive statistics documenting the characteristics of clients served by the PST and PAT, (2) PST and PAT descriptive statistics and validation analyses (to assess whether the tools functioned as intended), and (3) analyses of clients' administrative service records to determine how these tools impacted service delivery. As noted in this report's Evaluation Methodology section, because the PST and PAT were not tested with a representative sample of clients, *the results we report should not be considered accurate estimates of the prevalence of polyvictimization at the Queens Family Justice Center or in New York*. An additional limitation is that the samples available are small (75 clients or fewer), further limiting the generalizability of the findings that follow. As such, these results should be interpreted with caution.

In total, 114 unique clients were involved in the Polyvictimization Initiative during the final implementation phase. Of these, 84 completed a PST and consented to being included in the study and having their records analyzed by Urban researchers (five clients completed a PST but did not consent to being part of the study). A total of 75 clients completed a PAT; 45 of these had completed a PST, and 30 had not. Table 4 displays the characteristics of the 114 unique clients who completed a PST and/or PAT. Because the PAT is the initiative's primary focus, we include the characteristics of the 75 who completed a PAT (with or without a PST).

TABLE 4

Full Implementation Phase, Client Characteristics

	All PST and PAT Clients (*N*=114)		PAT clients only (*N*=75)	
	Frequency/ Median	% / Range	Frequency/ Median	% / Range
Gender				
Female	111	97.37	73	97.33
Male	2	1.75	1	1.33
Sexual orientation				
Heterosexual	102	89.47	63	84.00
Gay, lesbian, or bisexual	5	4.38	5	6.67
Race/ethnicity				
Asian/Southeast Asian	11	9.65	4	5.33
Black	23	20.18	16	21.33
Caribbean/West Indian	10	8.77	7	9.33
Hispanic/Latinx	54	47.37	40	53.33
White	12	10.52	5	6.67
Age	35	22-66	34	22-66
Primary language				
English	66	57.89	42	56.00
Spanish	40	35.09	31	41.33
Other language	8	7.02	2	2.67
Education level				
Less than high school	27	23.68	22	29.34
High school/GED	38	33.33	23	30.67
Some college and/or Associate's degree	29	25.44	20	26.67
4-year college	8	7.02	3	4
Graduate degree	6	5.26	2	2.67
Employment status				
Full time	26	22.81	18	24.00
Part time	20	17.54	14	18.67
Self-employed	4	3.51	4	5.33
Unemployed	61	53.51	36	48.00
Student	1	0.88	1	1.33
Housing status				
Living in shelter	11	9.65	8	10.67
Not living in shelter	101	88.60	65	86.67
Client type				
New	17	14.91	7	9.33
Returning	97	85.09	68	90.67

Source: Urban's analysis of QFJC administrative data, PST, and Modified-PAT.

Notes: Percentages may not add up to 100 because of missing data. For each category, the number of clients missing observations ranged from 3 to 10 (or, roughly 2.6 to 8.8 percent). The "white" race/ethnicity category includes clients who identify as Arab and/or Arab American.

Overall, nearly every client the initiative served was female (roughly 97.4 percent). Most identified as heterosexual (89.5 percent), though some identified as lesbian, gay, or bisexual (4.4 percent). The majority identified as Hispanic (47.4 percent) or Black (20.2 percent). The average client was 35 years old. Although the majority (57.9 percent) indicated English as their primary language, more than one-third (35.1 percent) spoke Spanish as their primary language. Clients were also diverse as regards their highest level of education completed: roughly a quarter (23.7 percent) reported having completed less than a high school education, roughly one-third reported having a high school degree (33.3 percent), and another quarter reported having completed some college or having received an Associate's degree (25.4 percent). Clients also had varied employment statuses: although the majority reported being unemployed (53.5 percent), nearly 43.9 percent reported being employed full time or part time or being self-employed. Roughly 9.7 percent reported living in a shelter. Finally, clients served by the initiative were mostly returning clients (85.1 percent), and 14.9 percent were new when they completed a PST or PAT.

RESULTS FROM PST AND PAT

Urban's analysis included (1) descriptive statistics documenting the types of victimization, adverse life experiences, and trauma symptoms clients reported having experienced, and (2) validity analyses of the PAT and PST to assess the extent to which the tools functioned as intended.

CLIENTS' VICTIMIZATION, ADVERSE LIFE EXPERIENCES, AND TRAUMA SYMPTOMS

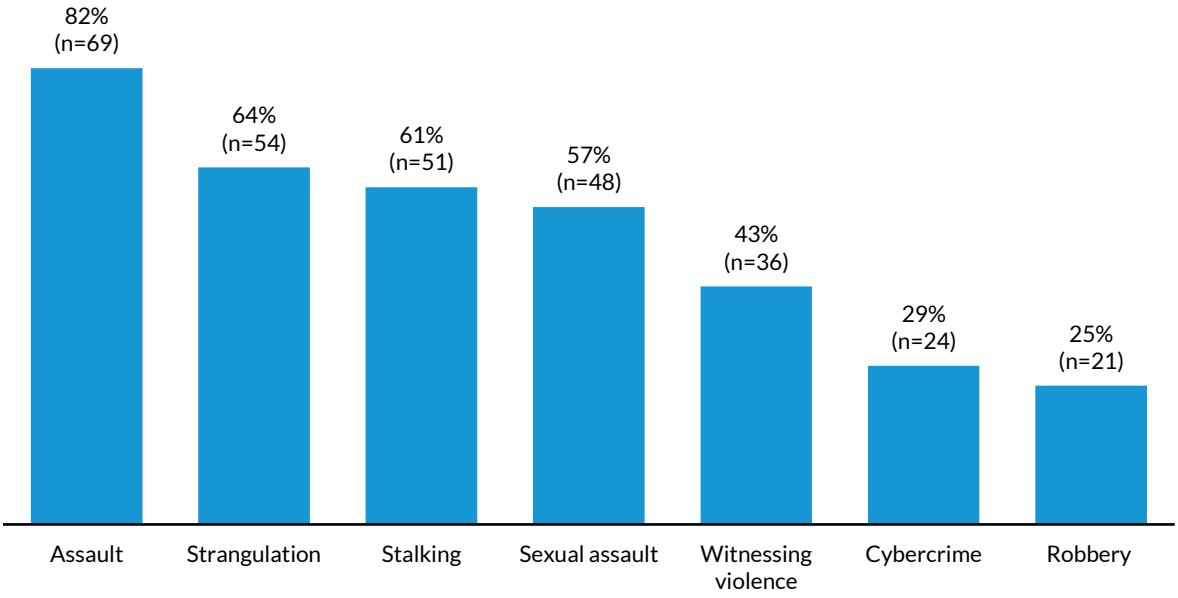
The polyvictimization screening tool (developed by Urban and QFJC administrative and partner agency staff) included seven questions about clients' past victimization experiences. The Modified-PAT contained 26 events-based questions focused on victimization and adverse life experiences, and 18 questions about trauma symptoms. The PAT (developed by all Polyvictimization Initiative sites and partners) asked clients to report on these items in the past year and over their lifetimes.

At the screening stage, clients reported having experienced an average (median) of four victimizations; clients reported as few as zero and as many as seven lifetime victimizations. As illustrated in figure 7, the most frequently reported victimization was assault (by any person, including an intimate partner, family member, or stranger), having impacted 69 clients (roughly 82 percent of clients). Strangulation, stalking, and sexual assault were also reported by a majority of clients. Fewer clients reported having witnessed violence or having experienced cybercrime and robbery, but these were still reported at a notable rate (25 percent or higher).

FIGURE 7

PST: Client "Yes" Responses

Percent (and number) of clients reporting



Source: Urban analysis of PST data, 2019.
Notes: Excludes missing responses. *N*=84.

