



Institute for Social and Behavioral Science

UNIVERSITY OF CENTRAL FLORIDA

Evaluation of the Children’s Home Society of Florida’s Enhanced Domestic Violence Services: Final Report

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The University of Central Florida's Institute for Social and Behavioral Science (ISBS) was contracted to evaluate the effectiveness of the implementation of the Children's Home Society of Florida's (CHS) Enhanced Domestic Violence Services that was implemented in the greater Lakeland area, referred to as the Partners for Safe Families Program (P4SF). CHS's Enhanced Domestic Violence Services aimed to more accurately identify and address domestic violence in their child welfare cases. To conduct the evaluation, we utilized a mixed-methods research design comprised of quantitative secondary program data and qualitative interview data.

Methodology

Partners for Safe Families Program (P4SF) Enhanced Domestic Violence Services

As part of the Partners for Safe Families Program (P4SF), cases received enhanced domestic violence services administered by a specially trained CHS clinician, including the Danger Assessment (DA), a tool to help determine the level of danger an abused woman has of being killed by her violent partner, and the HITS (Hurt, Insult, Threaten, Screen), a screening tool for intimate partner violence (IPV). P4SF program cases had case management services by a Domestic Violence (DV) Advocate and were also offered clinical services that varied depending on the needs of the client.

Clinical Interviews

Between July of 2021 and May of 2023, ISBS project managers and research assistants conducted interviews with CHS staff members and clinicians via Zoom or telephone. The interviews were structured using an interview questionnaire, which included a total of 16 questions (see Appendix). In brief, the questions guiding the interviews focused on each participant's role in the organization's new domestic violence program and their assessment of the effectiveness of the program.

During the interviews, the ISBS team recorded participant responses using the Qualtrics software. While all responses were recorded, no identifiable participant information were included within the notes taken by the ISBS team that were uploaded to the Qualtrics software. The interview responses were all de-identified and stored separately from the list of interview participants utilized for recruitment. Once all the interviews were conducted, responses were analyzed thematically using the interview guide as a framework. The results of the analysis are highlighted in the report below.

In total, seven staff members from CHS participated in interviews. The positions of the staff members who participated in interviews included the clinical director, clinical therapists, clinical counselors, and the domestic violence liaison.

Secondary Data Analysis

To conduct the secondary data analysis, data was provided by CHS for P4SF program cases that entered the program between 12/1/22 and 5/31/23 (n=8), a group of comparison cases that did not receive enhanced domestic violence services but were admitted into child welfare between 1/1/21

and 6/30/21 and had evidence of household domestic violence (verified or not substantiated household violence that threatens child, intimate partner violence that threatens child, and/or family violence that threatens child (n=14)), and 12-months of aggregate case data in the child welfare system between 9/1/2021 and 9/1/2022, representing cases prior to the implementation of the P4SF program.

P4SF data included information from the Danger Assessment (DA), the HITS (Hurt, Insult, Threaten, Scream), clinician reports, and the Family Functioning Assessment-Ongoing (FFA-O). Comparison case data and the aggregate case data included information from the FFA-O.

Once data were provided, it was cleaned and organized by case. Given the small sample size, descriptive statistics were analyzed for the purposes of this report and are highlighted below. Additionally, as a note, in all the tables below missing data and data points that are not applicable to certain cases are visualized as a dash.

Ethical Concerns

The UCF Institutional Review Board approved this study. To protect the identity of participants, none of the included quotes are attributed to specific individuals throughout this report. Further, to protect the identity of clients, case numbers were de-identified.

Results

Clinical Interviews

Number of Cases

Aside from the participant's title and roles the first question participants were asked was:

How many of these new cases have you worked on since the program has been implemented?

Responses to this question ranged given the participants role in the organization and were also contingent on whether the clinicians were sharing their caseload with other clinicians. Additionally, while clinicians were asked how many new cases they have worked on since the initiation of the new program, responses did not clearly indicate if all cases were a part of the new program. For instance, one participant specifically mentioned that while they were working with an average of 15 clients per week, they only incorporated the Danger Assessment with one client. While it is unclear if all responses indicate clinicians use of the new enhanced domestic violence indicators and services, clinicians noted that their caseload overall ranged from 3 to 17. Participants who suggested they were working with over 10 cases either worked collaboratively with other clinicians or were in leadership roles in which they oversaw all cases.

Child(ren) Removal Cases

After discussing the number of cases, participants were asked:

Can you please describe your involvement in each of the child removal cases?

When addressing this question, the professional role of the staff member determined their involvement in child removal cases. Only one interviewee did not participate in child removal cases. All participants described themselves using a title or describing their title, such as “clinical counselor,” “therapist/clinical therapist,” and “domestic violence liaison.” Further, they described their roles aside from their title, which included providing therapy and counseling services for the child(ren) and parents, conducting parenting classes, intake evaluations, and helping non-offending parents navigate the system through referrals and providing resources. One participant explained,

“With the non-offending parent, if they need to get an injunction, I can provide assistance with that. If they need to fill out paperwork provide them with a lawyer. I can be an advocate for them to receive an escort to the courthouse for the injunction hearing as well providing any kind of support and reassurance during the process if they need it. I can act as a liaison between the caseworker as well CPI for DCF. I can also provide them with childcare assistance or help with employment. I can guide them in the right direction as far as housing, support groups, counseling, and basic needs.”

Administration of the Danger Assessment

After discussing involvement in child removal cases, participants were asked:

Have you been able to consistently administer the Danger Assessment?

When addressing this question, the professional role of the participant determined if they consistently administered the Danger Assessment. Of the seven interview participants, two did not administer the Danger Assessment because it fell outside their professional roles. However, while their roles did not include administering the Danger Assessment, they did note that they had completed the training to comprehend and acknowledge the importance of the Danger Assessment and its effectiveness at the time of the interview.

Aside from those two participants, the remaining interview participants were able to consistently administer the Danger Assessment with their clients. The clinicians stated that the Danger Assessment is usually administered when the case is first opened. More specifically, participants explained,

“We do the Danger Assessment when we first open the case. Some of the numbers are not that high, even though we know there's been domestic violence, because a lot of the cases when they come in, you're asking some of these questions and they respond, "no" to them because they're not occurring at the moment. The cases come in due to that (domestic violence) so they're obviously not in that relationship and they've been told they cannot be in that relationship. So, they're not in it. So, when you ask them some of the questions you kind of have to go back in time with them, and sometimes they don't realize that they should be responding yes and they're responding no.”

“Some cases had like crisis like you know like with frequency, other cases were a little bit more stable, and we were able to work a little bit more on trauma. But yes, the answer is yes.”

Next, after discussing the consistency of administering the Danger Assessment, participants were asked:

What is the process you take when administering the Danger Assessment?

To address this question, the professional role of the participant determined if they administered the Danger Assessment. Only two of the interviewees did not participate in the administering of the Danger Assessment, but they had completed the training to comprehend and acknowledge the importance of Danger Assessment and its effectiveness. The remaining participants did administer the Danger Assessment. The Danger Assessment was typically administered in person, but there were instances where it was conducted via Zoom at the parents' discretion.

Overall, the participants emphasized in the process of administering the Danger Assessment that each case is different, which made the session less of a questionnaire and more of a casual at ease conversation. Through the Danger Assessment, interviewees stated that they were able to ask questions they haven't previously asked. In one interview the participant explained,

“Since those questions can be sometimes sensitive, I try to time it out at the right time when to ask those questions during the initial session. I first introduce myself and kind of hear

their side of the story. That's when I will apply the assessment and that way, I will know the emotional climate. “

Another participant explained,

“It's different with each one. One of my clients, she was able to identify many times when she was dealing with DV. Yet in another question, she basically denied a lot of it when I started pointing out stuff. And that's even still going on even in continued therapy. She was told that she's not allowed to have contact with the ex, and they were still texting, and I was like, no. She's like but I didn't know that's what they meant by no contact. I was like, yeah, any kind of contact, text messages, phone calls, video chats, even if you're not physically in contact, it's still contact. So even after that's administered, even in therapy, later on, you're going to get more responses.”

Following, participants were asked:

About how long does it take you to administer the new Danger Assessment?

While covering this question, one participant explained due to their professional role they do not administer the Danger Assessment. Another participant explained the Danger Assessment is not administered because their concerns are more child(ren) focused. The remaining staff stated the time duration of the Danger Assessment typically depends on the client. On average the time duration of the Danger Assessment can range from five to sixty minutes. Participants elaborated that they were able to move quickly through the assessment with some of the clients, while others took longer. Administration varied too, with some participants preferring to incorporate the assessment questions throughout the session. In one interview the participant explained,

“It really depends on how much domestic violence there's been. Some of them, run through the questions and don't take hardly any time, maybe five or 10 minutes. Sometimes there's more information and or you're getting clarity, so it does take a little bit longer.”

After discussing the duration of administering the Danger Assessment, participants were asked:

What are the reactions of your clients when reviewing the Danger Assessment?

Two participants do not participate in reviewing the Danger Assessment. All other staff members participated in reviewing the Danger Assessment with clients. Participants emphasized being truthful and bringing awareness to the severity of domestic violence. Some of the participants described their clients as being surprised because they don't understand they are in danger or how dangerous the other individuals' behaviors are. Many of the clients pause and sometimes try to change their answers. Participants explained that the wording in the assessment is “harsh” on the clients' emotions as well as them. One staff stated,

“They don't like it, a lot of them are going to try to say no or deny it. So, some questions are really harsh. It's even hard for me to ask it sometimes. Yeah, so they don't like some of the wording. The wording is really harsh.”

Consistently Reviewing the Femicide Scale

In addition to asking participants about the consistency, process, length of time, and client reactions when administering the Danger Assessment, participants were asked:

When administering the Danger Assessment, have you also consistently reviewed the Femicide Scale with clients?

