Final Report

Environmental Scan of Family Justice Centers

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Executive Summary

On January 1, 2015, the National Institute of Justice (NIJ), with support from the Office on Violence Against Women (OVW), awarded a grant to Abt Associates Inc., in partnership with Alliance for HOPE International (hereafter referred to as the Alliance). Grant funds were used to conduct an environmental scan of current Family Justice Centers (FJCs) across the United States as part of a multi-phase effort to develop a formal evaluation plan to measure the effectiveness of FJCs and similar multi-agency co-located collaboratives. The goal of this project was to identify a complete picture of the national FJC landscape, the services FJCs provide, the communities they serve, and the infrastructure available to support evaluation efforts. The scan was designed to answer the following two questions, which will drive future evaluation efforts: (1) What do FJCs look like and how do they vary? and (2) Can they support formal evaluation efforts?

Introduction

Background

Although accurate prevalence estimates for both domestic violence (DV) and intimate partner violence (IPV) are difficult to ascertain given the well-known problem of victim underreporting, it is clear that both are a pervasive issue. IPV can have a devastating impact on survivors' physical and emotional well-being (e.g., Ellsberg, Jansen, Heise, Watts, & Garcia-Moreno, 2008), and the deleterious effects of IPV are extraordinarily expensive—one estimate suggests that the US loses $12.6 billion annually on medical and mental health care, which is in addition to productivity losses related to IPV (Waters, Hyder, & Rajkotia, 2004). In addition to underreporting their abuse, survivors of IPV underutilize formal support services, due to issues that include unavailable or inaccessible services, lack of culturally competent resources, and economic constraints (e.g., Gwinn & Strack, 2010). To address the problems of victim underreporting and access to services, from 1996-2000 the Centers for Disease Control and Prevention (CDC) funded a total of 10 Coordinated Community Response (CCRs) projects tasked with enhancing community response and service provision to survivors of IPV (Klevens, Baker, Shelley, & Ingram, 2008). CCRs aim to improve communication between different agencies responsible for responding to IPV survivors, both to provide a more effective response to the survivor and to prevent secondary victimization or victim-blaming (e.g., National Advisory Council on Violence Against Women, 2001; Shepard & Pence, 1999). Studies have found that CCRs promote greater coordination of activities, which allows programs to assist survivors more efficiently; more information sharing and survivor contact with IPV services; improvements in victim safety; and lower rates of offender recidivism (Robinson, 2006; Klevens, et al., 2008; Shepard, Falk & Elliott, 2002).

Family Justice Centers

The FJC movement, which began in the early 2000s with the opening of the San Diego FJC, is a strategy for communities to take collaboration a step above what CCRs have been able to achieve, by bringing together government and non-government service providers into one centralized location, providing multiple services for survivors of DV under one roof (Gwinn, Strack, Adams, Lovelace, & Norman, 2007). In 2004, the President's Family Justice Center Initiative (PFJCI) further institutionalized the movement by providing federal funding to support the implementation of FJCs in 15 communities across the country. The PFJCI attempted to expand on the CCR model by supporting the provision of all relevant services (medical, law enforcement, prosecution, social services, community based organizations, etc.) in one location, making it less burdensome on survivors who would otherwise have to travel from location

to location to access services. While the FJC model has been defined by certain principles like co-location, multi-agency involvement, use of a centralized intake processes, and a focus on survivor safety and confidentiality, there has been no attempt to establish a national model, leaving it up to communities to determine how best to apply these principles to serve survivors and their children in their communities.[1] Given the absence of a national model and the need for flexibility to allow communities to tailor application of the guiding principles to their needs, not all FJCs in operation today subscribe to the guiding principles established through the experiences of the earlier FJCs (Gwinn & Strack, 2010). As a result, it was important that this scan capture the range of programs operating across the country and collect sufficient information on the elements of each program to identify the different types of programs in operation and the extent to which certain elements of the model are present, if at all.