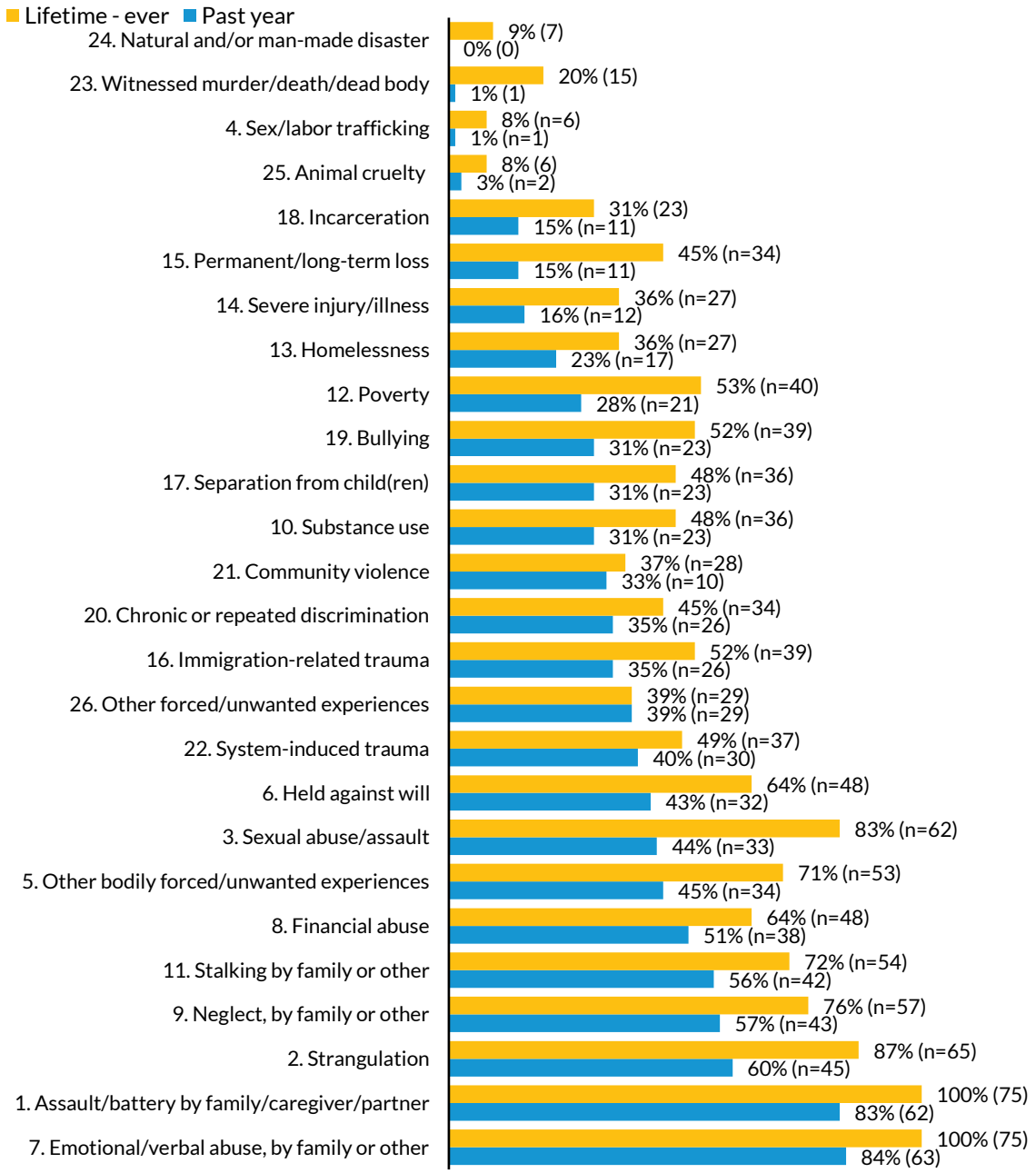
Among the 84 clients screened, 58 (69.1 percent) met the criteria for being designated a high-needs polyvictim by (1) reporting at least four of the seven PST victimization experiences, and/or (2) reporting having experienced strangulation, stalking, *or* sexual assault in addition to any two additional victimization experiences.

Clients who screened positively as high-needs polyvictims were intended to be referred to a specialized case manager to receive further services and complete the Modified-PAT. As noted above, among the 58 clients who screened positively on the PST, 41 (70.7 percent) went on to complete a PAT during the final implementation phase, and another four clients who *did not* screen as high-needs polyvictims nonetheless went on to complete a PAT. An additional 30 clients who did not complete a PST eventually completed a PAT (appendix C); these clients were typically identified as high-needs polyvictims because they were returning clients who were already working with a case manager or therapist who had learned about their experiences through ongoing service provision. Ultimately, 75 clients completed a PAT during the final implementation phase.

FIGURE 8

Modified-PAT Event-Based "Yes" Responses, Past Year and/or Lifetime (n=75)

Percent (and number) of clients reporting



Source: Urban analysis of QFJC Modified-PAT data, 2019.

Notes: Excludes missing responses. PAT question numbers are listed on the left-hand side of each label.

Clients who completed the PAT reported having experienced 0 to 17 events during the past year, and 5 to 21 events in their lifetime.[29] On average (median), clients reported having experienced 9

events in the past year and 13 events throughout their lifetimes. The victimizations that clients most frequently reported having experienced in the past year and/or their lifetime include emotional/verbal abuse by a family member or other person (84 percent experienced in the past year; 100 percent experienced in their lifetime), assault by a family member, caregiver, or partner (83 percent experienced in the past year; 100 percent experienced in their lifetime), and strangulation (60 percent experienced in the past year; 87 percent experienced in their lifetime). The majority of clients also reported having experienced neglect, stalking, and financial abuse in the past year.

The adverse life experiences (ALEs) clients most frequently reported having experienced in the past year or in their lifetime—including system-induced trauma, immigration-related trauma, or chronic/repeated discrimination—were ultimately reported less frequently than the most common forms of victimization. However, these ALEs still impacted a substantial share of clients (35 to 40 percent in the past year 45 to 52 percent in their lifetime). Finally, certain events-based questions were less relevant to this client population; for instance, 0 to 3 percent of clients reported experiencing a natural or man-made disaster, witnessing murder/death/a dead body, and animal cruelty in the past year. Notably, relatively few clients reported having experienced sex/labor trafficking, though QFJC stakeholders reported that this type of victimization is common among their clients. This may suggest either (1) that the manner in which the question about sex/labor trafficking was asked did not elicit accurate responses from clients (e.g., clients do not identify as victims of sex trafficking), or (2) that clients with histories of trafficking victimization selected out of the initiative for some reason.

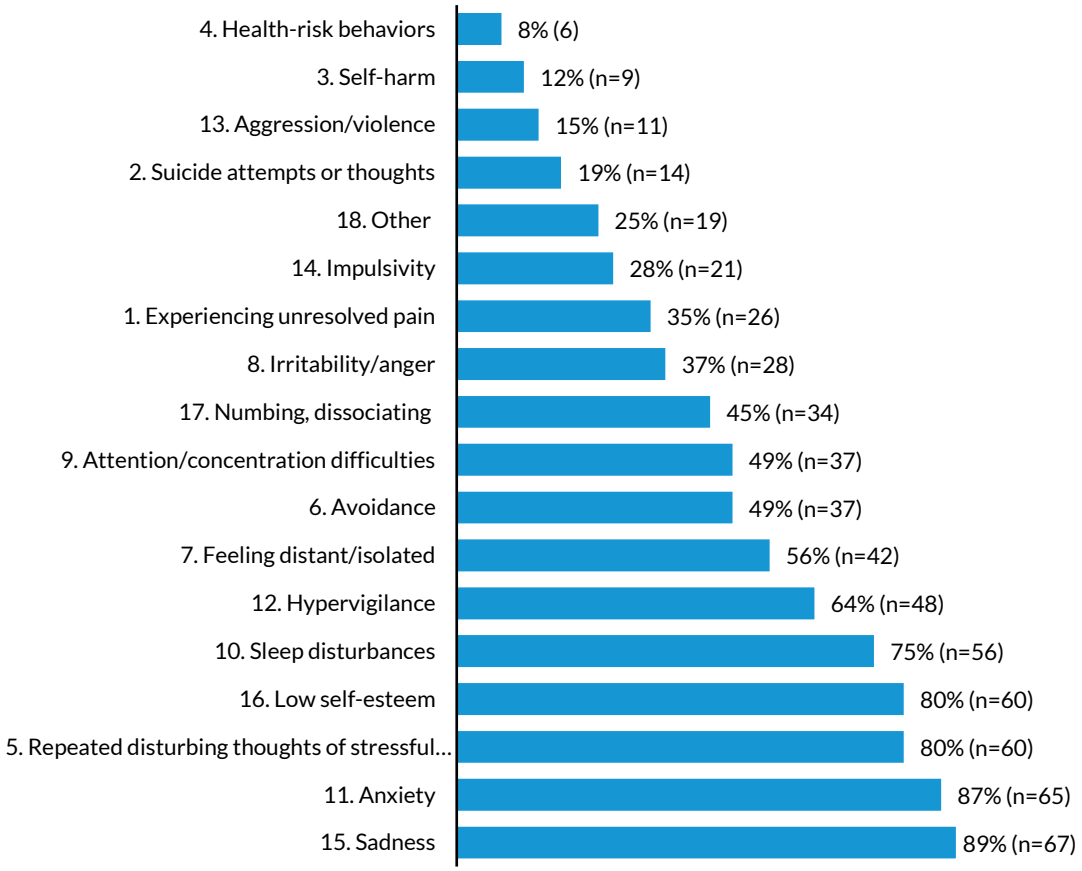
In the second part of the PAT, clients were asked about 18 trauma symptoms. Figure 9 displays how often clients reported experiencing these symptoms in the past year.

FIGURE 9

Modified-PAT Symptom "Yes" Responses, Past Year

Percent (and number) of clients reporting

Source: Urban analysis of QFJC PAT data, 2019.



Notes: Excludes missing responses. *N*=75. PAT question numbers are listed on the left-hand side of each label.

On average (median), clients reported having experienced nine trauma symptoms in the past year; however, clients reported anywhere from 0 to 16 symptoms. Clients most commonly reported experiencing sadness (89 percent), anxiety (87 percent), repeated disturbing thoughts (80 percent), and/or low self-esteem (80 percent) during the past year. Several symptoms were not commonly reported, including health-risk behaviors, self-harming behaviors, and aggression/violence.

VALIDATION ANALYSES OF PST AND PAT

In addition to examining the frequency and proportions of victimization, adverse life experiences, and trauma symptoms reported by clients in the PST and PAT, Urban analyzed the tools' psychometric properties to determine whether they were working as intended. The field currently lacks agreed upon

"gold standard" polyvictimization screening and assessment tools; the validation analyses[30] reported here ought to therefore be considered **exploratory**, as the field lacks an ideal measure to use as a metric for assessing the validity of these tools. Below, we report key psychometric properties including factorial validity, internal consistency reliability, convergent validity, concurrent validity, and tests of tool sensitivity and specificity. Full results from these analyses are detailed in appendix F.

Note that the PST's *face* (the relevance of the tool's questions) and *content validity* (the extent to which the content is appropriate and comprehensive) were established when Urban collaborated with QFJC administrative and partner agency staff on the consulting committee to develop the tool. Alliance for HOPE and the Center of Applied Research led a collaborative process to ensure the PAT's face and content validity; however, as previously discussed, QFJC stakeholders expressed concerns that some of the questions (e.g., a question about experiences with natural disasters) were less relevant to their client population.