Similar to whether participants administered the Danger Assessment, two of the participants did not review the Femicide Scale based on their professional role in the organization. Another participant aside from those two was unfamiliar with the Femicide Scale. The remaining participants admitted they do consistently review the Femicide Scale with clients. More specifically, participants admitted,

“Yes but, that's a little gray area I don't know that well. I do the scale, originally, but I don't really do a lot of reviews with them. I'll talk to them and give them a lot of that clinical stuff and they shut down sometimes. So, yeah, it's not something that I really go into direct therapy, it's really just in the beginning, the first session or so.”

“Yes. It'll be more of a conversation because when you ask, especially with femicide, when you ask the questions, it's never a yes or no question. It's a question that the client will think about it. It's never checking out boxes.”

Safety in the Program

After discussing clients' reactions when reviewing the Danger Assessment, participants were asked:

Based on your perceptions, do your clients feel safer in this program with direct domestic violence support compared to clients in the past that may have faced domestic violent issues?

Addressing this question, all participants stated that they believed clients felt safer in this program with direct domestic violence support compared to the past. The staff expressed that participating in weekly routine check-ins makes a difference in educating clients. For example, one participant expressed,

“We really try to help them, and we can make change happen in the department. One of my clients right now, was a transferred case. And she just got reunified with her daughter, and she was almost to the point of TPR, termination of parental rights before we started working with her. So, she totally understands how important and useful this program is.”

Barriers to the Danger Assessment

After discussing participant's perceptions of clients feeling safer in this program than in the past, participants were asked:

What barriers or challenges have you faced when administering the new Danger Assessment?

When discussing this question, participants addressed it in a variety of ways. Only one participant was not able to answer this question because their professional position is more child(ren) focused. Participants stated that although they have been able to successfully get through the assessment, they worry clients may suffer from re-traumatization. Additionally, because some clients are involved with the dependency system, they are not comfortable sharing their reality. These clients will become defensive and deny accusations because they are not ready to share their experiences. Further, clinicians also suggested that some clients like to minimize certain behaviors because they are afraid that the assessment is going to count against them or their partner. One participant expressed,

“These cases that we have are in the Department of Children and Families records. So, they're very wary about what they're going to say, because they don't want to make their case, worse, and they try to downplay everything. It takes time. “

When discussing this question, participants felt certain barriers existed with the harshness of the questionnaire. As one staff member stated, “It's got a lot of alarming wording.” Participants understand that the questions in the Danger Assessment cannot be answered with a simple yes or no. The questions in the Danger Assessment are related to behaviors and need to be further explained. The participants also explained that sometimes there is a cultural difference when administering the assessment. Participants mentioned having to break the question down differently depending on the cultural and ethnic background of the client.

Participant's Ability to Work with Clients

After discussing barriers and challenges associated with the Danger Assessment, participants were asked:

Do you feel the new assessment has hindered your ability to work with your clients in any way? If yes, how so?

All of the participants in this interview except for one, agreed that the Danger Assessment does not hinder their ability to work with clients in any way. It should be noted that the cases are referred by the Department of Children and Families because there is some history of domestic violence and through this program, clinicians are able to provide a clinical assessment within legal systems for better understanding. The participants agreed the Danger Assessment is a useful tool to identify domestic violence cases because the assessment provides detail to gain greater insight into the client's situation and for the client to learn and understand what is happening. As one participant expressed “It's shedding some light to the survivor as far as them seeing exactly what's been happening and to the extent of how dangerous things can be for them!”

Identifying Domestic Violence

After discussing if the new Danger Assessment hinders participants from working with clients, the interviewees were asked:

If domestic violence is identified in your case, what are the next steps you take?

In responding to this question, all participants had a variety of methods when responding to domestic violence if identified in their cases. Additionally, methods varied depending on when domestic violence was reported or identified. Participants noted that in most cases when domestic violence is identified, the cases are received from a referral from a community partner (i.e., Department of Children and Families). After the referrals, typically a victim liaison reaches out to the family and explains the program and concern and assesses if they would like counseling or other forms of support.

However, new reports can also be made while working with clients in the system. At this point, one participant noted that responses would slightly vary based on whether the child is in the home or not. More specifically, they noted that if it is after a removal then an incident report would be created and the case managers would be notified and if the child is present, after the incident report is created, they'd contact their supervisor and law enforcement to determine if the child would need to be removed from the home.

Overall, responses were generally consistent, and participants mentioned that their overall goal is to ensure the client's safety. Doing this usually consists of determining the level of risk associated with the identification of domestic violence, constructing a safety plan, determining if clients have money and appropriate shelter, and providing therapy with a domestic violence component as well as any other necessary components depending on the clients' needs.

Addressing Clients Wellbeing

Following, participants were asked whether this new program addresses the client's well-being. Specifically, ISBS staff asked participants the following question:

Overall, do you think that this program addresses the client's well-being? If yes, how so? If not, why not? How could it be improved?

When addressing this question, all participants agreed that administering the Danger Assessment as part of the new program address client's well-being. Participants noted that although the training for the Danger Assessment is extremely necessary, it doesn't fully prepare you for the "what if" scenarios and at times participants have needed a translator.

Nonetheless, participants suggested that the new program provides clients with support they did not receive before. Moreover, they indicated that the program provides clients with a sense of well-being and it allows the client to know the level of danger in the home in addition to their child(ren)'s safety. Clients often feel responsible and at fault for the actions of their partner, but participants noted that the Danger Assessment helps clients understand what is happening and rid the emotions of self-blame. As one interviewee stated "This program helps them to see that, even though I made this decision you know I don't control the behavior of that parent. This program helps them understand it's not their fault." Further, participants explain,

"Yes, it's a good program, I think it definitely provides them with something that they did not have before. And we need to provide this better because we have so many cases where women are getting charged with stuff when you know they're just defending themselves half the time. And it's not well known. You think they would be very well known in the court

system, but it doesn't seem to be, and then they get their kids taken away for domestic violence when we should be working with them not taking their children.”

“Yes, the best outcome or the best idea that I'm getting from this program is the fact that we are talking to our clients straight to the point. Like this is what is happening, this is how it's gone, these are the resources you have, or this is what can happen...working with the tools and in the program, made a difference, which is different from when you just go there. We know domestic violence because we have the training and of course, we work with our clients and we work on safety, as well, but think it came from a completely different perspective. If I have to say anything to improve the program, I will think about connecting the program to more resources. You know like networking the program and letting them know there is a program here and there. We have the clinical part resolved. And then I have a client that's ready to move on to the next chapter but doesn't have the resources and have to go back to the abuser or has to stay with the abuser.”

Impact of the Danger Assessment

After discussing if the Danger Assessment addressed the client's well-being, participants were asked:

Overall, what impact do you think this program has on clients achieving permanency?

When addressing this question participants explained they were able to help clients relocate and ensure safety for themselves and their kids. Participants acknowledged they have helped clients develop healthier thinking patterns, process trauma, and be aware of harmful behaviors. Client independence was another notable aspect of the new program. One of the participants explained,

“I definitely feel like there is an ability to go forward and get them towards permanency and independence and to a safe place away from the domestic violence. I feel like this program is definitely built to help them succeed for sure because there are a lot of services that we have access to in order to make sure the survivor and their children are in the safest place possible and can maintain that as well without the help of the aggressor or without you know the dependence on the aggressor.”

The participants also mentioned that for some of their clients, this was their first-time achieving independence for themselves and their child(ren), suggesting that the new program provides more opportunities to support families and clinicians to better prepare for the future. This new program also provides case managers with more insight into helping clients.

Additional Comments

Lastly, participants were asked:

Is there anything else you would like to report on this new program?

Participants stated they would like to continue to implement the Danger Assessment as part of the new program, in addition to more ongoing dialog and conversation about how counselors are doing,

what they are learning, what is working, and what is not working. The participants also admitted that the Danger Assessment should be implemented in law enforcement due to the high number of domestic violence cases in Polk County.

Lastly, one participant also stated difficulties in sustaining the program given their limited funds as a non-profit. The participant notes that although they're a Medicaid provider none of their liaison services are billable through Medicaid, which results in a struggle with funding to sustain and build the program without additional revenue streams or resources.

Secondary Data Analysis

Presence of Domestic Violence and Intimate Partner Violence

This section highlights the presence of domestic violence and intimate partner violence in the Children’s Home Society (CHS) cases. Table 1 provides a breakdown of the presence of family violence, household violence, and intimate partner violence amongst all cases under CHS’s care prior to the implementation of the P4SF program (between 9/1/2021 and 9/1/2022). Following, Table 2 highlights all domestic violence-related maltreatment allegations for all cases admitted during this same one-year period (9/1/2021 and 9/1/2022).

Table 1. Total Domestic Violence Related Maltreatments Allegations for all Cases

	Family Violence	Household Violence	Intimate Partner Violence	Violence Totals
No Indicator	95 34%	98 16%	9 24.4%	202 21.2%
Some Indicator	15 4.4%	0 0%	0 0%	15 1.6%
Not Substantiated	107 38.4%	283 45%	16 43.2%	406 42.6%
Verified	62 22.2%	255 40%	12 32.4%	329 34.6%
Total	279 29.3%	636 66.8%	37 3.9%	952 100%

Of the data provided by CHS, there were a total of 5,980 maltreatment allegations for all cases under CHS’s care between 9/1/2021 and 9/1/2022. Out of the 5,980 maltreatment allegations, 952, or approximately 16% of all maltreatment allegations, were described as family violence, household violence, or intimate partner violence. Of the 952 maltreatment allegations, 279 (29.3%) were identified as family violence, 636 (66.8%) were described as household violence, and 37 (3.9%) were described as intimate partner violence (shown in Table 1).

While there were a total of 952 maltreatment allegations of family violence, household violence, or intimate partner violence, the largest percentage of maltreatment allegations were not substantiated. Overall, approximately 43% of the 952 maltreatment allegations were not substantiated (see Table 1). Specifically, 107, or 38.4%, of family violence maltreatment allegations were not substantiated, 45% of household violence maltreatment allegations were not substantiated, and 16, or 43.2%, of intimate partner violence maltreatment allegations were not substantiated.