Capturing the breadth of programs is important given that preliminary evidence suggests that FJCs can have a positive effect on the number of DV-related homicides, victim safety, autonomy, empowerment for survivors and professionals, fear and anxiety for survivors and their children with the court system, peer support, witness recanting, and the number of survivors receiving services (Gwinn & Strack, 2006). Improved collaboration among multi-disciplinary agency partners, increased hope and resiliency, and high satisfaction levels among clients served have been documented in FJCs and other types of collaborative models (Giacomazzi, Hannah, & Bostaph, 2008; Hoyle and Palmer, 2014; Duke, Schleber, & Ruhland-Petty, 2015; Hellman & Gwinn, 2017). But what is lacking is support through rigorous evaluation to confirm both the impact of these programs and the relationship between specific program elements and outcomes. There have been only two multi-site evaluations (EMT Associates, 2013; Hellman & Gwinn, 2017). The research to date suggests positive results with respect to the number of clients served and service needs met, benefits of co-location and multi-agency services, and lack of barriers to access needed services (including immigration status, criminal history, and substance abuse and mental health issues), as well as promising results regarding FJCs' ability to better address offender accountability (e.g., EMT Associates, 2013), but it is clear that more systematic evaluation research is needed.

Methodology

Defining scope of the scan

In an effort to capture the variation in programs that fall under the FJC umbrella, while excluding other CCRs, the following four elements were used to define an FJC for the purposes of the scan: (1) co-located; (2) multi-agency; (3) multi-disciplinary; and (4) targeting provision of services to adult survivors of family violence. In other words, any program that involved *the co-location of multiple agencies representing different disciplines that have come together to provide services to adult survivors of family violence and their families* was included in the inventory. Other types of co-located models were not included. Using a limited set of criteria allowed us to be inclusive of the range of programs in operation and offered the flexibility to narrow our scope later, if necessary.

[1] In 2014, the Alliance created an affiliation process to promote best practices and the application of guiding principles to FJCs.

Identification of existing FJCs in the United States

A total of 87 FJCs were identified and included in the study. As described below, the study began with an inventory of 117 Centers, but 30 were excluded through investigations that occurred as part of study activities.

The identification of operational FJCs that met the above four criteria was initially generated using three primary sources: (1) a list of Centers known to the Alliance, (2) a list of recipients of federal funding from the OVW, and (3) an intensive on-line search for Centers that provide services to adult survivors of family violence. Using these three sources, 117 FJCs were identified. Seventy-six Centers were identified through the Alliance, 11 through the list of federal grantees, and 30 through on-line searches.

Instrumentation

Abt designed a survey to support the two primary research questions: (1) What do FJCs look like? and (2) Can they support formal evaluation efforts? Accordingly, the survey was designed to collect data from FJCs on (1) inputs and activities to measure variation across Centers and (2) the extent to which outputs were collected and maintained as part of an assessment of evaluability.

Data Collection

Instrument deployment

After a pre-test phase, the project team at Abt deployed the survey to the 117 FJCs either electronically to those with valid email addresses and/or by mailing hard copies to those with valid mailing addresses. Survey respondents were provided a small stipend to reimburse them for their participation.

Reminders and technical assistance

The project team made multiple rounds of follow-up to encourage participation and/or offer technical assistance in completing the survey. During the technical assistance phase, based on conversations with survey non-respondents, it was determined that 20 Centers should be removed from the study because they did not actually meet the study criteria, were duplicates, or still in the development stage at the time of the scan.

Data cleaning and follow-up

After reviewing survey responses to check for completeness and to see if any follow-up was necessary, Abt contacted survey respondents, as needed, for clarification on information provided. The study team also contacted respondents that reported operating as part of an FJC/Child Advocacy Center (CAC) collaborative and those that reported operating satellite facilities to learn more about the relationship between the FJC and CAC, and between primary sites and their satellites regarding how staff are allocated, how clients are served, and how the primary and satellite sites interact. Based on the findings from the follow-up, revisions were made to both the overall dataset (10 additional Centers were removed from the data because it was determined that they did not meet the inclusion criteria) and to add context to specific responses (e.g., the number of FJCs/CACs and Centers with satellite locations).