MANY—BUT NOT ALL—"YES" RESPONSES TO THE PAT GROUPED IN CONSISTENT WAYS

Though many client "yes" responses to the PAT questions grouped in meaningful and consistent ways, others did not. We conducted a factor analysis for the 14 lifetime-victimization-events questions, and a separate analysis for the 12 adverse-lifetime-experience questions. After initial analyses, we ultimately *excluded* nine events-based questions owing to their low frequency, high missingness, poor factor loadings, or a combination of the three. There were ultimately observations from **43 clients** (out of 75) with enough valid, nonmissing values to be included in final results. See appendix F for characteristics of these 43 clients.

Results from factor analysis allowed us to identify a subset of PAT questions that grouped together somewhat well (and in a manner that was practical for practitioners to apply). Though no set of factors met *all* of our criteria, the results summarized below identify a subset of PAT questions that ultimately performed better across key psychometric measures than other subsets we examined (see Appendix F for further discussion). Ideally, these analyses would be repeated with a larger sample size (and with fewer missing responses) to determine whether the findings reported here are consistent across a more representative sample of QFJC clients.

Findings from factor analysis[31] indicated that for nine lifetime *victimization* events, client responses group in three meaningful dimensions: (1) violent, nonsexual victimization, (2) nonviolent victimization, and (3) violent, sexual victimization. Notably, these results align well conceptually with the PST questions, in that both sets of questions emphasize lifetime victimization experiences that this client

population commonly reports. We discuss the implications of this below, including how well the PST identifies clients with high needs compared with the PAT.

Additionally, results from factor analysis indicate six adverse lifetime experiences group together along two dimensions: (1) material ALEs, and (2) physical ALEs. Importantly, outside these 15 lifetime events questions, an additional two lifetime victimizations were reported by 100 percent of clients (assault and emotional/verbal abuse); these two questions could not be included in factor analysis (owing to lack of variation in response), but we contend they are meaningful for this client population because of their frequency and because they align well conceptually with the other victimization questions that grouped well together.

The remaining nine lifetime events questions *did not* group well with other questions—these tended to be questions that had fewer "yes" responses. These results establish "factorial validity" for a *subset* (15) of the PAT questions, meaning that those 15 questions correlate in a manner that is conceptually meaningful. Without further analyses on a larger sample, it is unclear that the other lifetime events questions are as meaningful for this client population. Table 5 summarizes these findings.

TABLE 5

Lifetime Events Questions

Questions that grouped together well

Victimization questions		*Adverse life experience questions*	
2	Strangulation	10	Substance use
3	Sexual abuse/assault	12	Poverty
5	Other bodily forced/unwanted experiences	13	Homelessness
6	Held against will	14	Severe injury/illness
8	Financial abuse	15	Permanent/long-term loss
9	Neglect, by family or other	18	Incarceration
11	Stalking		
19	Bullying		
21	Community violence		

Notes: Numbers denote questions' order on the PAT, not their frequency. Lifetime assault and emotional/verbal abuse were reported by clients 100 percent of the time; this lack of variation means we were unable to include them in our factor analysis. However, given the frequency with which they were reported, they should be considered meaningful for this client population. The nine excluded events were: sex/labor trafficking; immigration-related trauma; separation from children; chronic discrimination; system-induced trauma; witness murder; natural/man-made disaster; animal cruelty; and other forced experiences.

Internal consistency. For each dimension of experiences of polyvictimization, we examined internal consistency reliabilities using Cronbach's alpha. This establishes whether the questions in each group/dimension tend to measure the same type of information.

Lifetime victimization and ALE questions. For the three lifetime-victimization-events dimensions, alpha values ranged from .32 to .63, indicating weak to moderate internal consistency reliability (appendix F provides further details). Although these values should ideally be higher (.70 or higher), as a whole, these were some of the better results among the various victimization factors we examined. The alpha values for the physical and material ALE dimensions were .19 and .74, respectively. The alpha value of .19 is very weak, and suggests that the physical ALE questions (i.e., substance use and severe injury/illness) *do not* group together well—in other words, these questions are likely capturing different dimensions of polyvictimization. Nevertheless, these questions performed well according to other psychometric properties, suggesting they are still valuable to retain in the PAT. The alpha of .74 for the material ALE dimension indicates stronger internal consistency reliability. Finally, the alpha values for the nine lifetime victimization and six lifetime ALE questions were .62 and .68, respectively. This indicates weak to moderate internal consistency reliability for the two subsets. Notably, the alpha value for the PST was .67, indicating moderate internal consistency reliability.

Convergent validity. "Convergent validity" is an additional measure that indicates the extent to which various PAT dimensions that we expect to correlate actually correlate. Specifically, we examined the degree to which sums of "yes" responses for each of the five PAT events dimensions correlated with each other, and with the 10 most commonly reported past-year trauma questions (see figure 9) and QFJC partner agency staff assessments of clients' levels of polyvictimization (appendix F).[32] Overall, there is not a clear relationship between clients' "yes" responses on various dimensions of the PAT's events-based questions, nor between the PAT and PST. The only meaningful result was that clients appear to be responding consistently to similar questions about lifetime victimization that appear on both the PST and PAT; this suggests questions on violent victimization are being measured well.

Concurrent validity. We anticipated that if the PAT events-based questions and the PST captured clients' experiences of polyvictimization well, clients' responses to these sets of questions would be related to PAT symptoms-based questions and staff assessments of clients' polyvictimization experiences. Specifically, we examined correlations to test whether clients who answered "yes" to dimensions of PAT events-based questions and/or PST questions were also likely to answer "yes" to the 10 most common PAT symptoms-based questions; these correlations are used to establish the "concurrent validity" of the PAT and PST. Overall, however, we did not find any statistically significant relationships; this indicates that neither the PAT nor the PST correlate with trauma symptoms or staff

assessments in the way we would expect. However, when we approached this problem differently—by examining thresholds rather than correlations—we found more promising and actionable results.

DETERMINING A MEANINGFUL THRESHOLD FOR HIGH-NEEDS POLYVICTIMS

To determine how well the PAT events-based questions and the PST identified high-needs polyvictims, we examined sensitivity and specificity measures. "Sensitivity" refers to the true positive rate—that is, the share of high-needs polyvictim clients who a tool identifies as such. "Specificity" refers to the true negative rate—that is, the share of non-high-needs polyvictim clients who a tool identifies as such. Because the field has not reached a consensus on what constitutes a polyvictim or what constitutes more severe polyvictimization experiences, we compared several approaches for establishing sensitivity and specificity.

For each client, Queens Family Justice Center staff administering the PAT and PST completed a question indicating, on a scale of 1 to 10, the extent to which they considered the client to have experienced polyvictimization (a "1" being no experiences of polyvictimization, and a "10" being the most severe experiences of polyvictimization). We examined the distributions of (1) practitioner reports, and (2) the 10 most common trauma symptoms found on the PAT to assess sensitivity and specificity, and to develop recommendations for QFJC stakeholders to move forward with defining criteria for identifying polyvictim clients who need services the most.

TABLE 6

PST Sensitivity and Specificity

	PST Validation question, 50th percentile (rating: 6+)
	Percent (frequency)
High-Needs Polyvictims*	
Sensitivity	**96.2** (51/53)
Specificity	**77.4** (24/31)

Source: Urban analysis of QFJC PST data, 2019.

Notes: *N*=84.

*This refers to the 58 clients screened with the PST who were identified as high-needs polyvictims after reporting strangulation, stalking, or sexual assault, and at least two other victimizations.

TABLE 7

Modified-PAT Sensitivity and Specificity

	Top 10 Past-Year Trauma Symptoms, 50th percentile (7+ symptoms)
	Percent (frequency)
PAT Lifetime Events–abbreviated, 50th percentile (10+ events)*	
Sensitivity	**81.4** (35/43)
Specificity	**34.4** (11/32)

Source: Urban analysis of QFJC PAT data.
Notes: *N*=75.
*PAT Lifetime Events–abbreviated refers to the 17 lifetime events questions that were found to be meaningful for the QFJC client population because of their frequency and/or factorial validity (see table 5 for a summary).

Findings reveal that the PST and abbreviated PAT, if used in combination, are effective at identify high-needs polyvictims and assessing clients for higher levels of trauma. Specifically, the PST's high-needs-polyvictim designation identifies more than 96 percent of clients whom screeners perceive as having more severe experiences of polyvictimization (sensitivity). Moreover, the PST high-needs-polyvictimization screen also helps staff screen *out* the correct people: it correctly identifies roughly 77 percent of people whom screeners believe have had less severe experiences of polyvictimization (specificity).

The subset of 17 lifetime events on the Modified-PAT also effectively identifies clients with higher needs. In particular, if an abbreviated version is used (i.e., the 17 questions mentioned above), then a score of 10 or higher should correctly identify higher-trauma clients roughly 81 percent of the time (sensitivity). This method is less effective for determining which clients have lower levels of trauma: it identifies only roughly 34 percent of such clients correctly. However, because the PAT is intended to help staff connect clients with services, this should not be a major concern and should not impact clients negatively. In sum, it appears the PST and PAT—used in combination and in the manner described above—are reasonably effective at helping staff route and assess clients properly.

SERVICE DELIVERY FOR POLYVICTIMIZATION INITIATIVE CLIENTS

A major goal of the Polyvictimization Initiative at the Queens Family Justice Center was to provide intensive services to clients identified as high-needs polyvictims. Overall, quantitative analyses of clients' administrative records indicate the QFJC successfully provided intensive services to high-needs

polyvictim clients, relative to the average QFJC client who did not complete a PST or PAT during the full implementation phase. Urban also examined trends in all the appointments for clients that occurred between December 1, 2018, and May 10, 2019 (Although the QFJC stopped using PST and PAT on March 31, 2019, Urban analyzed records through early May to follow up on all clients—including those screened in late March—for a minimum of six weeks).