Although the largest percentage of maltreatment allegations overall were not substantiated, Table 1 highlights that approximately one-third of maltreatment allegations, or 34.6%, were verified (n=329). When specifically exploring verified maltreatments by maltreatment type, 62 (22.2%) of those identified as family violence were verified, 255 (40%) of those identified as household violence were verified, and 12 (32.4%) of those identified as intimate partner violence were verified.

Table 2. Domestic Violence Related Maltreatment Allegations between 9/1/2021 – 9/1/2022

	Family Violence	Household Violence	Intimate Partner Violence	Violence Totals
No Indicator	0 0%	12 9%	4 50%	16 11.6%
Some Indicator	0 0%	0 0%	0 0%	0 0%
Not Substantiated	0 0%	51 40%	4 50%	55 40.2%
Verified	0 0%	66 51%	0 0%	66 48.2%
Total	0 0%	129 94%	8 6%	137 100%

Table 2 illustrates maltreatment allegations within the 12-month period prior to the implementation of the P4SF program (9/1/2021 – 9/1/2022) for cases admitted during this time. Overall, during this time frame, the data provided included a total of 1,016 maltreatment allegations. Of the 1,016 maltreatment allegations, there were 137 (13.5%) allegations identified as household violence or intimate partner violence. There were no allegations of family violence.

Further, out of the 137 total maltreatment allegations highlighted in Table 2, the largest percentage were verified (48.2%) and all of these verified maltreatments were identified as household violence (n=66). During this time frame, there were no verified intimate partner violence maltreatments.

Demographics

This section provides an overview of the demographic characteristics of parents and children in the P4SF program (shown in Table 3) as well as the demographic characteristics of parents and children in the selected comparison cases (shown in Table 4).

P4SF Program Cases

Table 3. Demographics: P4SF Program Cases

	Parent 1 (n=8)		Parent 2 (n=7)		Child (n =23)	
	n	%	n	%	n	%
Race						
White	6	75%	4	66.6%	19	86.4%
Black	1	12.5%	1	16.7%	1	4.5%
Asian	1	12.5%	1	16.7%	2	9.1%
Ethnicity						
Hispanic	2	25%	2	28.6%	10	43.5%
Sex						
Male	0	0%	7	100%	9	39%
Female	8	100%	0	0%	14	61%
Age (range)	24 - 52		26 - 53		1-18	
Education						
Elementary	-	-	-	-	9	53%
Middle School	-	-	-	-	3	18%
High School	-	-	-	-	5	29%
Employment Status						
Employed	4	67%	2	50%	-	-
Unemployed	2	33%	1	25%	-	-
Incarcerated	-	-	1	25%	-	-
Marital Status						
Married	3	43%	1	20%	-	-
Single	4	57%	4	80%	-	-

Note: Dashes (-) represent not applicable.

Table 3 highlights demographic information for all P4SF program cases in which demographic data was provided and available. Overall, there were data for 8 cases, which included 8 parents primarily working with CHS (parent 1), 7 secondary parents (parent 2), and 23 children. While those were the total number of parents and children, there was not demographic data available for each case.

Parent 1

More specifically, of the 8 parents identified as ‘parent 1’ in Table 3, 75% were identified as White, 12.5% were identified as Black (n=1), and 12.5% were identified as Asian (n=1). Further, 2 of the 8

total parents identified as Hispanic. The 2 parents who identified as Hispanic also identified as White.

Moreover, amongst parents described as ‘parent 1’, all were female with ages ranging from 24-52. Most were employed (67%), while 33% were unemployed (n=3). Additionally, most, or 57% of those whose marital status was able to be determined (n=7), identified as single, while 43% identified as married.

Parent 2

Table 3 also highlights all data available for parents identified as ‘parent 2’ by CHS (n=7). While there were a total of 7 parents who were identified as ‘parent 2’, there were only 6 parents that CHS was able to determine a racial identity for. Of those 6 parents, the majority identified as White (66.6%). Additionally, of those 6 parents, 2 identified as White and Hispanic.

While parents described as ‘parent 1’ were all female, those described as ‘parent 2’ were all male (n=7; 100%) with ages ranging from 26 to 53. Most parents in this category were employed (50%), while 25% were unemployed, and another 25% were listed as incarcerated. Lastly, most, or 80% of parents identified as ‘parent 2’ were single, while only 20% were married.

Children

The last set of demographic information provided for P4SF program cases was for all the children in each household (see Table 3). Overall, there were a total of 23 children identified within the program cases. Of the 23 children identified, data on racial identity was provided for 22. Of those 22 cases, a majority were White (86.4%), while 9.1% identified as Asian (n=2), and 4.5% identified as Black (n=1). Of the 23 children within the program, 10, or 43.5% identified as White and Hispanic.

Additionally, of the 23 children in the program, approximately 61% identified as male, while 39% identified as female with ages ranging from 1 to 18. Despite the wide range in age among children in the program, over 50% were in Elementary School, while 29% were in High School, and 18% were in Middle School.

Comparison Cases

Table 4. Demographics: Comparison Cases

	Parent 1 (n=14)		Parent 2 (n = 14)		Child (n=25)	
	n	%	n	%	n	%
Race						
White	10	71.4%	5	41.7%	15	60%
Black	4	28.6%	6	50%	9	36%
Biracial	-	-	1	8.3%	1	4%
Ethnicity						
Hispanic	1	7.1%	1	7.1%	2	8%
Sex						
Male	0	0%	14	100%	12	48%
Female	14	100%	0	0%	13	52%
Age (range)	23-43		23-47		2-17	
Education						
Elementary	-	-	-	-	9	69.2%
Middle School	-	-	-	-	3	23.1%
High School	-	-	-	-	1	7.7%
Employment Status						
Employed	3	50%	4	80%	-	-
Unemployed	3	50%	1	20%	-	-
Marital Status						
Married	1	9%	1	11%	-	-
Single	10	91%	8	89%	-	-

Note: Dashes (-) represent not applicable.

Next, Table 4 highlights demographic information for all identified comparison cases in which demographic data was provided and available. Overall, there was data for 14 cases, which included 14 parents primarily working with CHS, 14 secondary parents, and 25 children. While those were the total number of parents and children, there was not demographic data available for each case.

Parent 1

Of the 14 parents described as ‘parent 1’ in Table 4, 71.4% identified as White and 28.6% identified as Black (n=4). Further, of the 14 total parents in this category, when asked about ethnicity, 1 identified as Hispanic. For the 1 parent who identified as Hispanic, they identified their race as White.

Additionally, amongst parents identified as ‘parent 1’, 100% were female with ages ranging from 23-43. Moreover, of these 14 parents, employment data was only available for 6 cases. Of those 6 parents, about 50% were employed (n=3), while the other 50% were unemployed. Additionally,

most, or 91% of those whose marital status was able to be determined (n=11), identified as single, while only 1 was married.

Parent 2

Table 4 also highlights all data available for parents identified as ‘parent 2’ by CHS (n=14). While there were a total of 14 parents who were identified as ‘parent 2’, there were only 12 parents that CHS was able to determine a racial identity for. Of those 12 parents, the majority identified as Black (50%), while 41.7% identified as White, and 8.3% identified as biracial (n=1). Additionally, of the 14 parents in this group, 1 identified as White and Hispanic.

While parents described as ‘parent 1’ were all female, those described as ‘parent 2’ were all male with ages ranging from 23-47. Most parents in this category that data were available for (n=5) were employed (80%), while 20% were unemployed. Lastly, most, or 89% of, parents described as ‘parent 2’ who also had data on marital status available, were described as single, while only 11% were married.

Children

The last set of demographic information provided for the comparison cases was for all the children in each household (see Table 4). Overall, there were a total of 25 children identified within the comparison cases. Of the 25 children in the comparison cases, a majority were White (60%), while 36% identified as Black (n=9), and 4% identified as biracial (n=1). Of the 25 children within the program, 2, or 8% identified as White and Hispanic.

Additionally, of the 25 children in the comparison cases, approximately 52% identified as female, while 48% identified as male with ages ranging from 2 to 17. Despite the wide range in age among children in the program, approximately 70% were in Elementary School, 23% were in Middle School, and about 7.7% were in High School.

Comparison of P4SF Program Cases and Comparison Cases

This section of the report provides data for all P4SF program cases as well as selected comparison cases. Throughout this section, comparisons are made between P4SF cases that received clinical services and those that did not and between P4SF cases and comparison cases. More specifically, of the 8 total P4SF program cases, 4 were categorized as clinical cases with a determined treatment plan, while the other 4 were categorized as non-clinical with no treatment plan because clients chose not to engage with clinical services after the domestic violence assessments were administered.

First, Table 5 highlights data on the identification of domestic violence including variables for the new domestic violence assessments utilized by clinicians, as well as all verified maltreatments for each case at intake, the 6-month follow-up, and the 12-month follow-up. All verified maltreatments listed include maltreatments that were listed as family violence, household violence, and intimate partner violence. All verified maltreatments that were included at intake represent all verified maltreatments in the dataset provided per each case. All verified maltreatments included at the 6-month follow-up represent verified maltreatments between intake and the 6-month follow-up per each case and all verified maltreatments included at the 12-month follow-up represent verified maltreatments between the 6-month follow-up and the 12-month follow-up per case.

Next, Table 6 provides data on child removals and child permanency for both the P4SF program cases and comparison cases. Variables in Table 6 include whether the children were placed in-home (IH) or out-of-home (OOH) at intake, the 6-month follow-up, and the 12-month follow-up and whether the child was reunified with their parent(s) at the time of the 6-month and 12-month follow-ups.

Lastly, Tables 7-9 highlight data on child well-being outcomes for both the P4SF program cases and comparison cases. The child well-being outcomes that are included in the tables are as follows: emotional trauma, behavioral, physical health, developmental, educational, family relationships, peer/adult relationships, cultural identity, substance awareness, and life skills. These tables include both the mean score of each measured outcome as well as scores for each child.