Number of respondents

Of the final set of 87 Centers included in the study, Abt received survey responses from 52.

Data limitations

Low response rate

The response rate of 60 percent was lower than the anticipated rate of 75 percent. Given the low response rate, findings may not be generalizable to centers nationwide because we cannot predict responses for the FJCs that did not respond to the scan.

Response bias

The analyses presented throughout this report are dependent on self-reported data. Given the stated objectives of the scan, responses may be biased toward FJCs that are more established; more likely to adhere to best practices promoted through the PFJCI and, more recently, the Alliance; and/or more likely to be interested in participating in an evaluation. There may also be Centers that fit the criteria but do not identify themselves as a FJC or multi-agency center and therefore did not respond to the scan.

Facility Characteristics[2]

One of the objectives of the scan was to identify similarities and differences among FJCs. Respondents were asked to provide information in six areas of interest: operational status, program governance and structure, funding, geographic location, client population, and service provision.

Operational status

- *Implementation status.* Eighty-eight percent of respondents indicated that their Center is "fully operational," meaning the center is open, operating, and serving clients as intended.
- *Years in operation.* While the implementation of CCRs dates back to the 1990s, the FJC movement did not become prevalent until the early 2000s. As expected, all but one of the responding Centers became/planned to become fully operational after 2001. The average time in operation (at the time of the scan) was approximately six years.
- *Coordinated FJC/CAC model.* Fourteen respondents indicated that their Center is part of a coordinated FJC/CAC model.
- *Employees and volunteers*. Among the small number of respondents who answered the question, the average number of full-time staff assigned to the Center was 25 and the average number of part-time staff was 11. Of those Centers who provided the number of volunteers at the *primary* Center, the average number of volunteers was nine.

Naming convention and program governance

- *Naming conventions.* Seventy-seven percent of respondents use the term "Family Justice Center" in their name. The majority of the other respondents have the word "family" in their name.
- *Governance structure*. Centers were most commonly led by an existing city or county department (44%) or an existing non-profit 501(c)3 organization (31%); about a third were overseen by a nonprofit board of directors (33%), followed by a city/county department head only (26%).
- *Guiding principles and policies*. Eighty-one percent of respondents indicated that their Center has (or subscribes to) guiding principles, all of the respondents have a mission statement, and nearly all have confidentiality agreements (96%), partnership agreements and intake procedures (94% each).

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[2] Percentages presented in the next two sections reflect the percentage of respondents who answered a survey item and exclude missing responses.

- *Centralization*. Most of the respondents (87%) reported that their Centers are centralized at a single location, but six respondents indicated that they have satellite locations, with an average of three satellites.
- *Partner agencies*. Forty percent of respondents indicated that their Center maintains between six and 10 partner agencies. Nearly all Centers partner with a victim service agency (94%), and the majority have a partnering community based organization (85%), criminal justice agency (85%), local or state government agency (75%), and/or civil legal services agency (67%).

Funding status

- *Annual budget.* Centers' most recent annual operating budget was an average of approximately $635,000 (n=49); 69 percent indicated that their Center met the operating budget the previous fiscal year.
- *Primary sources of funding.* The most common sources of funding for the responding Centers were public funding (63%), federal grants (57%), and donations/fundraising (53%). The most commonly received federal grant was "Grants to Encourage Arrest and Enforce Protection Orders Improvement" (75% of Centers reported receiving federal grants).

Geographic location

- *Geographic spread of respondents.* Thirty-nine percent of responding Centers were located in the West, as determined by project staff from the Centers' mailing address. An additional 37 percent were located in the South and 20 percent in the Northeast. Only six percent were located in the Midwest.
- *Location type.* The majority (82%) of respondents indicated that their Centers were located in urban areas.