POLYVICTIMIZATION-INITIATIVE CLIENTS RECEIVED ENHANCED SERVICES

Specifically, client administrative records show that clients served through the Polyvictimization Initiative differed from other clients in several important ways. First, the 114 clients served through the initiative **received a higher volume of QFJC services**. On average, these clients visited the QFJC **4.90 times** during the final implementation phase, whereas noninitiative clients visited **1.95 times** during the same period. Similarly, clients served through the initiative were more likely to return to the QFJC after their first visit: whereas approximately 21.1 percent of initiative clients completed one visit and *did not* return during the final implementation phase, 57.2 percent of noninitiative clients completed one visit and did not return. In other words, approximately **four in five** initiative clients completed two or more visits to the QFJC, whereas just **two in five** typical clients completed two or more visits. Moreover, initiative clients tended to receive different types of services than noninitiative clients. Table 7 details these differences.

TABLE 8

Service Receipt by Client Type

Frequency and percentage

	Typical QFJC clients (*N*=5,062 visits)	Polyvictimization Initiative clients (*N*=558 visits)
Assistant district attorney	29.3 (1,485)	6.6 (36)
Safe Horizon frontline services	22.8 (1,155)	15.8 (88)
Sanctuary for Families children's counseling	7.4 (375)	5.9 (33)
Health + Hospital mental health program	6.3 (320)	3.4 (19)
Polyvictimization Initiative services	0 (0)	45.9 (256)
Other services	34.1 (1,727)	22.6 (126)
Total visits by all clients	**5,062**	**558**

Notes: Results are for visits occurring between December 1, 2018, and May 10, 2019, for a total of 2,596 unique noninitiative clients and 114 initiative clients. Polyvictimization Initiative services include those provided by the Mt. Sinai Sexual Assault and Violence Intervention Program, Safe Horizon, and Voces Latinas. Services used most frequently are highlighted above; less frequently used services are grouped together in the general category "Other services."

Notably, the purpose of nearly one-third of typical QFJC client (i.e., noninitiative client) visits is to meet with a prosecutor at the district attorney's office. Far fewer visits by initiative clients (6.6 percent) were for the same purpose. Additionally, a substantial portion (45.9 percent) of the services initiative clients received involved intensive case management and counseling. Overall, initiative clients returned more often, received more services on average, and received more therapeutic services compared with their noninitiative counterparts. These findings suggest the Polyvictimization Initiative is shifting the Queens Family Justice Center's service delivery model as intended—that is, from a model focused on short-term intervention (such as meeting with an assistant district attorney (ADA) to discuss the next steps in the criminal justice process) to one that allows staff to provide longer-term intensive services via case management and counseling for high-needs polyvictim clients.

Key Findings and Recommendations

The Polyvictimization Initiative presented QFJC stakeholders with opportunities to reflect on the center's service provision and forge a new path to serve clients with complex, long-term needs for trauma-informed services owing to experiences with polyvictimization. These opportunities led to several successes, as well as some ongoing challenges.

The Initiative Provided Opportunities for Staff Training and Increased Resources for QFJC Clients

The resources that the Polyvictimization Initiative provided the Queens Family Justice Center were a major boon. Stakeholders noted that the four new dedicated staff members and the trainings on trauma-informed service provision were particularly beneficial for QFJC clients. The additional staff were particularly important because they allowed the QFJC to continue providing crisis-focused services to clients while offering longer-term intensive services to subset of high-needs polyvictims. Administrative records supported these staff perceptions, showing that clients served by the initiative received a higher number of services on average and tended to participate in more intensive case management and counseling, compared to typical QFJC clients. However, the additional resources did not address some of the QFJC's longstanding challenges; for example, housing for clients is still a major unmet need.

Staff Relationships Improved via Opportunities for Enhanced Collaboration and Coordination

The Polyvictimization Initiative required QFJC stakeholders to coordinate and collaborate to develop and implement the new service delivery model, and to coordinate services for polyvictim clients. Stakeholders largely reported that the dedicated biweekly meetings benefited them and their clients because the meetings made services more effective. However, these new demands for coordination also meant that roles needed to be delineated more clearly as staff focused less on crisis intervention and more on long-term (and often overlapping) service provision.

The Service Delivery Model Improved for Clients Interested in Specialized Polyvictimization Services

Staff reported that focusing on coordinating and sharing information about high-needs polyvictim clients improved service delivery (again, the availability of dedicated resources was an essential improvement for clients with longer-term service needs). In some cases, staff also found the polyvictimization screening tool useful for sharing crucial information about clients' backgrounds between partner agencies; overall, staff also found the polyvictimization assessment tool helpful for providing clients psychoeducation, building relationships with clients, and raising staff awareness of client needs. However, staff reported that the PST and PAT presented difficulties for certain clients. The sensitive nature of the questions distressed certain clients, and other clients were confused by polyvictimization terminology. These challenges suggest that more can be done to improve QFJC partner agency staff members' ability to recognize whether clients are ready for these tools; similarly, staff members' capacity to explain specialized services in accessible ways can be strengthened. Finally, because of the QFJC's client-centered approach, the service delivery model works well for clients who are ready and willing to engage in more intensive services. By contrast, the additional specialized services are less relevant for clients who prefer to focus exclusively on a specific and/or immediate need (e.g., seeing a lawyer). Using the PST to route clients from the start should help staff address clients' diverse needs and preferences.

The Modified-PAT May Benefit from Further Refinement

Results from our validity and reliability analyses indicated that many of the PAT's events-based questions are working as intended—that is, that they group together in meaningful ways, correspond to higher levels of trauma, and/or align with QFJC partner agency staff members' perceptions of which clients have had the most severe polyvictimization experiences. Our results indicate that 17 PAT lifetime events questions (focused on victimization and adverse life experiences; see table 5 for a summary) performed as expected because as many as 100 percent of clients reported having experienced them, and/or because they performed moderately well on some key psychometric measures. Without a larger sample to analyze, it is unclear that the remaining nine PAT events-based questions are meaningful for the QFJC client population (at least as those questions are currently worded). Overall, the PST also worked as expected: clients frequently responded "yes" to the victimization questions, and the tool had some moderate to strong psychometric properties.

Recommendations

1. Ensure Program Operations Continue Supporting Collaboration and Coordination

The Polyvictimization Initiative has increased collaboration and coordination among QFJC administrative and partner agency staff working with the same polyvictim clients. However, this also meant roles and expectations for working with shared clients needed to be clearly defined. Ensuring proper coordination between supervisors and frontline staff across agencies is essential, and will ensure frontline staff are consistently supported. To the extent possible, we recommend that the QFJC continue holding regular biweekly polyvictimization-focused meetings between screeners, case managers, and therapists with special polyvictimization caseloads, as staff widely regarded these meetings as helpful and successful.

2. Consider Changes to the Modified-PAT and Tool Implementation

We recommend QFJC focus on using the PAT questions that performed better in our validity and reliability analyses (see table 5). Moreover, QFJC could drop the questions that performed weakly in these analyses entirely, as we did not find evidence that those questions are as relevant for the QFJC client population. We also recommend that *all* PAT questions be revised for clarity to include behaviorally specific language and examples to ensure QFJC partner agency staff and clients share an understanding of what the questions are asking.

Because staff feedback and our validity analyses indicate the PST is generally working well and because it already includes behaviorally specific questions, we support QFJC's plans to continue using the tool. However, the following section provides some recommendations about staff training and protocols for sharing information.

3. Develop Clear Standards for Using the PST/Modified-PAT

Using the PST and Modified-PAT. Staff who administer the PST and PAT should continue receiving training and supervision to help them use the tools properly and consistently. Staff particularly need additional training on how to ask the tools' questions in ways that do not create undue distress for clients. There should also be a clear set of standards for how staff should respond when clients appear to be distressed. To achieve this, QFJC should continue providing training on trauma-informed service delivery and de-escalation techniques to all nonclinical staff who use the tools; moreover, new staff

should be trained within a set period after beginning work. To ensure staff attend the trainings, leadership should establish shared expectations about training requirements, provide frontline staff clear guidelines, and offer staff support for attending trainings given their busy schedules.

In addition, protocols for using the tools should be implemented in a manner that accounts for staff members' varying skill levels. We recommend that newer and/or non-clinically trained staff focus on using the tools as scripts or checklists while remaining cognizant of clients' needs. More experienced staff—especially those with clinical backgrounds—may be able to use the tools conversationally, something that may put some clients at ease.

Other training. Training and/or supervision should be offered to prepare nonclinical staff to provide psychoeducation to clients. Staff should also be taught how to successfully review and interpret PST/PAT results, while continuing to use a respectful and sensitive approach. We would like to emphasize how much QFJC administrative and partner agency staff (including security guards and front-desk staff) valued the trainings on trauma-informed operations and service delivery. To the extent possible, these trainings should be institutionalized and offered to all staff who interact with clients (including staff at the district attorney's office).

4. Refine Plan for Using the PST and Build on Strengths

Staff widely agreed that it would be useful to share the PST with all partner agency staff who receive client referrals to ensure they are informed about clients' experiences and traumas. A formal protocol for sharing the PST as part of client referral packages could strengthen this process. The protocol should *explicitly* outline how to address concerns about confidentiality and privacy (for example, ensuring clients' experiences are not shared with district attorney office staff or with partner agencies without clients' informed consent). Moreover, screeners and case managers should receive training and supervision on how to review PST results with partner agency staff.