Note: for confidentiality purposes cases have been de-identified.

Identification of Domestic Violence

Table 5. Identification of Domestic Violence					
	DA Score	HITS Score	Verified Maltreatments (Intake)	Verified Maltreatments (6mo)	Verified Maltreatments (12mo)
Clinical Cases					
<i>Average Scores</i>	9.75	20.5	1.5	0.0	0.0
Case 1	18	22	2	0	0
Case 2	12	19	1	0	0
Case 3	7	-	0	0	0
Case 3	-	-	0	0	0
Case 3	-	-	0	-	-
Case 3	-	-	0	0	0
Case 3	-	-	0	0	0
Case 4	2	-	1	0	0
Case 4	-	-	1	0	0
Case 4	-	-	1	0	0
Case 4	-	-	0	0	0
Non-Clinical Cases					
<i>Average Scores</i>	17.5	14.7	2.75	1.25	0.0
Case 5	14	10	0	0	0
Case 5	-	-	0	0	0
Case 6	18	16	2	0	0
Case 6	-	-	2	0	0
Case 6	-	-	1	0	0
Case 7	19	18	1	0	0
Case 8	19	-	1	1	0
Case 8	-	-	1	1	0
Case 8	-	-	1	1	0
Case 8	-	-	1	1	0
Case 8	-	-	1	1	0
Comparison Cases					
<i>Average Scores</i>	-	-	2.6	0.6	0.0
Case 1C	-	-	3	1	0
Case 1C	-	-	3	1	0

Case 1C	-	-	3	1	0
Case 1C	-	-	2	1	0
Case 1C	-	-	2	1	0
Case 2C	-	-	2	0	0
Case 2C	-	-	2	0	0
Case 2C	-	-	2	0	0
Case 2C	-	-	2	0	0
Case 2C	-	-	2	0	0
Case 3C	-	-	1	0	0
Case 4C	-	-	2	0	0
Case 5C	-	-	1	0	0
Case 6C	-	-	2	1	0
Case 6C	-	-	2	1	0
Case 7C	-	-	2	0	0
Case 8C	-	-	1	0	0
Case 8C	-	-	1	0	0
Case 9C	-	-	1	1	0
Case 10C	-	-	1	0	0
Case 11C	-	-	0	0	0
Case 12C	-	-	0	0	0
Case 12C	-	-	0	0	0
Case 13C	-	-	0	0	0
Case 14C	-	-	0	0	0

Notes: Dashes (-) represent missing or not applicable data points.

*Average score represents number of verified maltreatments by total number of cases

Danger Assessment and HITS

CHS provided data on the new assessments implemented to identify domestic violence within their child welfare cases. The assessments CHS provided data on include the Danger Assessment (DA) and HITS scores that were determined by CHS clinicians. Higher scores on the DA represent higher risk of being killed by a violent partner. Specifically, a score less than 8 represents variable danger, a score of 8-13 represents increased risk, a score of 14-17 represents severe danger, and a score of 18 and over represents extreme danger. A HITS score greater than 10 is considered positive for intimate partner violence in the relationship.

Table 5 highlights both the DA and HITS scores for all P4SF program cases as well as all verified maltreatments per each case for both the P4SF cases and comparison cases. Cases are divided between clinical P4SF program cases, non-clinical P4SF program cases, and comparison cases. Although Table 5 includes scores and the number of maltreatments for each child in each individual case, averages for the DA and HITS scores and for verified maltreatments are also included. The

P4SF program cases with the highest DA and HITS scores and comparison cases with the highest number of verified maltreatments were bolded and remain bolded throughout the remainder of the report to assess the relationship between higher DA and HITS scores and a higher number of verified maltreatments, and child removal, child permanency, and child well-being outcomes. More specifically, all HITS scores greater than 10 were bolded since all scores greater than 10 indicate the presence of intimate partner violence, and all DA scores above 8 were bolded since that indicates an increased risk of danger for being killed by a violence partner.

Overall, DA scores for P4SF program cases ranged from 2 to 19 and HITS scores ranged from 10 to 22. More specifically, the DA scores for clinical cases ranged from 2 to 18 with an average score of 9.75 and the DA scores for non-clinical cases ranged from 14 to 19 with an average score of 17.5. Alternatively, there were only 2 clinical cases in which the HITS assessment was administered, and they ranged from 19 to 22 with an average of 20.5. While the HITS assessment was only administered for 2 clinical cases, it was administered to 3 non-clinical cases ranging from 10 to 18 with an average of 14.7.

Verified Maltreatments

Table 5 also highlights the number of verified maltreatments (family violence, household violence, and/or intimate partner violence) at the time of intake, at the 6-month follow-up, and at the 12-month follow-up per each child in all P4SF and comparison cases. Verified maltreatments were also included in this table to compare whether higher DA and HITS scores were associated with verified domestic violence-related maltreatments. In addition to presenting the number of verified maltreatments per child per case, the average number of maltreatments per case were calculated for P4SF clinical cases, P4SF non-clinical cases, and comparison cases by calculating the total number of maltreatments divided by the total number of cases per category.

The number of verified maltreatments at intake for P4SF program clinical cases ranged between 0 and 3 and the number of verified maltreatments per child ranged between 0 and 2. Overall, the average number of verified maltreatments for the P4SF clinical cases at intake per case was 1.5. Comparatively, the average number of verified maltreatments at intake for the P4SF non-clinical cases was 2.75 with a range of 0 to 5 verified maltreatments per case and a range of 0 to 2 per child. Alternatively, the number of verified maltreatments at intake for comparison cases ranged between 0 and 13 per case and 0 to 3 per child with an average of 2.6 verified maltreatments per case.

At the 6-month follow-up, there were no verified maltreatment allegations for P4SF program clinical cases. During the same time period, the number of verified maltreatments in the P4SF non-clinical cases ranged between 0 to 1. More specifically, 1 P4SF program non-clinical case had 5 verified maltreatments with 1 verified maltreatment per each of the 5 children in the case. Comparatively, at the 6-month follow-up, the number of verified maltreatments amongst the comparison cases ranged between 0 and 5 with an average of 0.6. Of the 14 comparison cases, 3 cases had 1 verified maltreatment per each child totaling to 8 verified maltreatments overall.

Lastly, at the 12-month follow-up there were no verified maltreatment allegations for the P4SF clinical cases, non-clinical cases, and comparison cases.

Summary

Overall, Table 5 shows that P4SF program non-clinical cases had higher DA scores, while P4SF program clinical cases had higher HITS scores. At intake, the 6-month follow-up, and the 12-month follow-up, P4SF program non-clinical cases had a higher average number of verified domestic-violence maltreatments compared to P4SF program clinical cases and comparison cases.

Additionally, almost all cases with higher DA and HITS scores were also cases with verified domestic violence-related maltreatments at intake, suggesting that DV-related maltreatments are generally being identified and verified. However, there is one case that received a high score on both the DA (score of 14, representing severe danger) and HITS (score of 10, representing IPV in the relationship) and the two children had zero domestic violence-related maltreatment verified at intake, or at the 6 or 12-month follow-ups.

Child Removal and Child Permanency

Table 6. Child Removal and Child Permanency					
	IH/OOH (Intake)	IH/OOH (6mo)	IH/OOH (12mo)	Number of Removals	Reunification
Clinical Cases					
<i>Average Scores</i>	-	-	-	<i>1.1</i>	-
Case 1	OOH	IH	IH	2	Yes
Case 2	OOH	OOH	OOH	1	No
Case 3	OOH	OOH	OOH	1	No
Case 3	OOH	OOH	OOH	1	No
Case 3 ^a	OOH	-	-	1	-
Case 3	OOH	OOH	OOH	1	No
Case 3	OOH	OOH	OOH	1	No
Case 3	OOH	OOH	OOH	1	No
Case 4	OOH	OOH	IH	1	Yes
Case 4	OOH	OOH	IH	1	Yes
Case 4	OOH	OOH	IH	1	Yes
Case 4	OOH	OOH	IH	1	Yes
Non-Clinical Cases					
<i>Average Scores</i>	-	-	-	<i>1</i>	-
Case 5	IH	IH	IH	-	-
Case 5	IH	IH	IH	-	-
Case 6	OOH	OOH	IH	2	Yes
Case 6	OOH	OOH	IH	2	Yes
Case 6	OOH	OOH	IH	1	Yes
Case 7	OOH	IH	IH	1	Yes
Case 8	IH	IH	IH	-	-
Case 8	IH	IH	IH	-	-
Case 8	IH	IH	IH	-	-
Case 8	IH	OOH	OOH	2	No
Case 8	IH	OOH	OOH	2	No
Comparison Cases					
<i>Average Scores</i>	-	-	-	<i>1.1</i>	-

Case 1C	IH	IH	IH	-	-
Case 1C	IH	IH	IH	-	-
Case 1C	IH	IH	IH	-	-
Case 1C	IH	IH	IH	-	-
Case 1C	IH	IH	IH	-	-
Case 2C	OOH	IH	IH	1	Yes
Case 2C	OOH	IH	IH	1	Yes
Case 2C	OOH	IH	IH	1	Yes
Case 2C	OOH	IH	IH	1	Yes
Case 2C	OOH	IH	IH	1	Yes
Case 3C	IH	IH	IH	-	-
Case 4C	IH	IH	IH	-	-
Case 5C	OOH	IH	IH	1	Yes
Case 6C	IH	IH	IH	-	-
Case 6C	OOH	IH	IH	1	Yes
Case 7C	IH	IH	IH	-	-
Case 8C	OOH	IH	IH	1	Yes
Case 8C	OOH	IH	IH	1	Yes
Case 9C	OOH	IH	IH	2	Yes
Case 10C	OOH	IH	IH	1	Yes
Case 11C	IH	IH	IH	-	-
Case 12C	OOH	IH	IH	1	Yes
Case 12C	OOH	IH	IH	1	Yes
Case 13C	IH	IH	IH	--	-
Case 14C	OOH	OOH	OOH	1	No

Notes: Dashes (-) represent missing or not applicable data points.