Client population

- *Total number of clients.* Nineteen percent of respondents providing information on clients reported that they served between 76 and 150 clients in the month prior to survey administration, while 16 percent reported serving between one and 75 clients and another 16 percent reported serving over 600 clients. The average number of clients served was 329. The average number of *new* clients was 125 and the average number of *returning* clients was 275.
- *Demographics of clients served.* Clients served in the last year were most commonly white (45%), female (84%), and between the ages of 30 and 50 (51%). On average, 25 percent of the clients served were identified as Hispanic.

Service provision

- *Types of services provided.* The most commonly reported types of services provided by respondents were advocacy, legal assistance, safety planning, and transportation; all of the Centers that responded to the question provided these services in some capacity.
- *On-site services.* The most common services provided on-site were safety planning and advocacy (both 100%).
- *Satellite services.* The most common services provided at a satellite location, as reported by respondents, were advocacy, food assistance, counseling for adults, sexual assault services, and emergency housing (50% of Centers reported providing each of these services).

- *Off-site services.* The most common service provided off-site was sexual assault forensic exams, followed by community outreach and education, and child protective services/child welfare services (39%, 34%, and 32%, respectively).
- *Referrals.* The most common referrals were for substance abuse services (77%), followed by medical services and probation/parole services (68% each).
- *Types of violence targeted for services.* The most common types of violence currently being targeted for services among respondents included domestic violence (92%), teen dating violence (71%), elder abuse (65%), and adult sexual assault (63%).
- *Types of special populations targeted for services.* Just over half of respondents indicated that their Centers target services to special populations. The most commonly identified special population was non-English speakers (92%).

Evaluability Assessment

In addition to describing Centers currently operating across the nation, we sought to understand their potential for future evaluation. We also asked about support the Center may need to participate in a formal evaluation. Centers were surveyed across five broad categories of interest: intake procedures, collection of client-level data, collection of data on services received, storage and retention of collected data, and willingness to participate in evaluation activities.

Collection of client-level data

To assess evaluation potential, Centers were surveyed about their capacity to collect and provide client-level data. Of primary interest was an understanding of client intake procedures and data collection practices. Assessing intake procedures allowed us to compare how similar the first point of engagement with clients is across Centers, and how useful intake policies and information may be in potential evaluations.

- *Centralized intake and use of intake forms.* Eighty-seven percent of respondents reported using a centralized intake procedure, suggesting the availability of individual-level data. An even larger majority (94%) use an intake form to collect client-level data. All of the Centers with centralized intake use an intake form.
- *Types of client-level data collected.* The most commonly collected data (75% of respondents or greater) includes visit dates, client demographic information, number/age of children, reason for visit, and information on the perpetrator.
- *Client-level data storage.* In almost every case, Centers stored client information collected at intake electronically.
- *Client-level data linkages.* Eighty-six percent of responding Centers link their electronic data to clients by name; 53 percent use a unique identifier.

It is clear that most Centers maintain sufficiently rich, and comparable, sources of client data at intake. These responses suggest that future evaluators are likely to be able to collect robust data about intakes from participating Centers.

Collection of data on services received

Centers were surveyed about client anonymity, the types of service data collected, how this information is stored, and the length of time these data are available.