5. Determine How to Maintain, Improve, and Expand Reach of Polyvictimization Initiative Model at the QFJC

There are many opportunities to build on the initiative's strengths. Staff widely reported that it was particularly beneficial to receive training and dedicated supervisory support, and to have dedicated, intensive case managers for high-needs polyvictim clients (including a Spanish-speaking case manager). Additionally, QFJC leadership should consider how to reach and engage clients who do not initially elect

to receive polyvictimization-track services, but who could benefit from such services after their immediate needs are met. For example, although there is a process whereby QFJC screeners and case managers refer clients to the district attorney's office (and the district attorney's office can informally refer them back to partner agencies for services), QFJC leadership should ensure the district attorney's office is aware of the QFJC's intensive-polyvictimization-services track (particularly if the victim decides not to participate in the case).

There is also potential for refining and expanding QFJC's service delivery model. Because QFJC was unable to hire some essential initiative staff until summer 2018, the center should continually monitor and assess PST/PAT performance and gather staff feedback. Expanding access to the PST/PAT to clients who do not speak English or Spanish would be helpful as well.

6. Use PST/PAT Data for Long-Term Performance Monitoring and Strategic Planning

Data from the PST and PAT confirm what QFJC stakeholders already knew from their professional experience: nearly all QFJC clients have experienced multiple forms of victimization and adverse life experiences, and many have high levels of trauma. Moving forward, QFJC stakeholders can leverage and build on the data presented in this report. We recommend that QFJC leadership use the data to establish standards for how staff are expected to work with polyvictim clients. Additionally, summaries of PST/PAT data could be incorporated into strategic long-term planning. One long-term challenge facing QFJC is how to maintain this new model of intensive service provision while potentially expanding availability and access to more clients.

Conclusion

In this report, we examined the development and implementation of the polyvictimization assessment tool at the Queens Family Justice Center and identified several successes and challenges. The resources that the Polyvictimization Initiative provided QFJC (e.g., dedicated polyvictimization staff and trauma-informed training) were beneficial; however, like issues other victim service agencies have faced, there were difficulties meeting other client needs, such as housing (affordable housing remains a huge need in New York). Coordination and collaboration were also important for implementing the PAT/PST and other initiative components. However, staff noted that coordinating client services requires roles that still needed to be clearly defined.

This evaluation found that the PST and PAT, used together, were useful for identifying polyvictims, routing them to services, and enhancing service delivery by providing staff richer information about client experiences and needs. Additionally, enhanced services were a major benefit of the initiative: clients on the polyvictimization track returned to the QFJC more often and received more services than typical QFJC clients. However, further refinements would make the PST and PAT more effective; quantitative analyses indicated that although both tools are reasonably effective, they did not perform as expected on all measures. The PAT in particular could be refined to ensure it works well for QFJC administrative and partner agency staff as well as clients.

Overall, the Polyvictimization Initiative brought attention to the needs of polyvictims and the importance of trauma-informed service provision at the Queens Family Justice Center. Through the lessons, challenges, and recommendations described throughout this report, Urban has provided a roadmap for New York to enhance the response to polyvictims at the QFJC.

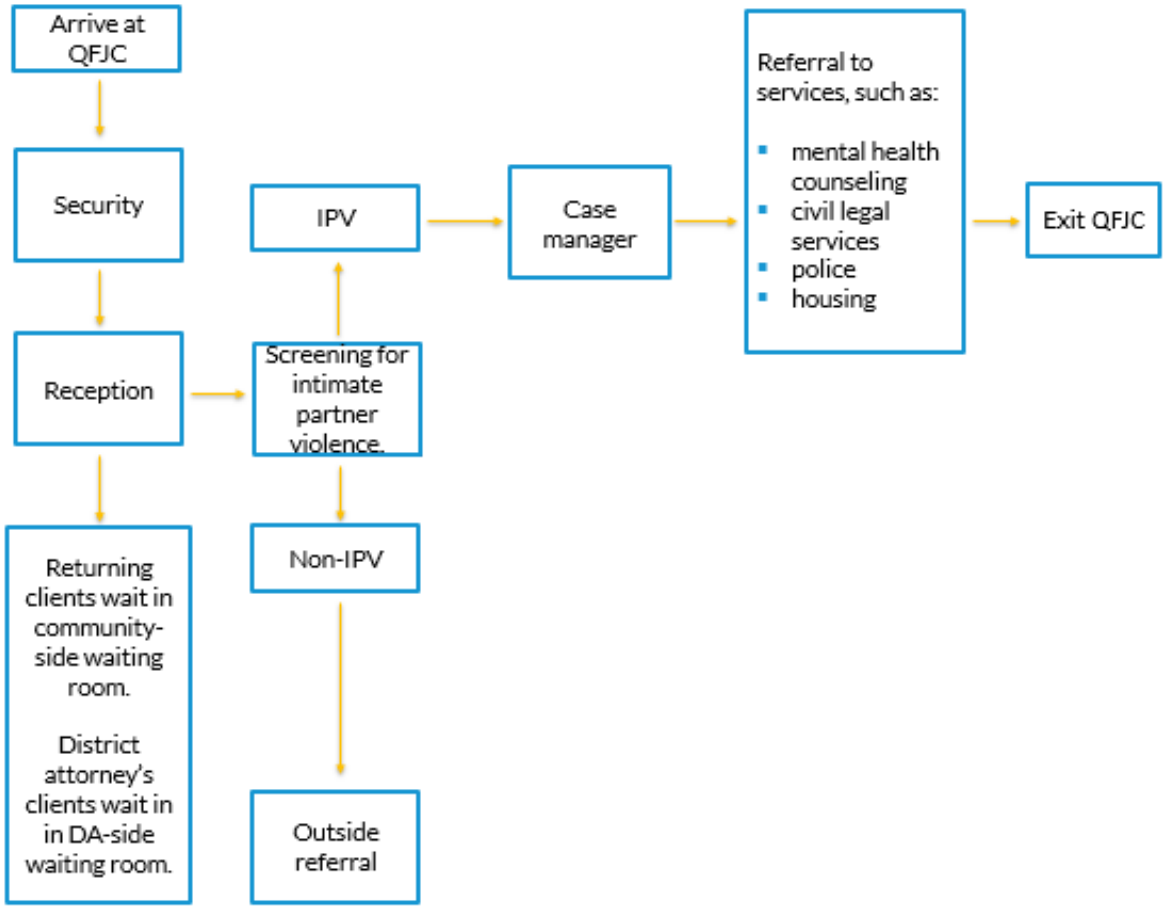
Appendix A. Polyvictimization Initiative Logic Model

Queens Family Justice Center: Urban Institute's Polyvictimization Screening Tool (PST) Process Evaluation

Goal: Develop and implement a Polyvictimization Screening Tool and tool administration guidelines that are suited to the QFJC's mission of serving clients in a trauma-informed and client-centered manner, in order to identify polyvictims and connect them to appropriate services.