^a this child turned 18 years of age and aged-out of care by the 6-month follow-up

Child Removal and Permanency

Table 6 highlights data related to child removals and child permanency amongst the 8 P4SF program cases and the 14 comparison cases. More specifically, Table 6 provides data on whether each child has an in-home (IH) or out-of-home (OOH) placement at intake, the 6-month follow-up, and the 12-month follow-up, the number of times the child was removed from the home, and if the child was reunified with their parent(s) at the time of the 12-month follow-up. All P4SF program cases with the highest DA and HITS scores, or identified domestic violence based on their DA and HITS scores are bolded. Similarly, comparison cases with the highest number of verified domestic violence-related maltreatments are bolded.

Of the 4 P4SF program clinical cases, which included 12 children, all children were OOH at intake. Alternatively, of the 4 P4SF program non-clinical cases, which included 11 children, 4 were OOH at intake, while 7 were IH. Moreover, there were 25 children within the 14 comparison cases and of those 25 children, 14 were OOH at the time of intake, while 11 were IH.

At the time of the 6-month follow-up, 1 child (8.3%) of the 12 children in the P4SF program clinical cases was reunified with their parent(s) and 1 turned 18-years-old and aged-out. Alternatively, among the P4SF program non-clinical cases, 1 of the 4 children (25%) was reunified with their parent(s) at the time of the 6-month follow-up and 2 other children were removed from their IH placement. Comparatively, at the time of the 6-month follow-up the 14 children in the comparison cases who were OOH at the time of intake, 13 (93%) were reunified with their parent(s).

Lastly, of the 10 children within the 4 P4SF clinical cases that remained OOH at 6 months, 4 were reunified with their parent(s) and 6 remained OOH at the time of the 12-month follow-up. Comparatively, of the 5 children in the 4 P4SF non-clinical cases who were OOH at 6 months, 3 were reunified with their parent(s) and 2 remained OOH. For the comparison cases, all but 1 of the 25 children in the 14 cases were IH at the time of the 12-month follow-up. More specifically, by 12-months, approximately 46% of the children in the P4SF clinical cases and 67% of the children in the P4SF non-clinical cases who were OOH were reunified with their parent(s) (53% of all P4SF program cases), whereas 93% of the children in the comparison cases who were OOH were reunified with their parent(s).

Altogether, the number of times each of the 12 children in the P4SF clinical cases were removed from the home ranged from 1-2 with an average of 1.1. Alternatively, the number of times each of the 11 children in the P4SF non-clinical cases was removed from the home ranged from 0-2 with an average of 1. Finally, amongst the 14 comparison cases, the number of times the 25 children were removed from the home ranged from 0-2 with an average of 1.1 removals per child.

Summary

Overall, there does not appear to be a relationship between DA and HITS scores or the number of verified domestic violence-related maltreatments and whether children were reunified with their parent(s) at the 12-month follow-up. Regardless of the DA and HITS scores a majority of the children in the P4SF program were removed from the home.

Additionally, there does not appear to be a relationship between P4SF program participation and reunification at the 12-month follow-up. More specifically, 9 out of 17 children (53%) in the P4SF program cases (clinical and non-clinical combined) were reunified with their parent(s) compared to 13 out of 14 children (93%) in the comparison cases at the 12-month follow-up. Similarly, a larger percentage of non-clinical P4SF cases (approximately 67%) were reunified with their parents at the 12-month follow-up compared to the clinical P4SF cases where about 46% of children were reunified with their parents after 12-months.

Child Well-Being Outcomes

Next, Tables 7-12 highlight all child well-being outcomes provided by CHS, which include ratings for the following categories: emotional trauma, behavioral, physical health, developmental, educational, family relationships, peer/adult relationships, cultural identity, substance awareness, and life skills. Scores ranged from 1 to 4, with 4 indicating more concern.

Table 7. Child Well-Being Outcomes: Emotional and Behavioral						
	Emotional (Intake)	Emotional (6mo)	Emotional (12mo)	Behavioral (Intake)	Behavioral (6mo)	Behavioral (12mo)
Clinical Cases						
<i>Average Scores</i>	2.6	2.7	2.7	2	2.2	2.2
Case 1	2	3	3	2	2	2
Case 2	3	-	3	2	-	2
Case 3	4	4	4	2	2	2
Case 3	4	4	4	3	4	4
Case 3	4	-	-	2	-	-
Case 3	4	4	4	2	2	2
Case 3	4	4	4	4	4	4
Case 3	4	4	4	4	4	4
Case 4	1	1	1	1	1	1
Case 4	1	1	1	1	1	1
Case 4	1	1	1	1	1	1
Case 4	1	1	1	1	1	1
Non-Clinical Cases						
<i>Average Scores</i>	2	2.1	1.4	1.5	1.5	1.5
Case 5	1	2	1	1	1	1
Case 5	2	3	1	1	1	1
Case 6	1	2	1	1	2	2
Case 6	1	2	1	1	2	2
Case 6	2	2	2	2	2	2
Case 7	1	1	1	1	1	1
Case 8	4	3	2	2	2	2
Case 8	4	3	2	2	2	2
Case 8	4	3	2	3	2	2
Case 8	1	1	1	1	1	1
Case 8	1	1	1	1	1	1

<i>P4SF Average Scores</i>	2.4	2.4	2.1	1.8	1.9	1.9
Comparison Cases						
<i>Average Scores</i>	1.9	1.93	2	1.5	1.8	1.6
Case 1C	3	-	-	1	-	-
Case 1C	3	-	-	1	-	-
Case 1C	3	-	-	1	-	-
Case 1C	3	-	-	1	-	-
Case 1C	3	-	-	2	-	-
Case 2C	-	3	3	-	2	2
Case 2C	-	3	3	-	2	2
Case 2C	-	3	3	-	2	2
Case 2C	1	1	1	1	1	1
Case 2C	1	1	1	1	1	1
Case 3C	2	-	-	2	-	-
Case 4C	1	-	-	1	-	-
Case 5C	1	1	1	1	1	1
Case 6C	2	2	-	2	2	-
Case 6C	2	3	-	2	2	-
Case 7C	1	1	1	1	1	1
Case 8C	2	2	2	2	2	2
Case 8C	2	2	2	2	2	2
Case 9C	2	-	-	2	-	-
Case 10C	3	3	3	3	3	3
Case 11C	1	-	1	2	-	1
Case 12C	1	2	-	1	2	-
Case 12C	3	3	-	1	2	-
Case 13C	1	-	-	-	-	-
Case 14 C	1	-	-	-	-	-

Notes: Dashes (-) represent missing or not applicable data points.

Tables 7 and 8 specifically highlight health-related child well-being outcomes, including the following ratings: emotional, behavioral, and physical health. Similar to the tables above the cases are split by clinical P4SF program cases, non-clinical P4SF program cases, and comparison cases. All P4SF program cases with the highest DA and HITS scores, or identified domestic violence

based on their DA and HITS scores are bolded. Similarly, comparison cases with the highest number of verified domestic violence-related maltreatments are bolded.

Emotional Rating

At intake, the emotional rating scores averaged 2.6 for the P4SF program clinical cases (range 1-4), 2 for the P4SF program non-clinical cases (range 1-4), and 1.9 for the comparison cases (range 1-3). At the 6-month follow-up, the emotional rating scores averaged 2.7 for the P4SF program clinical cases (range 1-4), 2.1 for the P4SF program non-clinical cases (range 1-4), and 1.95 for the comparison cases (range 1-3). Following, at 12-months, the emotional rating scores averaged 2.7 for the P4SF clinical cases (range of 1-4), whereas the average emotional rating scores for the P4SF non-clinical cases was 1.4 (range 1-2) and the average emotional ratings scores for the comparison cases was a 2 (range 1-3).

Behavioral Rating

Next, at intake, the behavioral rating scores averaged 2 for the P4SF program clinical cases (range 1-4), 1.5 for the P4SF program non-clinical cases (range 1-2), and 1.5 for the comparison cases (range 1-2). At the 6-month follow-up, the behavioral rating scores for the P4SF program clinical cases averaged to a 2.2 with a range of 1 to 4. Comparatively, at the 6-month follow-up the average for the P4SF program non-clinical cases was a 1.5 (range 1-2), and 1.8 for the comparison cases (range 1-3). Similar scores were reported at the 12-month follow-up with an average behavioral rating score for the P4SF clinical cases of 2.2 (range 1-4), 1.5 for the P4SF non-clinical cases (range 1-2), and 1.6 for the comparison cases (range 1-3).

Table 8. Child Well-Being Outcomes: Physical Health

	Physical (Intake)	Physical (6mo)	Physical (12mo)
Clinical Cases			
<i>Average Scores</i>	<i>2.4</i>	<i>2.4</i>	<i>2.5</i>
Case 1	2	2	3
Case 2	1	-	2
Case 3	4	4	4
Case 3	3	4	4
Case 3	3	-	-
Case 3	3	3	3
Case 3	4	4	4
Case 3	4	4	4
Case 4	1	1	1
Case 4	1	1	1
Case 4	1	1	1
Case 4	1	1	1
Non-Clinical Cases			

<i>Average Scores</i>	<i>1</i>	<i>1.3</i>	<i>1.3</i>
Case 5	1	1	1
Case 5	1	1	1
Case 6	1	2	2
Case 6	1	2	2
Case 6	1	2	2
Case 7	1	1	1
Case 8	1	1	1
Case 8	1	1	1
Case 8	1	1	1
Case 8	1	1	1
Case 8	1	1	1
<i>P4SF Average Scores</i>	<i>1.7</i>	<i>1.9</i>	<i>1.9</i>
Comparison Cases			
<i>Average Scores</i>	<i>1.3</i>	<i>1.5</i>	<i>1.6</i>
Case 1C	1	-	-
Case 1C	1	-	-
Case 1C	1	-	-
Case 1C	1	-	-
Case 1C	2	-	-
Case 2C	-	1	1
Case 2C	-	3	3
Case 2C	-	3	3
Case 2C	1	1	1
Case 2C	1	1	1
Case 3C	2	-	-
Case 4C	1	-	-
Case 5C	1	1	1
Case 6C	1	1	-
Case 6C	1	1	-
Case 7C	1	1	1
Case 8C	2	2	2
Case 8C	2	2	2

Case 9C	2	-	-
Case 10C	2	2	2
Case 11C	1	-	1
Case 12C	1	1	-
Case 12C	1	1	-
Case 13C	1	-	-
Case 14 C	2	-	-

Notes: Dashes (-) represent missing or not applicable data points.