- *Client anonymity and data collection.* Sixty-four percent of responding Centers allow clients to opt out of providing personal information at intake, and 64 percent allow clients providing information to opt out of having their information entered into a database. Eleven Centers indicated that they may limit or refuse services if clients opt out of providing intake information (although 10 of the 11 said they only sometimes limit or refuse services). Some services offered by the FJCs, particularly law enforcement investigation and prosecution-related services, are likely to require initial information disclosure before they can be offered.
- *Collection of service data.* The majority (84%) of responding Centers electronically track services requested by clients, and even more (92%) reported tracking services received at the Center. Centers reported that most of the service data may be reported at both the de-identified individual and aggregate levels.
- *Types of client service data collected.* Eighty-seven percent of responding Centers track services received, most of which do so via case management/intake-related systems. Over half also collect data on services partially received. Over two-thirds collect data on satisfaction with services, primarily collected via exit surveys. A majority of responding Centers also reported an ability to provide data on measures such as number of clients seeking and receiving services (93% each), broken down by new (90%) and returning (81%) clients; sources referring clients (76%); services sought by client (81%); reasons for seeking services (63%); and services received on-site (93%). Smaller percentages of Centers track services received at a satellite (20%), offsite (17%), or based on referral (20%); and services not received (39%) and reason services were not received (27%). Seventy-nine percent of responding Centers perform some degree of client follow-up, mostly occurring at client exit. Most Centers (98%) use the data collected, most frequently for internal analysis/staff feedback (95%), improving service delivery (93%), and funding justifications (98%).
- *Storage of client-level data.* Of the 37 Centers who responded to this question, all but four maintain electronic records from their databases for over a year. However, all four Centers with less than one year of data had only recently begun operations at the time of the survey. Centers had data available on average for approximately four years, and nearly three quarters reported that they do not purge their data at specific intervals.
- *Evaluation willingness.* About 80 percent of responding Centers expressed willingness to participate in a formal evaluation. Roughly two-thirds of respondents reported that they would need funding (average of $15,000) or staff support (average of 30 hours/week) to participate. About a third of Centers indicated that they had some involvement in a current or prior evaluation; 80 percent of the Centers involved in evaluations to date were involved in process evaluations.

Proposed Research Designs For National Evaluation

While the results of the scan are not reflective of all FJCs in operation across the US, the findings suggest that there are variations in center structure and operation that should be explored as part of evaluation efforts. The findings also suggest the availability of data and interest among FJCs in evaluation. Presented below are recommendations regarding how FJCs might be evaluated.

Design for cross-site evaluation of FJCs

The critical goals of FJCs are to increase safety for survivors of DV through collaboration and coordination that increases access to and utilization of a range of services. The co-location of services into one center is intended to offer and encourage utilization of a range of needed services, minimize travel to multiple agencies, reduce the number of times a client has to repeat her story, shorten case processing

time, and generally improve the efficiency and capacity of service providers and reduce victimization in an area. The basic questions for an evaluation of FJCs are whether the program works as intended and whether the effect of the Centers programming can be isolated from other factors that may produce those effects. To answer these questions an evaluation would examine two aspects of the Centers' programs—did the program get implemented as planned and with fidelity, and did it make a difference in the outcomes at the client and service levels?

- *Measuring processes and impacts.* The basic research questions for a multi-site evaluation can be divided into questions regarding ***program processes*** and questions regarding ***outcomes or impacts***. Answers to the first set of questions on how a program was implemented are critical for understanding how the program achieved the answers to the second set of questions. The purpose of describing program processes is to understand how they operate and any issues with how they execute their models, as well as to gather data on what individual program-level characteristics are potential predictors of client level outcomes. This part of the evaluation would also include monitoring program implementation by collecting data on program outputs such as number of MOUs signed, service providers trained, and services provided. Given the variation observed in the scan, an important question for the larger evaluation is whether there are significant differences in outcomes related to program characteristics such as increasing victim safety, access to services, and institutional response to domestic violence.

We offer two possible designs for looking at Center outcomes and impacts:

- *Examining comparative effectiveness.* This analysis strategy assumes that some version of Center programming will be useful (i.e., there is no "no programming" option in the analysis) and examines which variation in the services, operations (e.g., centralized intake), and activities of the centers are likely to produce different outcomes on the client and systems level. The first questions to address are comparisons within the samples of programs in comparison to each other. These outcome questions include, for example, which combination of FJC components or services is the most effective in producing client and system level outcomes, among others. These types of questions can address the differential effects of programming on outcomes, but not the question of whether the presence of the programming itself in any form had the desired effect. Those questions are answered only by introducing a non-program comparison or a counterfactual.
- *Determining the impact of programming compared to the absence of programming.* This evaluation design focuses on answering the difficult question of whether the program effected change or if any changes observed were the result of historical trends or occurred by chance (i.e., what would have happened doing nothing at all). Impact questions include, among others, whether the presence of a FJC significantly increases the number of survivors served in relevant agencies. In terms of sampling, we suggest an approach often used in observational studies in which the programs are self or government selected. This approach identifies an area similar to the program service area and uses data over time on that area as a comparison—but not a control. This technique is called a difference in differences (DiD) approach.