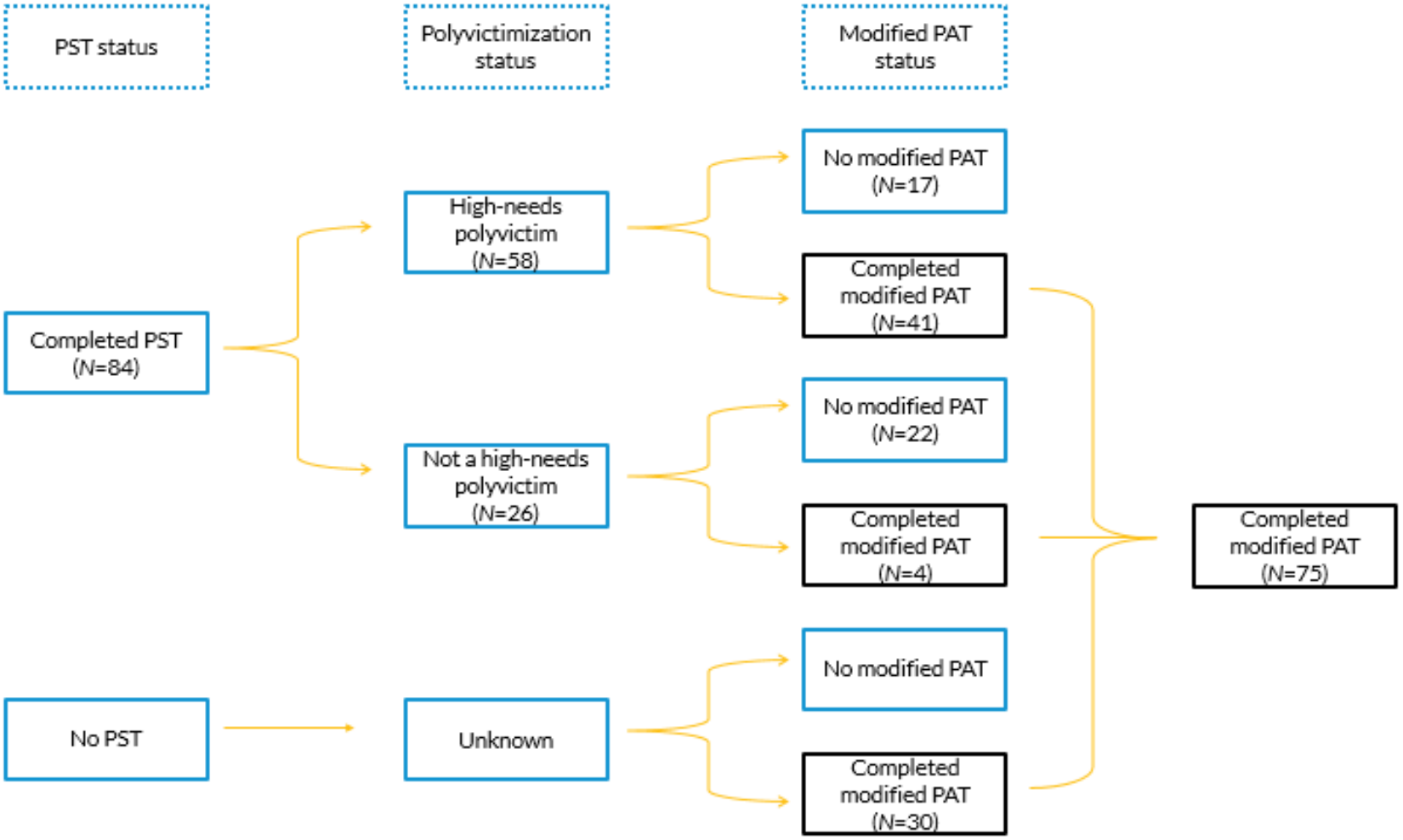
Objectives	Outputs (Activities and Indicators)	Outcomes	Data Collection Activities
Local Inter-Agency Collaboration Promote regular collaboration and communication between the QFJC and local partner agencies (e.g. Voces Latinas, Sanctuary for Families).	• Number of new formalized collaboration agreements developed • Number of new letters of support (or MOUs) • Number of planning activities (including meetings) undertaken by the Consulting Committee	• Increased collaboration and communication about polyvictimization, the PST, and services for polyvictims between the QFJC and partner agencies.	• Urban's stakeholder interviews and surveys • Records of outputs collected by the QFJC
Local Capacity to Serve Polyvictims Increase capacity to serve polyvictimized clients at the QFJC and partner agencies, by adopting new policies, hiring new staff, and training new and existing staff about polyvictimization and the PST.	• Number of agency policies or procedures created, amended, or rescinded during the reporting period • Number of groups/organizations/agencies participating in the quarter prior to grant funding; as well as the number participating as a result of grant funding during the reporting period • Number of agencies involved in the partnership • Number of agencies involved in partnership that utilize an evidence-based program practice in the delivery of service • Number of staff designated to administer the PST • Number and types of trainings provided to staff using the PST • Number of staff hired to use the PST at the QFJC and partner agencies	• Improved capacity to use PST and serve polyvictim clients. • Increased knowledge of polyvictimization, trauma-informed care, and partners who support polyvictims. • Utilization of evidence-based practices.	• Records of outputs collected by the QFJC • Urban's stakeholder interviews and surveys
Implementation of the Polyvictimization Screening Tool Develop an implementation plan and administer the PST with clients at the QFJC and partner agencies.	*Spring 2018: Pilot Stage* • Number of clients administered the PST at the QFJC • Number and type of service referrals made for polyvictims • Number and type of services received by polyvictims • Number of clients identified as a polyvictim *Fall 2018: Modified Tool Stage* • Number of clients administered the PST and the Adult Hope Scale at the QFJC and at partner agencies • Number and type of service referrals made for polyvictims • Number and type of services received by polyvictims • Number of clients identified as a polyvictim	• Increases in hope, self-efficacy, justice, and safety among polyvictimized clients, following service provision. • Increased knowledge of services. • Polyvictimized clients are satisfied with the availability of services at the QFJC and partner agencies. • Improved QFJC and partner agencies' knowledge about the service needs of polyvictim clients (with an eye toward expanding the range of services available).	• Urban's client surveys, interviews, and focus groups • Analyses of client PST data and client administrative data

Appendix B. QFJC Client Flow Analysis



Notes: This diagram was drafted by QFJC staff prior to changes in service delivery and revised by Urban Institute. As of September 2018, non-intimate-partner-violence clients are no longer referred out. The QFJC currently serves all GBV clients.

Appendix C. PST and Modified-PAT Client Flow



Appendix D. Polyvictimization Screening Tool

Polyvictimization Screen: Short Tool for Intake

Instructions: At the QFJC, we ask every client visiting for the first time if they would agree to answer some questions in order to find out if you have experienced multiple types of victimizations which is called polyvictimization. Asking these specific questions about whether or not you have been a victim of certain types of crimes will help us figure out with you the best service plan to meet your needs. It will also provide important information about your past experiences to the agencies that you will eventually meet with at the Center. Knowing this, would you agree to answer 7 short screening questions?"

If they agree, please ask them to read and sign the consent form and then ask the following 7 polyvictimization screening questions to each client exactly as they are written.

After you ask the questions, please then ask the client if they would like an appointment with a case manager or counselor specially trained in polyvictimization if:

(1) The client answers **"Yes"** to any four screening questions; or

(2) The client answers **"Yes"** to the sexual abuse/assault question or the stalking question or the strangulation question **and** answers **"Yes"** to at least two of the other screening questions (these two other victimizations can include sexual abuse/assault, stalking or strangulation so for example, a person could meet this threshold by reporting sexual assault + strangulation + stalking and zero other victimizations, or reporting sexual assault + strangulation + one other victimization.

To share screen with staff please print before your hit submit. You can print by right clicking mouse and choosing "print" from the menu options that appear.

First Name: *

Last Name: *

Client FJC Client ID: *

Did Client Sign the Consent Form: *

Yes

No

Polyvictimization Screening Questions

1. Assault: Have you been ever been **assaulted or harmed** with a gun, knife, or any other weapon,

or has someone hit you with a fist or kicked you? This could be a completed or attempted incident, by a partner, dating partner, family member, caregiver, non-relative, or stranger :

Yes

No

2. Sexual abuse/assault: Have you ever been forced or coerced to engage in unwanted **sexual activity?** This could be a completed or attempted incident, by a partner, dating partner, family member, caregiver, non-relative, or stranger:

Yes

No

3. Stalking: Have you ever been **stalked** or inappropriately pursued by a partner, friend, or someone else? Stalking refers to unwanted repeated contact, including through text messages, phone calls, social media, or in-person:

Yes

No

4. Strangulation: Have you ever experienced **strangulation**, or having someone put pressure on your neck or anywhere that made it hard to breathe? This could be through choking, use of body weight or arms, by sitting on your, or another way:

Yes

No

5. Robbery: Have you ever been **robbed**, **mugged**, or had your home or car **burgled**? This could be a completed or attempted incident:

Yes

No

6. Cybercrime: Have you ever experienced **cybercrime**, such as cyber bullying, bullying on social media like Facebook, or online identify theft, where someone has used your email, bank account, or other online account without your permission :

Yes

No

7. Witnessing Violence: Have you seen or heard (in-person, not on TV) violence, such as shootings or gunshots, stabbings, beatings, sexual assaults, etc. inside your home or in your neighborhood:

Yes

No

8. Physical Pain: In the past year, have you experienced physical pain for any reason:

Yes

No

The screener should complete the following question:

In your opinion, to what extent did this client experience polyvictimization? (with 1 being not at all and 10 being very severe experiences of polyvictimization) *Note: Polyvictimization has been defined as multiple victimizations of different kinds*:

1

2

3

4

5

6

7

8

9

10

Appendix E. Modified Polyvictimization Assessment Tool

Polyvictimization Assessment Tool

Name of Center: _____ **Dates Utilized:** _____/_____/_____/_____

Client Name: _____ **Client ID:** _____ **Over the age of 18? Yes ☐ No ☐**

Name of Staff Member(s): _____/_____/_____/_____

New Client: ☐ **Returning Client:** ☐ **Number of sessions it took to gather the information below:** _____

The Polyvictimization Assessment Tool is an information integration tool. Please ensure confidentiality is explained and honored for each client. For each event below circle "Y" for yes or "N" for no in the boxes to the right as applicable for the different stages of the client's life (Child and Teen, Adult, and In the last year). In addition to "Y" and "N" user may circle other possible responses which include "A" for the **client did not respond** to the question; "B" for the **user did not ask** due to time constraints or other limitations; and "C" for the user did not ask since it was **not appropriate to ask.** For questions that are not applicable to all clients, an additional "Does not apply" response has been included. When marking an event "In the last year," please also mark the respective time period that it would fall under (Child and Teen OR Adult). Answers should be from the *client's perspective*. If the user has additional input or thoughts, particularly around minimizing, this should be included in the "Notes" section. The number of events calculated for "In the last year" is not a victimization score but should trigger a response at the Center.

Part A: Events

		Child and Teen (0-17)	Adult (18+)	In the last year	Notes
1. Assault/battery by parent, caregiver, partner, or relative (completed or attempted) (ex: with a gun, knife, or other weapon including fist, feet, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	Note if parent, caregiver, partner, or relative:
2. Strangulation and/or positional asphyxia (pressure applied by any means to the neck or anywhere that made it difficult to breathe) (ex: choking, use of body weight or arms, sitting on top of you, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	
3. Sexual abuse/assault by parent, caregiver, partner, relative, friend, or other (completed or attempted) (ex: rape, made to perform any type of sexual act through force or threat of harm)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	Note if parent, caregiver, partner, relative, friend, or other:
4. Sex or labor trafficking (ex: being prostituted, forced involvement in sexual performances, forced pornography, involved in domestic servitude or other exploitative labor, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	
5. Other forced/unwanted experience(s) related to your body not including abuse or assault (ex: touching, flashing, reproductive coercion such as forced abortions and family planning, revenge pornography, sexual remarks, sexual jokes, or demands for sexual favors by someone at work or school like a coworker, boss, customer, another student, teacher, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	