Physical Health Rating

Lastly, Table 8 shows that at intake, the physical health rating scores averaged 2.4 for the P4SF program clinical cases (range 1-4), 1 for the P4SF program non-clinical cases (range 1), and 1.3 for the comparison cases (range 1-2). At the 6-month follow-up, the physical rating scores averaged 2.4 for the P4SF program clinical cases (range 1-4), 1.3 for the P4SF program non-clinical cases (range 1-2), and 1.5 for the comparison cases (range 1-3). At the 12-month follow up the average physical health rating scores averaged 2.5 for the P4SF clinical cases with a range of 1 to 4. Alternatively, the physical health rating scores for the P4SF non-clinical cases averaged to 1.3 (range 1-2) and the average of the physical health rating scores for the comparison cases was 1.6 (range 1-3).

Summary

Overall, clinical P4SF program cases had higher averages for emotional, behavioral, and physical health child-wellbeing outcomes when compared to both non-clinical P4SF program cases and comparison cases at intake, at the 6-month follow-up, and at the 12-month follow-up.

Moreover, the combined average scores for clinical and non-clinical P4SF program cases are also higher than comparison cases at intake, the 6-month follow-up, and the 12-month follow-up. Specifically, the emotional rating for P4SF cases at intake and at 6-months was 2.4 compared to a 1.9 for comparison cases. At 12-months, the average for all P4SF cases dropped to 2.1 compared to an average of 2 for comparison cases. Similarly, at intake the average behavioral rating for the P4SF cases was 1.8, which slightly increased to 1.9 at both the 6-month and 12-month follow-up. Comparatively, the average behavioral ratings for comparison cases at intake, the 6-month follow-up, and the 12-month follow-up were 1.5, 1.8, and 1.6 respectively. Lastly, the averages for physical health at intake for all P4SF cases was 1.7 at intake compared to 1.3 for the comparison cases. At the 6-month follow-up and the 12-month follow-up, the averages for P4SF cases were both 1.9 compared to 1.5 at the 6-month follow-up and 1.6 at the 12-month follow-up for the comparison cases.

However, despite the fact that averages for P4SF cases are higher, it is unclear if there is a relationship between DA and HITS scores or the number of verified domestic violence-related maltreatments and health outcomes as some of the clinical cases with the highest scores are missing DA and/or HITS scores and some of the cases with the lowest health scores have either higher DA and HITS scores or a higher number of maltreatments.

Table 9. Child Well-Being Outcomes: Family and Adult/Peer Relationships						
	Family (Intake)	Family (6mo)	Family (12mo)	Adult/Peer (Intake)	Adult/Peer (6mo)	Adult/Peer (12mo)
Clinical Cases						
<i>Average Scores</i>	2.5	2.7	2.6	2.2	2.5	2.2
Case 1	3	2	1	2	2	1
Case 2	1	-	2	1	-	2
Case 3	3	3	3	2	2	2
Case 3	3	3	3	2	4	4
Case 3	3	-	-	2	-	-
Case 3	2	3	3	2	3	3
Case 3	4	4	4	4	4	4
Case 3	4	3	3	4	4	4
Case 4	2	3	3	2	2	1
Case 4	1	1	1	1	1	1
Case 4	2	3	3	2	2	1
Case 4	2	3	3	2	2	1
Non-Clinical Cases						
<i>Average Scores</i>	1.5	1.9	1.3	1.3	1.6	1.6
Case 5	1	2	1	1	1	1
Case 5	1	2	1	1	1	1
Case 6	1	2	1	1	2	2
Case 6	1	2	1	1	2	2
Case 6	2	2	2	2	2	2
Case 7	1	2	1	1	2	2
Case 8	3	2	1	1	2	1
Case 8	2	3	2	2	2	2
Case 8	3	2	2	2	2	2
Case 8	1	1	1	1	1	1
Case 8	1	1	1	1	1	1
<i>P4SF Average Scores</i>	2.4	2.3	2	1.7	2.1	1.9
Comparison Cases						

<i>Average Scores</i>	<i>1.4</i>	<i>1.6</i>	<i>1.6</i>	<i>1.5</i>	<i>1.8</i>	<i>1.5</i>
Case 1C	1	-	-	1	-	-
Case 1C	1	-	-	1	-	-
Case 1C	1	-	-	1	-	-
Case 1C	1	-	-	1	-	-
Case 1C	1	-	-	1	-	-
Case 2C	-	2	2	-	-	-
Case 2C	-	2	2	-	-	-
Case 2C	-	2	2	-	-	-
Case 2C	1	1	1	1	-	-
Case 2C	1	1	1	1	-	-
Case 3C	-	-	-	2	-	-
Case 4C	-	-	-	1	-	-
Case 5C	1	1	1	1	1	1
Case 6C	1	1	-	2	2	-
Case 6C	1	1	-	2	2	-
Case 7C	1	1	1	1	1	1
Case 8C	2	2	2	2	2	2
Case 8C	2	2	2	2	2	2
Case 9C	2	-	-	2	-	-
Case 10C	3	3	3	2	2	2
Case 11C	1	-	1	1	-	1
Case 12C	2	2	-	2	2	-
Case 12C	2	2	-	2	2	-
Case 13C	-	-	-	1	-	-
Case 14 C	-	-	-	1	-	-

Notes: Dashes (-) represent missing or not applicable data points.

Tables 9 and 10 display the ratings for the following child well-being outcomes: family relationships, peer/adult relationships, and cultural identity. Similar to the tables above, the cases are split by clinical P4SF program cases, non-clinical P4SF program cases, and comparison cases. All P4SF program cases with the highest DA and HITS scores, or identified domestic violence based on their DA and HITS scores are bolded. Similarly, comparison cases with the highest number of verified domestic violence-related maltreatments are bolded.

Family Relationship Rating

At intake, the family relationship rating scores averaged 2.5 for the P4SF program clinical cases (range 1-4), 1.5 for the P4SF program non-clinical cases (range 1-3), and 1.4 for the comparison

cases (range 1-3). At the 6-month follow-up, the family relationship rating scores averaged 2.7 for the P4SF program clinical cases (range 1-4), 1.9 for the P4SF program non-clinical cases (range 1-3), and 1.6 for the comparison cases (range 1-3). Following, at the 12-month follow-up the family relationship rating scores slightly dropped for the P4SF cases with the average score for clinical cases declining to 2.6 (range 1-4) and the average score for the non-clinical cases declining to 1.3 (range 1-2). While the average scores for the P4SF cases dropped between the 6-month and 12-month follow-up, the average family relationship rating score for the comparison cases stayed the same at 1.6 (range 1-3).

Adult/Peer Relationship Rating

Next, at intake, the adult/peer relationship rating scores averaged 2.2 for the P4SF program clinical cases (range 1-4), 1.3 for the P4SF program non-clinical cases (range 1-2), and 1.5 for the comparison cases (range 1-3). At the 6-month follow-up, the adult/peer relationship rating scores averaged 2.5 for the P4SF program clinical cases (range 1-4), 1.6 for the P4SF program non-clinical cases (range 1-2), and 1.8 for the comparison cases (range 1-2). At the 12-month follow-up, the adult/peer relationship rating scores dropped to 2.2 for the P4SF clinical cases (range 1-4), remained at a 1.6 for the non-clinical P4SF program cases (range 1-2), and dropped to 1.5 for the comparison cases (range 1-2).

Table 10. Child Well-Being Outcomes: Cultural Identity			
	Cultural Identity (Intake)	Cultural Identity (6mo)	Cultural Identity (12mo)
Clinical Cases			
<i>Average Scores</i>	<i>1.9</i>	<i>1.9</i>	<i>1.9</i>
Case 1	2	1	1
Case 2	1	-	1
Case 3	2	2	2
Case 3	2	3	3
Case 3	2	-	-
Case 3	2	3	3
Case 3	4	4	4
Case 3	4	3	3
Case 4	1	1	1
Case 4	1	1	1
Case 4	1	1	1
Case 4	1	1	1
Non-Clinical Cases			
<i>Average Scores</i>	<i>1.7</i>	<i>1.5</i>	<i>1.5</i>
Case 5	1	2	2
Case 5	1	2	2

Case 6	4	2	2
Case 6	4	2	2
Case 6	2	2	2
Case 7	1	1	1
Case 8	1	1	1
Case 8	2	2	2
Case 8	1	1	1
Case 8	1	1	1
Case 8	1	1	1
<i>P4SF Average Scores</i>	<i>1.8</i>	<i>1.8</i>	<i>1.7</i>
Comparison Cases			
<i>Average Scores</i>	<i>1.4</i>	<i>1.4</i>	<i>1.5</i>
Case 1C	1	-	-
Case 1C	1	-	-
Case 1C	1	-	-
Case 1C	1	-	-
Case 1C	1	-	-
Case 2C	-	-	-
Case 2C	-	-	-
Case 2C	-	-	-
Case 2C	1	-	-
Case 2C	1	-	-
Case 3C	2	-	-
Case 4C	1	-	-
Case 5C	1	1	1
Case 6C	2	-	-
Case 6C	2	-	-
Case 7C	1	1	1
Case 8C	2	2	2
Case 8C	2	2	2
Case 9C	2	-	-
Case 10C	2	2	2
Case 11C	1	-	1

Case 12C	1	1	-
Case 12C	1	1	-
Case 13C	1	-	-
Case 14 C	2	-	-

Notes: Dashes (-) represent missing or not applicable data points.