Conclusions

The guiding principles for FJCs established in 2004 through the PFJCI–-including multi-agency collaboration and service co-location—continue to be promoted by the Initiative's federal training and technical assistance provider, the Alliance, but there has been no effort to establish a national FJC model.

As a result, while FJCs may share the core principles of co-location to provide services to adult survivors of family violence, there is likely to be variation in how other principles have been applied across the country. And while there has been some movement over the past few years to establish criteria to set standards for FJCs, achieving the study goal of documenting the similarities and differences in structure and programming across operational FJCs required that the scan was designed to be broad enough to be inclusive of centers that call themselves FJCs as well as similar multi-agency co-located collaboratives.

Through the data collection and follow-up process, combined with preliminary analysis of the respondent data, the study team reduced the number of operational Centers to 87. While we are fairly confident that this is an accurate reflection of the number of FJCs that were in operation in 2016, we were not able to confirm that 29 percent of the Centers met the criteria established for the study because they did not participate in the scan—the total number of eligible respondents was 52.

We found it encouraging that among the 52 Centers that participated in the scan (and that met the inclusion criteria), a high proportion of Centers participating in the scan are actively collecting and maintaining data, which would make the task of data collection for an evaluation far less burdensome. And the vast majority of respondents collecting information expressed a willingness to share their data, and an interest in participating in an evaluation. We also identified programmatic differences (e.g., absence of criminal justice partners, lack of centralized intake) that would be important to explore through evaluation.

The variation found in the environmental scan provides both a challenge and an opportunity for the next phase, a full evaluation. Since there is no national model of what definitively constitutes a FJC, the collection of data across Centers on the different services, staffing, partner agencies, etc. they employ to reach the common goal of victim safety is critically important to learning what works, how it works and for whom so that resources can be targeted as effectively as possible. This means that a full evaluation needs to include data to assess implementation, processes and outcomes across all Centers included in the study.

1. Introduction

On January 1, 2015, Abt Associates Inc., in partnership with Alliance for HOPE International (hereafter referred to as the Alliance), was awarded federal funding from the National Institute of Justice (NIJ) and the Office on Violence Against Women (OVW) to conduct an environmental scan of current Family Justice Centers (FJCs) across the United States as part of a multi-phase effort to develop a formal evaluation plan to measure the effectiveness of FJCs. The goal of this project was to generate a comprehensive understanding of the national landscape of FJCs, the services the Centers are providing, the communities they serve, and the infrastructure available to support evaluation efforts. The scan was designed to answer the following two research questions, which will drive future evaluation efforts: (1) What do FJCs look like and how do they vary? and (2) Can they support formal evaluation efforts?

The report is organized into six chapters and includes seven appendices:

- Chapter 1 discusses prevalence and effects of domestic violence, provides an overview of Coordinated Community Responses (CCRs), and introduces the FJC model and the influence of the President's Family Justice Center Initiative (PFJCI) on the FJC movement
- Chapter 2 describes the scope of the scan, the process used to identify FJCs included in the scan, and the design and administration of the scan
- Chapters 3 and 4 present information on Centers that participated in the scan:
  - Chapter 3 presents results on characteristics of the Centers
  - Chapter 4 presents results from questions designed to assess evaluability of the Centers
- Chapter 5 presents recommendations for future evaluation efforts to measure the effectiveness of FJCs
- Chapter 6 presents our conclusions and recommendations
- Appendices
  - Appendix A: List of Centers
  - Appendix B: Information on Non-respondents
  - Appendix C: Consent Language for Scan Instrument
  - Appendix D: Scan Instrument
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  - Appendix G: Reference List