		Child and Teen (0-17)	Adult (18+)	In the last year	Notes
6. Held against will (ex: being kidnapped, abducted, held hostage, held captive, prisoner of war, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	
7. Emotional/verbal abuse by parent, caregiver, partner, relative, friend, or other (ex: putting down, fear of physical violence, name calling, mind games, humiliating, guilt trips, spiritual abuse, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	Note if parent, caregiver, partner, relative, friend, or other:
8. Financial abuse (ex: forbidden from working, given allowance, not allowed to access bank accounts, online financial fraud, other financial cybercrimes, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	
9. Neglect by parent, caregiver, partner, relative, friend, or other (ex: being left unattended for long periods, lack of love or support system at home, very often feeling like not loved by family, malnutrition due to lack of adequate food/water, failure to provide necessary medical care that results in hospitalization, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	Note if parent, caregiver, partner, relative, friend, or other:
10. Substance use (ex: you, partner, or a close family member misuse prescription drugs, alcohol, or illicit drugs)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	Note if client, parent, caregiver, partner, or relative:
11. Stalking/inappropriate pursuit by parent, caregiver, partner, relative, friend, or other (ex: unwanted repeated contact in-person or via text messages, phone calls, social media, other online platforms including email, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	Note if parent, caregiver, partner, relative, friend, or other:
12. Poverty (ex: did not have enough food to eat, lack of basic needs such as clothes, shoes, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	
13. Homeless (ex: transitional housing, shelter, hotel/motel paid by voucher, someone else's home, a vehicle, an abandoned building, anywhere outside, or anywhere not meant for people to live without having any other options)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	

		Child and Teen (0-17)	Adult (18+)	In the last year	Notes
14. Severe physical injury/illness and/or mental illness resulting in hospitalization or incapacitation (ex: severe pain requiring treatment at home, due to an accident, mental health condition, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	
15. Permanent or long-term loss (ex: of a spouse, romantic partner, child, parent or caregiver, due to incarceration, deportation, illness, suicide, death, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	
16. Immigration related trauma (ex: separated from support network, language barriers, trouble finding a job, unfamiliar environment and food, deportation, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	
	Does not apply ☐				
17. Separation from child(ren) or disrupted caregiving as a child (ex: the loss of custody, visitation, or kidnapping/abduction of a child; a change of custody among family members, numerous changes in foster care placements, or deportation as a child)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	
	Does not apply ☐				
18. Jail/prison/probation/parole/detention time (ex: you, partner, close family member, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	**Note if client, parent, caregiver, partner, or relative:**
19. Bullying (ex: verbal or physical violence in-person or online via social media and other online platforms in the workplace, school, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	
20. Chronic or repeated discrimination (ex: discrimiation based on race, ethnicity, where family comes from, gender, gender identity/expression, sexual orientation, ability/disability, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	
21. Community violence (ex: physical assault/battery by a stranger; robbery, burglary, mugging, or identity theft; victim of terrorist attack; mass shootings; street riots; drive-by shootings; stabbings; beatings; heard gunshots; etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	

		Child and Teen (0-17)	Adult (18+)	In the last year	Notes
22. System-induced trauma (ex: violent arrest situations, difficult experiences testifying against abuser at trial, police brutality, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	
23. Seen someone who was dead, or dying, or watched or heard them being killed (in real life not on T.V. or in a movie, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	
24. Natural and/or man-made disaster (ex: a hurricane, earthquake, flood, tornado, fire, train crash, building collapse, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	
25. Animal cruelty (ex: abuse or threats to pet in attempts to create fear or manipulate)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	
	Does not apply ☐				
26. Other (ex: anything really scary or very upsetting that occurred that is not included above or any other experiences that were not covered)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	
Total lived victimizations by age group:					

Part B: Symptoms

For each symptom circle "Y" for yes or "N" for no in the boxes to the right as applicable for the different stages of the client's life (Child and Teen, Adult, In the last year, and Current Symptom). In addition to "Y" and "N" user may circle other possible responses which include "A" for the **client did not respond** to the question; "B" for the **user did not ask** due to time constraints or other limitations; and "C" for the user did not ask since it was **not appropriate to ask**. When marking a symptom as a "Current Symptom" and "In the last year," please also mark the respective time period that it would fall under (Child and Teen OR Adult). Answers should be from the *client's perspective*. If the user has additional input or thoughts, particularly around minimizing, this should be included in the "Notes" section. The number of symptoms for "In the last year" and "Current Symptoms" are calculated and should assist in guiding service delivery.

		Child and Teen (0-17)	Adult (18+)	In the last year	Current Symptom	Notes
1. Experiencing pain and/or physical symptom(s) that have not been diagnosed or are resistant to treatment	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
2. Suicide attempt, discussion, or thoughts of suicide	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
3. Self-harming behavior(s) (ex: cutting, eating disorder including overeating, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
4. Health-risk behavior(s) (ex: excessive use of drugs/alcohol, sharing needles, unprotected sex with multiple partners, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
5. Repeated disturbing memories, thoughts, or images of a stressful experience	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
6. Avoidance (ex: avoiding places, people or other stimuli associated with past trauma, feelings, or physical sensations that remind you of the trauma, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
7. Cut off (ex: feeling distant or isolated)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
8. Irritable/angry (ex: feeling irritable, having angry outbursts, or rage)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	Y N A B C	

		Child and Teen (0-17)	Adult (18+)	In the last year	Current Symptom	Notes
9. Attention/concentration difficulties (ex: easily distracted/inattentive)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
10. Sleep disturbances (ex: night terrors, sleeplessness, excessive sleepiness, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
11. Anxiety (ex: overly tense, worried, or stressed to the point of withdrawal from activities, experiencing panic attacks, or needing excessive reassurances)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
12. Hypervigilance (ex: jumpy, startles easily, overly aware or concerned about potential dangers, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
13. Aggressive or violent behaviors, even if done so unintentionally or unexpectedly (ex: physically or verbally aggressive, destroys property, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
14. Impulsivity (sudden, strong, even irrational urge to engage in behavior without considering consequences first) (ex: stealing, truancy, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
15. Sadness (apathy/despair)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
16. Low self-esteem (ex: I am bad, there is something seriously wrong with me, self-blame for the experience, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
17. Numbing, dissociating (ex: limited emotional range, avoiding thinking or talking about the future or goal setting, "feeling flat," etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
18. Other (ex: any changes in behavior, physical well being, or mood that have occurred since the incident(s) that are not included above)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
Symptoms Present in the last year and Current Symptoms:						

Appendix F. Results from Validity and Reliability Analyses

To examine the extent to which the Modified-PAT's events-based section grouped in a meaningful way, we conducted a factor analysis on the subset of questions about victimization experiences, and the subset of questions about adverse life experiences (ALEs) that have occurred over the client's lifetime. We used principal components analysis with an orthogonal (Varimax) rotation. Initial results were weighed against several considerations, including the relative frequency with which an item was reported, the conceptual meaning of extracted factors/dimensions (i.e., the extent to which this grouping makes sense for this client population, given what we have learned from the research literature and our qualitative data collection), the total variance explained by extracted factors, the factor loadings, the factor's Eigen value, communalities, and internal consistency reliabilities for each dimension as well as the entire subscale (Victimization, ALEs) as a whole. Although no set of extracted factors that we examined met all our criteria (for example, several factors had low internal consistency reliability), the results summarized in tables A.1 and A.2 offered a solution that was straightforward, practical to apply, and performed better on psychometric measures than other solutions we examined. Ideally, these analyses would be repeated with a larger sample size and with fewer missing responses.

Note that factor analysis was also completed for *past-year* events. However, results indicated that *lifetime* event responses grouped together in a more consistent and meaningful way; past year event responses grouped together more poorly by comparison. This finding—though subject to the limitations discussed in this report's "Evaluation Methodology" section—is consistent with previous research on polyvictimization (Finkelhor, Ormrod, and Turner 2007). It is also consistent with what QFJC administrative and partner agency staff reported to Urban during the PST development phase—that it is important to account for events that have occurred throughout a client's lifetime.

Table A.1 summarizes three factors/dimensions of lifetime victimization; together, these factors explain 59.5 percent of variation in lifetime victimizations. Similarly, table A.2 summarizes two dimensions of lifetime ALEs, which explain 58.1 percent of variation in lifetime ALEs. An important limitation here is that internal consistency reliability was weak for most of the factors. Among the lifetime events questions, factor 1 (violent victimization) had moderate internal consistency reliability (the alpha value is .63), however, factors 2 (nonviolent victimization) and 3 (violent, sexual victimization) were weaker in this regard. Similarly, among the lifetime ALE questions, factor 1 (material ALEs) had strong internal consistency reliability (the alpha value is .74), yet factor 2 (physical ALEs) did not

perform well on this measure. Taken together, these results support the use of questions on violent victimization and material ALEs. The remaining questions in the Modified-PAT had weaker internal consistency reliability; however, because some QFJC administrative and partner agency staff deemed these questions to be relevant and appropriate for understanding polyvictimization experiences among QFJC clients, and because they were reported with high frequencies by QFJC clients during final implementation, we conclude that these questions are worth retaining in the Modified-PAT. Further analyses using a larger sample (and fewer missing responses) could provide additional insights about the utility of the questions that did not group as well in our factor analysis.

Table A.3 displays correlation coefficients to test for convergent validity. Overall, results here show that for the most part, dimensions of lifetime victimization and lifetime ALEs are positively correlated—which is what we would anticipate—however, they are not statistically significant. The exception is the relationship between Physical ALEs and Material ALEs, which have a significant positive correlation. Notably, when we examined the correlation between the PST and these factors, we found that the PST is significantly correlated to violent victimization. This of course makes sense since the PAT violent victimization questions are very similar to the PST questions. It affirms that for clients who took both the PST and PAT, they appear to have responded consistently to similar questions that are asked across both tools.

Finally, table A.4 summarizes results from tests for convergent validity. In sum, lifetime victimization factors, lifetime ALE questions, and the PST are generally positively correlated to the 10 most frequent trauma symptoms and the staff assessment of client polyvictimization, none of the relationships are statistically significant, so it is difficult to draw conclusions here. The lack of statistical significance may be meaningful, or may be due to a small sample.