Cultural Identity Rating

Finally, Table 10 highlights the cultural identity rating scores for the P4SF cases and comparison cases. At intake, the cultural identity rating scores averaged 1.9 for the P4SF program clinical cases (range 1-4), 1.7 for the P4SF program non-clinical cases (range 1-4), and 1.4 for the comparison cases (range 1-2). At the 6-month follow-up, the cultural identity rating scores averaged 1.9 for the P4SF program clinical cases (range 1-4), 1.5 for the P4SF program non-clinical cases (range 1-2), and 1.4 for the comparison cases (range 1-2). Lastly, at the 12-month follow-up the cultural identity rating scores averages remained the same for both the clinical and non-clinical P4SF cases, while the average slightly increased for the comparison cases to 1.5 (range 1-2).

Summary

In sum, clinical P4SF program cases had higher averages for all child well-being outcomes listed in Tables 9 and 10 when compared to non-clinical P4SF program and comparison cases. Further, when combined, P4SF case averages were all higher than the comparison cases as well. At intake, the average family relationship rating for P4SF cases was 2.4, compared to 1.4 among the comparison cases. Following, at the 6-month and 12-month follow-up, the average family relationship rating for all P4SF cases were 2.3 and 2, respectively, compared to 1.6 at both the 6-month and 12-month follow-ups for the comparison cases.

Similarly, the averages for adult/peer relationship ratings were higher amongst P4SF cases when compared to clinical cases. Specifically, at intake the adult/peer relationship rating was 1.7, compared to 1.5 for the comparison cases. Following, at 6-months, the adult/peer relationship rating for all P4SF cases was 2.1, while the average for the comparison cases was 1.8. At 12-months, while the averages for adult/peer relationship declined for both P4SF and comparison cases, the average was still higher for P4SF cases at 1.9 compared to 1.5 for the comparison cases.

Lastly, at intake, the 6-month follow-up, and the 12-month follow-up, cultural identity averages were higher for P4SF cases compared to the comparison cases. More specifically, at intake and the 6-month follow-up the average for P4SF cases was 1.8 compared to 1.4 for the comparison cases. At the 12-month follow-up, the cultural identity rating for the P4SF rating was 1.7, while the average for the comparison cases was 1.5.

Even though the averages for P4SF cases were consistently higher than the comparison cases, when assessing cases at an individual level there does not appear to be as clear of a relationship between cases with higher DA and HITS scores or a higher number of verified maltreatment allegations and child well-being outcomes. Further, there does not appear to be a pattern in whether scores improved between intake and the 12-month follow-up.

Table 11. Child Well-Being Outcomes: Developmental and Educational

	Dev. (Intake)	Dev. (6mo)	Dev. (12mo)	Educ. (Intake)	Educ. (6mo)	Educ. (12mo)
Clinical Cases						
<i>Average Scores</i>	<i>1</i>	<i>1</i>	<i>1</i>	<i>2.8</i>	<i>2.7</i>	<i>2.7</i>
Case 1	-	-	-	2	2	2
Case 2	-	-	-	-	-	2
Case 3	-	-	-	4	4	4
Case 3	-	-	-	3	4	4
Case 3	-	-	-	3	-	-
Case 3	-	-	-	3	3	3
Case 3	-	-	-	4	4	4
Case 3	-	-	-	4	3	3
Case 4	-	-	-	1	1	1
Case 4	1	1	1	-	-	-
Case 4	1	1	1	-	-	-
Case 4	-	-	-	1	1	1
Non-Clinical Cases						
<i>Average Scores</i>	<i>1.5</i>	<i>1.8</i>	<i>1.8</i>	<i>1.6</i>	<i>1.6</i>	<i>1.6</i>
Case 5	-	-	-	1	1	1
Case 5	-	-	-	1	1	1
Case 6	3	3	3	-	-	-
Case 6	1	3	3	-	-	-
Case 6	2	2	2	-	-	-
Case 7	1	1	1	-	-	-
Case 8	-	-	-	2	2	2
Case 8	-	-	-	2	2	2
Case 8	-	-	-	2	2	2
Case 8	1	1	1	-	-	-
Case 8	1	1	1	-	-	-
<i>P4SF Average Scores</i>	<i>1.3</i>	<i>1.6</i>	<i>1.6</i>	<i>2.4</i>	<i>2.3</i>	<i>2.3</i>
Comparison Cases						
<i>Average Scores</i>	<i>1.6</i>	<i>1.7</i>	<i>1.5</i>	<i>1.3</i>	<i>2</i>	<i>1.7</i>
Case 1C	2	-	-	1	-	-

Case 1C	2	-	-	1	-	-
Case 1C	2	-	-	1	-	-
Case 1C	2	-	-	1	-	-
Case 1C	2	-	-	1	-	-
Case 2C	-	-	-	-	1	1
Case 2C	-	-	-	-	2	2
Case 2C	-	-	-	-	-	-
Case 2C	1	-	-	-	-	-
Case 2C	1	-	-	-	-	-
Case 3C	2	-	-	-	-	-
Case 4C	1	-	-	-	-	-
Case 5C	1	1	1	-	-	-
Case 6C	2	2	-	-	-	-
Case 6C	2	2	-	-	-	-
Case 7C	1	1	1	-	-	-
Case 8C	2	2	2	-	-	-
Case 8C	2	2	2	-	-	-
Case 9C	2	-	-	-	-	-
Case 10C	-	-	-	2	2	2
Case 11C	1	-	-	-	-	-
Case 12C	-	-	-	-	-	-
Case 12C	-	-	-	2	3	-
Case 13C	1	-	-	-	-	-
Case 14 C	-	-	-	-	-	-

Notes: Dashes (-) represent missing or not applicable data points.

Lastly, Tables 11 and 12 display the ratings for the following child well-being outcomes: developmental, educational, substance awareness, and life skills. Similar to the tables above, the cases are split by clinical P4SF program cases, non-clinical P4SF program cases, and comparison cases. All P4SF program cases with the highest DA and HITS scores, or identified domestic violence based on their DA and HITS scores are bolded. Similarly, comparison cases with the highest number of verified domestic violence-related maltreatments are bolded.

Developmental Rating

For the clinical P4SF program cases, developmental ratings at intake, the 6-month follow-up, and the 12-month follow-up were only reported for 2 children (shown in Table 11). Clinicians assessed the developmental ratings for both children as 1 at all 3 points of time. Alternatively, the developmental ratings at intake averaged 1.5 (range 1-3) for the non-clinical P4SF program cases

(range 1-3), and 1.6 for the comparison cases (range 1-2). At the 6-month follow-up, developmental ratings averaged 1.8 for the non-clinical P4SF program cases (range 1-3) and 1.7 for the comparison cases (range 1-2). Lastly, at the 12-month follow-up developmental rating scores for the P4SF non-clinical cases remained the same as the 6-month follow up, while the average of developmental rating scores for the comparison cases slightly dropped between the 6-month and 12-month follow-up from 1.7 to 1.5 (range 1-2).

Educational Rating

Next, at intake, the educational ratings scores averaged 2.8 (range 1-4) for the clinical P4SF program cases (range 1-4), 1.6 for the non-clinical P4SF program cases (range 1-2), and 1.3 for the comparison cases (range 1-2). At the 6-month follow-up, the educational ratings averaged 2.7 for the clinical P4SF program cases (range 1-4), 1.6 for the non-clinical P4SF program cases (range 1-2), and 2 for the comparison cases (range 1-3). At the 12-month follow-up the averages of the educational rating scores remained the same for the clinical and non-clinical P4SF cases, while slightly declining for the comparison cases to 1.7.

Table 12. Child Well-Being Outcomes: Substance Awareness and Life Skills						
	Sub. Aware. (Intake)	Sub. Aware. (6mo)	Sub. Aware. (12mo)	Life Skills (Intake)	Life Skills (6mo)	Life Skills (12mo)
Clinical Cases						
<i>Average Scores</i>	2.3	2.3	2.3	3.5	3.75	3.75
Case 1	4	2	2	-	-	-
Case 2	1	-	2	-	-	-
Case 3	3	3	3	-	-	-
Case 3	3	3	3	3	3	3
Case 3	3	-	-	3	-	-
Case 3	2	3	3	-	4	4
Case 3	4	4	4	4	4	4
Case 3	4	4	4	4	4	4
Case 4	1	1	1	-	-	-
Case 4	1	1	1	-	-	-
Case 4	1	1	1	-	-	-
Case 4	1	1	1	-	-	-
Non-Clinical Cases						
<i>Average Scores</i>	2	1.7	1.7	-	-	-
Case 5	1	2	2	-	-	-
Case 5	1	2	2	-	-	-
Case 6	4	2	2	-	-	-

Case 6	4	2	2	-	-	-
Case 6	2	2	2	-	-	-
Case 7	1	1	1	-	-	-
Case 8	3	2	2	-	-	-
Case 8	2	2	2	-	-	-
Case 8	2	2	2	-	-	-
Case 8	1	1	1	-	-	-
Case 8	1	1	1	-	-	-
<i>P4SF Average Scores</i>	2.2	2	2	3.5	3.75	3.75
Comparison Cases						
<i>Average Scores</i>	<i>1.7</i>	<i>1.7</i>	<i>1.4</i>	<i>1</i>	-	-
Case 1C	1	-	-	1	-	-
Case 1C	1	-	-	1	-	-
Case 1C	1	-	-	1	-	-
Case 1C	1	-	-	1	-	-
Case 1C	2	-	-	1	-	-
Case 2C	-	1	1	-	-	-
Case 2C	-	1	1	-	-	-
Case 2C	-	1	1	-	-	-
Case 2C	1	1	1	-	-	-
Case 2C	1	1	1	-	-	-
Case 3C	2	-	-	-	-	-
Case 4C	1	-	-	-	-	-
Case 5C	1	1	1	-	-	-
Case 6C	2	2	-	-	-	-
Case 6C	2	3	-	-	-	-
Case 7C	1	1	1	-	-	-
Case 8C	2	2	2	-	-	-
Case 8C	2	2	2	-	-	-
Case 9C	2	-	-	-	-	-
Case 10C	3	3	3	-	-	-
Case 11C	1	-	1	-	-	-
Case 12C	2	2	-	-	-	-

Case 12C	3	3	-	-	-	-
Case 13C	1	-	-	-	-	-
Case 14 C	4	-	-	-	-	-

Notes: Dashes (-) represent missing or not applicable data points.