1.1 Background

Accurate prevalence estimates for both domestic violence (DV)[3] and intimate partner violence (IPV) are difficult to ascertain given the well-known issue of victim underreporting, both in self reports (surveys)

[3] It is important to note that there are several different definitions of "domestic violence," some of which include or exclude specific victim relationship types. For the purposes of this report, the term "domestic violence" reflects the broader application of the term, unless specified.

and official reports (law enforcement) (e.g., Felson, Messner, Hoskin, & Deane, 2002). Even so, data from both types of sources make it clear that these forms of violence are pervasive. For example, according to the Centers for Disease Control and Prevention's (CDC) National Intimate Partner and Sexual Violence Survey, more than 35 percent of women and more than 28 percent of men in the US report having experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime, and about 1 in 4 women and 1 in 7 men have experienced *severe* physical violence (e.g., hit with fist or something hard) by an intimate partner in their lifetime (Black, Basile, Breiding, Smith, Walters, Merrick, Chen, & Stevens, 2011).[4] Data from the Bureau of Justice Statistics' National Crime Victimization Survey suggest that DV accounted for 21 percent of all violent crime between 2003-2012 (Truman & Morgan, 2014).[5] Violence perpetrated by intimate partners (current or former spouses, boyfriends, or girlfriends) accounted for 15 percent of all violent victimizations during that time period. Uniform Crime Report statistics compiled by the Federal Bureau of Investigation (FBI) indicate that in 2014, intimate partner homicides accounted for 10 percent of all homicides (Federal Bureau of Investigation [FBI], 2015).[6] Finally, data collected through the FBI's National Incident-Based Reporting System, a system in which agencies collect data on individual crime occurrences, found that of all the crimes against persons in 2013, the victim was a family member of the offender nearly a quarter of the time (FBI, 2014).[7]

A growing body of research points to evidence that survivors' experiences can have devastating implications for survivors' physical and emotional well-being. Individuals who experience IPV are often physically injured during the violent encounters and are more likely than those who are not exposed to IPV to have other health problems such as chronic pain and high blood pressure (e.g., Ellsberg, Jansen, Heise, Watts, & Garcia-Moreno, 2008; Vos, Astbury, Piers, Magnus, Heenan, & Stanley, 2006). They are also at greater risk for mental health issues such as depression and anxiety, substance abuse and dependence, and suicidal thoughts (Ellsberg et al., 2008; Howard, Feder, & Agnew-Davies, 2013). Moreover, exposure to DV has been shown to affect survivors' daily functioning at work, school, or social events (Helfrich, Fujiura, & Rutkowski-Kmitta, 2008).

Children are also deeply impacted by witnessing DV. Researchers estimate that between three and 10 million children witness DV each year in the US, and many children suffer profound impacts from this exposure (Karr-Morse & Wiley, 2012). The Adverse Childhood Experiences (ACE) Study has documented lifelong consequences from multiple types of co-occurring childhood trauma, including children growing up in homes with IPV (Anda, Brown, Dube, Felitti, & Giles, 2008).

In addition to the human costs, the deleterious effects of DV are extraordinarily expensive. One estimate of the economic impact suggests that IPV-related injuries (e.g., medical care for injuries, mental health care, productivity losses) cost the US 12.6 billion dollars annually (Waters, Hyder, & Rajkotia, 2004).

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4 The CDC's definition of intimate partner violence includes current or former spouses (including married spouses, common-law spouses, civil union spouses, and domestic partners), boyfriends/girlfriends, dating partners, and ongoing sexual partners.

5 The National Crime Victimization Survey definition of domestic violence includes offenses committed by intimate partners (current or former spouses, boyfriends, or girlfriends), immediate family members (parents, children, or siblings), and other relatives.