TABLE A.1

Lifetime Victimizations

Results from factor analysis (N=43)

		Factor loading				Communalities
		Alpha	F1	F2	F3	
	Factor 1: Violent Victimization	.63				
2	Strangulation		.76			.60
6	Held against will		.71			.70
11	Stalking by family or other		.67			.54
19	Bullying		.63			.53
21	Community violence		.48			.42
	Factor 2: Nonviolent Victimization	.32				
8	Financial abuse			.74		.58
9	Neglect, by family or other			.74		.58
	Factor 3: Violent, Sexual Victimization	.46				
3	Sexual abuse/assault				.81	.71
5	Other bodily forced/unwanted experiences				.79	.70

Source: Urban's analysis of PAT data.

Notes: Cronbach's alpha for lifetime victimizations in this table was .62. The number corresponding to the experiences' order on the PAT are included to the left of the measures.

TABLE A.2

Lifetime Adverse Life Experiences

Results from factor analysis

		Factor loading			Communalities
		Alpha	F1	F2	
	Factor 1: Material ALEs	.74			
12	Poverty		.83		.70
13	Homelessness		.76		.78
15	Permanent/long-term loss		.80		.65
18	Incarceration		.51		.46
	Factor 2: Physical ALEs	.19			
10	Substance use			.88	.78
14	Severe injury/illness			.30	.12

Source: Urban's analysis of PAT data.

Notes: Cronbach's alpha for past-year adverse life experiences in this table was .68. The number corresponding to the experiences' order on the PAT are included to the left of the measures.

TABLE A.3

Correlations between PAT Lifetime Events Factors (*N*=43)

	Violent victimization (factor 1)	Nonviolent victimization (factor 2)	Violent, sexual victimization (factor 3)	Material ALEs (factor 1)	Physical ALEs (factor 2)
Lifetime					
Violent victimization (factor 1)	1				
Nonviolent victimization (factor 2)	.11 (not sig.)	1			
Violent, sexual victimization (factor 3)	.25 (not sig.)	.05 (not sig.)	1		
Material ALEs (Factor 1)	.31 (not sig.)	.00 (not sig.)	.09 (not sig.)	1	
Physical ALEs (Factor 2)	.16 (not sig.)	.24 (not sig.)	-.09 (not sig.)	.30*	1
PST (summary score)	.57 ***	-.08 (not sig.)	.20 (not sig.)	.33 (not sig.)	.13 (not sig.)

Source: Urban's analysis of PAT data.

Notes: *p<.05, **p<.01, and ***p<.001.

TABLE A.4

Correlations between PAT Lifetime Events, PAT Past-Year Trauma Symptoms, and PAT Staff Assessment of Client Polyvictimization (*N*=43)

Lifetime	Top 10 trauma symptoms (summary score)	Staff assessment (validation question)
Violent victimization (factor 1)	.10 (not sig.)	.12 (not sig.)
Nonviolent victimization (factor 2)	.11 (not sig.)	.07 (not sig.)
Violent, Sexual victimization (factor 3)	.03 (not sig.)	.07 (not sig.)
Material Adverse Life experiences (factor 1)	.15 (not sig.)	.17 (not sig.)
Physical Adverse Life experiences (factor 2)	.05 (not sig.)	.18 (not sig.)
PST (summary score)	-.00 (not sig)	.19 (not sig.)

Source: Urban's analysis of PAT and PST data.

Notes: *p < .05, **p < .01, and ***p < .001

TABLE A.5

Client Characteristics of Factor Analysis Subgroup (*N*=43)

	Freq.	Percent	Median	Range
Gender				
Female	43	100.00		
Male	0	0.00		
Sexual Orientation				
Heterosexual	36	83.72		
Gay, lesbian, or bisexual	3	6.98		
Race/ethnicity				
Asian/Southeast Asian	3	6.98		
Black	6	13.95		
Caribbean/West Indian	4	9.30		
Hispanic/Latinx	25	58.14		
White	4	9.30		
Age			34	22–63
Primary language				
English	22	51.16		
Spanish	19	44.19		
Other language	2	4.65		
Education Level				
Less than high school	17	39.53		
High school/GED	10	23.26		
Some college and/or Associates degree	10	23.26		
4-year college	0	0.00		
Graduate degree	2	4.65		
Employment status				
Full time	12	27.91		
Part-time	8	18.60		
Self-employed	2	4.65		
Unemployed	20	46.51		
Student	0	0.00		
Housing status				
Living in shelter	3	6.98		
Not living in shelter	39	90.70		
Client type				
New	4	9.30		
Returning	39	90.70		

Source: Urban's analysis of QFJC, PST, and PAT data.

Notes: Percentages may not add up to 100 owing to missing data. For each category, the number of clients missing observations ranged from 3 to 10 (or, roughly 2.6 to 8.8 percent). "White" racial/ethnic category includes clients who identify as Arab and/or Arab American.

Notes

[1] Because the research base on polyvictimization interventions is nascent, here we draw from the more robust research literature on domestic violence interventions (since the QFJC most frequently serves victims of domestic violence).

[2] The other five demonstration sites include the Family Justice Center Sonoma County, Stanislaus Family Justice Center, New Orleans Family Justice Center, Sojourner Family Peace Center, and the Tulsa Family Safety Center.

[3] United States Census Bureau. (2018). 2017 American Community Survey. Retrieved from https://www.census.gov/programs-surveys/acs

[4] Throughout the report, we use various terms to describe different stakeholders involved in the initiative. These terms include the following: QFJC administrative staff, referring to the QFJC executive director and staff responsible for the QFJC's operations; QFJC partner agency staff, referring to staff of community-based organizations (such as Safe Horizon, SAVI, Voces Latinas, Sanctuary for Families, and NYC Alliance Against Sexual Assault) who work directly with QFJC clients; and QFJC stakeholders, referring to QFJC administrative, partner agency staff, as well as leadership from ENDGBV and partner agencies who were involved with the initiative via their service on the consulting committee.

[5] "What is Process Mapping," Lucidchart, accessed September 23, 2019,, https://www.lucidchart.com/pages/process-mapping?ab=b.

[6] Notably, the lack of a link between data systems is intentional, designed to protect client confidentiality in case of a subpoena.

[7] Although not the focus of this evaluation, QFJC and its partner agencies did make progress toward these goals during the project period. Changes included (1) the creation of a mentoring program for all case managers during new staff orientation; (2) work on updated memoranda of understanding (MOUs) and operations manuals; (3) efforts to update the data-tracking system; and (4) initiatives to allow QFJC and community-based organization staff to tour each other's facilities.

[8] Eighteen of the events-based questions—for the past year only—and nine of the symptoms-based questions were required to be asked by the person administering the Pilot PAT. All other questions were optional.

[9] Staff and stakeholder quotes that appear throughout this report are drawn from Urban's stakeholder interviews, and were used with the permission of stakeholders; QFJC stakeholder, Urban interview, February 2018.

[10] QFJC stakeholder, Urban interview, February 2018.

[11] QFJC stakeholder, Urban interview, February 2018.

[12] QFJC stakeholder, Urban interview, February 2018.

[13] QFJC stakeholder, Urban interview, May 2018.

[14] QFJC stakeholder, Urban interview, May 2018.

[15] QFJC stakeholder, Urban interview, May 2018.

[16] QFJC stakeholder, Urban interview, May 2018.

[17] QFJC stakeholder, Urban interview, May 2018.

[18] QFJC stakeholder, Urban interview, May 2018.

[19] The Center for Victim Research is a national resource center co-run by the Urban Institute in collaboration with the Justice Research and Statistics Association and the National Center for Victims of Crime. The Center for

Victim Research provides free research-focused technical assistance to victim service providers nationwide to encourage the use of data and research to improve service provision to crime survivors.

[20] QFJC stakeholder, Urban interview, February 2019.

[21] QFJC stakeholder, Urban interview, February 2019.

[22] The only exception was clients who had already been working with a case manager through family court.

[23] Notably, the PST was only available in English. Accordingly, screeners had to translate the questions to Spanish-speaking clients on the spot. As such, researchers cannot verify that the tool was administered using behaviorally specific language for Spanish-speaking clients.

[24] QFJC client, Urban focus group, February 2019.

[25] QFJC stakeholder, Urban interview, February 2019.

[26] QFJC stakeholder, Urban interview, February 2019.

[27] QFJC stakeholder, Urban interview, February 2019.

[28] QFJC stakeholder, Urban interview, February 2019.

[29] The PAT had categories for clients to report experiences that had occurred during the past year, as an adult, and/or as a child. For these analyses, if a client reported a victimization or adverse life experience that occurred during childhood and/or adulthood, it is reported in the single category of an experience that occurred during the client's lifetime.

[30] In this section, we report on the tools' key psychometric properties, including measures of validity *and* reliability. However, to align with the language used most commonly by the nationwide initiative, we use the terms "validity analyses" and "validation analyses" to refer to all of the psychometric properties we examined.

[31] Full results from factor analysis are detailed in appendix F.

[32] Staff administering the PAT were asked to complete their own assessments of the extent to which they thought the client was a polyvictim on a scale of "1" to "10," with a "1" meaning not at all and a "10" indicating the most severe experiences of polyvictimization.

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About the Authors

Sara Bastomski is a research associate in the Justice Policy Center at the Urban Institute, where she conducts research and evaluations in crime victimization, gender-based violence, and criminal justice reform.

Alexandra Ricks is a former research analyst in the Justice Policy Center, where her portfolio of work focused on crime victimization, juvenile justice, and school discipline.

Erica Henderson is a research analyst in the Justice Policy Center, where she works on projects related to juvenile justice and victimization. She has additional interests in reentry and recidivism reduction.

Jennifer Yahner is a senior research fellow in the Justice Policy Center and associate director of the new Center for Victim Research, a national resource center funded by the Office for Victims of Crime.

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