Substance Awareness Rating

Next, Table 12 highlights the ratings for substance awareness and life skills for the P4SF clinical and non-clinical cases as well as for the comparison cases. At intake, the 6-month follow-up, and the 12-month follow-up substance awareness ratings scores averaged 2.3 for the clinical P4SF program cases (range 1-4). While the average score for the clinical cases remained stagnant, the average score for the P4SF non-clinical cases slightly declined over time. More specifically, at intake the average of the substance awareness scores was 2 for the non-clinical P4SF program cases (range 1-4) and at both the 6-month and 12-month follow-ups it was 1.7 (range 1-2). Comparatively, for the comparison cases scores also declined overtime with the average of the substance awareness scores at intake and the 6-month equating to 1.7 (range 1-4) and declining to 1.4 at the 12-month follow-up (range 1-3).

Life Skills Rating

Finally, life skills ratings were only recorded for 4 children within 1 of the clinical P4SF program cases. The range of scores for these 4 children were between 3 and 4 at intake, the 6-month follow-up, and the 12-month follow-up. However, as the case has 6 children, 1 of the 4 children who received a rating at intake aged out (turned 18-years-old) and at the 6-month and 12-month follow-ups, 1 child became old enough to accurately provide the rating (turned 13-years-old). Because of these changes, the average changed slightly between intake and the 6-month and 12-month follow-ups as the ratings represent different children. More specifically, the average rating scores slightly increased from 3.5 at intake to 3.75 at the 6-month and 12-month follow-ups. Comparatively, there were no life skills ratings for children in the non-clinical P4SF program cases and only 5 children (all in 1 case) had a life skills rating of 1 assigned at intake.

Summary

Overall, aside from the developmental rating scores, which were only reported for 2 children in the clinical P4SF program cases, clinical P4SF program cases did have higher averages reported for educational ratings, substance awareness ratings, and life skills at intake, the 6-month follow-up, and the 12-month follow-up when compared to non-clinical P4SF program cases and comparison cases.

Similarly, aside from the average developmental ratings, in which the average for the P4SF cases was lower than the comparison cases, and the average of the life skill ratings, which were not reported for any non-clinical P4SF or comparison cases at 6-months or 12-months, P4SF cases overall had higher averages at all 3 points in time when compared to the comparison cases. More specifically, at intake the average educational rating for P4SF cases was 2.4 compared to 1.3 for the comparison cases. At the 6-month and 12-month follow-up the average of the educational rating scores was 2.3 for the P4SF cases compared to 2 and 1.7 for the comparison cases. The average substance awareness rating was also higher for P4SF cases compared to the comparison cases at intake, 6-months, and 12-months. At intake, the average score for the P4SF cases was 2.2, which declined to 2 at the 6-month and 12-month follow-up, while the average score for the comparison

cases at intake and the 6-month follow-up was 1.7, which later declined to 1.4 at the 12-month follow-up.

While it is evident that clinical P4SF program cases did report higher averages overall, these averages were calculated based on a very few number of children. Because of this, it is hard to determine if there is a relationship between these outcomes and case type, DA and HITS scores, or the number of verified domestic violence-related maltreatments.

Conclusion

In sum, the results of both the qualitative and quantitative data analysis illustrate the overall need for utilizing the DA and HITS to consistently identify DV as well as provide clinical treatment options to improve the outcomes for families in cases that are referred to CHS. The results of the analysis of the qualitative interview data highlight the clinicians' thoughts on administering the DA, including the importance of administering it and continuing to use it as well as barriers to administering it. More specifically, clinicians did emphasize the importance of utilizing the DA and continuing to use it, however some did indicate that continued support and open dialog were needed amongst the CHS team while implementing the new program including conversations about what is working, not working, and what counselors are learning. This is important because many did indicate that they faced barriers while implementing the assessment tool whether it be concern for re-traumatizing their client, cultural barriers, or the client minimizing their experiences.

Further, the results of the quantitative data analysis also highlight the need for utilizing the DA to consistently identify DV and be able to provide clinical case management services to victims. However, given the limited number of cases, it is difficult to concretely conclude whether there is a relationship between DA and HITS scores, the number of verified maltreatments, case type, and the health and well-being outcomes for children over time. Nonetheless, despite the limited number of cases, it was evident throughout the data that DV was present. Overall, a majority of P4SF cases included domestic violence related maltreatments that were verified and a majority of children in P4SF cases were removed from the home, with a majority of children in clinical P4SF cases remaining out of the home at the 12-month follow-up.

Further, the clinical P4SF cases had higher reported health and well-being scores overall when compared to the P4SF non-clinical and comparison cases. While the cause for this cannot be conclusively determined and given the higher DA and HITS scores present amongst the non-clinical cases, the higher reported health and well-being scores amongst P4SF clinical cases are noteworthy as it provides context and highlights the importance of clinical treatment to improve outcomes over time. Altogether, given the presence of DV throughout the majority of the identified P4SF and comparison cases, it is imperative to continue to refine the mechanisms utilized to identify DV within cases referred to CHS and to assess and refine the pathways made available for clinical case management.

Recommendation #1: Consistently administer assessments.

To accurately assess the likelihood of the DA and HITS assessment's ability to identify DV, it is imperative the DA and HITS assessments are consistently administered for all cases (clinical and non-clinical). Additionally, based on the results of the qualitative data, all case workers should be provided specialized training in administering these assessments both given the sensitive nature of the topics discussed in the assessments and to be able to clearly assess impacts of consistent utilization of the assessment tools.

Recommendation #2: Develop pathways to ensure all cases with DV present (or with an increased risk of DV identified on the DA and HITS assessments) pursue clinical case management.

While many of the women and children who experience DV are focused on survival, it is crucial all cases with DV identified are presented with multiple pathways to pursue clinical case management

and are continuously offered case-sensitive treatment plans and services over time. At minimum (and if possible), for all cases with DV present, case workers should attempt to maintain contact with the women and families over time to continuously be a source of support. From an evaluation standpoint, doing this would also allow a comparison between cases who receive clinical treatment and those that do not.

Recommendation #3: Consistently collect data over-time for all cases.

Ideally, to assess both the impacts of utilizing the DA and HITS assessments to identify DV as well as the impacts of clinical case management on overall outcomes, it's necessary to consistently collect data for all cases over time utilizing measures that will effectively measure program impact. This may involve hiring someone who is solely responsible for collecting data and following cases over time.

Recommendation #4: Utilize tested measures to examine health and well-being outcomes over time.

Given the variable nature of the health and well-being scores provided by case workers, to accurately evaluate the impacts of the program on the health and well-being of the children involved in the cases, tested survey measures could be utilized and consistently administered semi-annually to each child. This also could involve collecting parental data (survivor and perpetrator) to evaluate the impacts of the program on adult well-being (something we were unable to evaluate at this time).

Recommendation #5: Conduct a longitudinal evaluation with more cases to allow for an accurate assessment of program impacts.

Due to the nature of DV and the length of time it often takes to improve health and well-being outcomes for victims of DV, to accurately assess the impacts of a clinical program a multi-year study would be beneficial. Further, from an evaluation standpoint, to statistically understand the impacts of the new program, it would be beneficial to have more cases in which the assessment tools were utilized as well as more cases in which clinical case management plans were developed as a result of the new tools. Lastly, as a part of a longitudinal evaluation, it would be effective to utilize a comparison county that did not receive DV training and services across the same period of time.

Recommendation #6: Increase involvement of evaluators.

If the evaluation continues or if the program expands and needs further evaluation, we recommend the evaluators be more involved throughout the process of developing and expanding the program in multiple ways. First, we recommend the evaluators be involved during any trainings provided on administering the DA and HITS assessments. Additionally, the evaluators should work more closely with the case workers over time to both gain a better understanding of barriers and facilitators in administering the new assessments and pursuing/providing clinical treatment as well as to gain more context and understanding behind each case.

Appendix

Interview Questions for Clinical Team Members

1. (SKIP if we get this information prior to interview) What is your role in working with child removal cases?
2. (SKIP if we get this information prior to interview) How long have you been working as a clinical therapist?
3. (SKIP if we get this information prior to interview) How many of these new cases have you worked on since the program has been implemented?
4. Describe your involvement in each of the child removal cases.
5. Have you been able to consistently administer the Danger Assessment?
6. What is the process you take when administering the Danger Assessment?
7. When administering the Danger Assessment, have you also consistently reviewed the Femicide Scale with clients?
8. About how long does it take you to administer the new DV assessment?
9. What are the reactions of your clients when reviewing the Danger Assessment?
10. In your perception, do your clients feel safer in this program with direct domestic violence support compared to clients in the past that may have faced DV issues?
11. What barriers or challenges have you faced when administering the new DV assessment?
12. Do you feel the new assessment has hindered your ability to work with your clients in any way? If yes, how so?
13. Has the Danger Assessment allowed you to more accurately and/or consistently identify DV in your cases? If yes, how so?
14. If DV is identified in your case, what are the next steps you take?
15. Overall, do you think that this program addresses clients wellbeing? If yes, how so?
16. Overall, what impact do you think this program has on clients achieving permanency?
17. Is there anything else you would like to report on this new program?