6 This figure includes homicides committed by husbands and wives (including both common-law and ex-spouses), boyfriends, and girlfriends. Homosexual relationships are excluded from "intimate partner" statistics because they are included under "acquaintance" along with other individuals known to the victim.

7 Family member includes spouse, common-law spouse, parent, sibling, child, grandparent, grandchild, in-law, stepparent, stepchild, as well as other family members.

The CDC also conducted a study to obtain national estimates of the occurrence of IPV-related injuries and estimate their costs to the health care system. Using data from the National Violence Against Women Survey, the CDC found that an estimated 5.3 million IPV victimizations occur among US women ages 18 and older each year (Gerberding, Binder, Hammond, & Arias, 2003). This violence results in nearly two million injuries, more than a quarter of which require medical attention. The costs of intimate partner rape, physical assault, and stalking exceed 5.8 billion dollars each year, more than two-thirds of which is for direct medical and mental health services. It is important to note that prevalence rates, and the costs associated with those rates, are dependent on victim reporting, which, as research has shown, is limited (e.g., Felson et al., 2002).

A number of factors may lead to survivors underreporting their abuse, including fear, embarrassment, distrust, economic dependency on the perpetrator, fear of losing their children, and previous negative encounters with the police (Bachman, 1994; Fischer & Rose, 1995; Felson et al., 2002; Buzawa & Buzawa, 1996; Gracia, 2004; Gwinn, 2015). These issues are exacerbated for marginalized populations such as immigrant and Gay, Lesbian, Bisexual, and Transgender (GLBT) survivors who face additional barriers, including English language proficiency, unfamiliarity with the US legal system, distrust of and/or inappropriate response by medical professionals and law enforcement, and lack of appropriate/culturally competent services (Ard & Makadon, 2011; Alhusen, Lucea, & Glass, 2010; Dutton & Hass, 2001; Orloff & Sullivan, 2004; Ammar, Orloff, Dutton, & Aguilar-Hass, 2005; Raj & Silverman, 2002). These underlying reasons for underreporting also contribute to a lack of service utilization.

The underutilization of services for survivors of DV has been a longtime concern for service providers. While survivors often reach out to friends and relatives for help or support, they are less likely to seek help from more formal sources. Survivors of DV are hesitant to access formal support services for the reasons outlined above, such as fear or distrust of the system or the perception that provision of services is predicated on survivors leaving their perpetrator. There is additional concern that survivors do not or cannot access services because the services do not exist, they are unaware of services that are available, and/or the services are not adequately provided (too scattered across the community, not culturally competent, too few spaces available to accommodate all survivors, etc.) (Koss & Harvey, 1991; Gamache & Asmus, 1999; Madigan & Gamble, 1991; Moe, 2007; Barrett & St. Pierre, 2011; Shannon, Logan, Cole, & Medley, 2006; Fugate, Landis, Riordan, Naureckas, & Engel, 2005; Gwinn & Strack, 2010). In other cases, survivors are hesitant to access available services due to economic constraints. Survivors may fear the potential cost of social or legal services, in addition to the cost of time off from work, additional transportation expenses, and the cost of childcare while they access services (Hart, 1992). In the 1990s, funding became available to help health and human services organizations and criminal justice agencies coordinate responses to survivors of DV as a way to address the problems of underreporting and access to services.

From 1996 to 2000, the CDC funded a total of 10 CCR projects tasked with enhancing community response and service provision to survivors of IPV (Klevens, Baker, Shelley, & Ingram, 2008). CCRs aim to improve communication between different agencies responsible for responding to survivors of IPV, both to provide a more effective response to the victim and to prevent secondary victimization (National Advisory Council on Violence Against Women, 2001; Shepard & Pence, 1999). In addition to helping individual agencies and organizations operate more effectively, CCRs also aim to improve first responders' efforts. Furthermore, many CCRs attempt to reduce the number of IPV incidents in their community through education and community outreach (Burt, 1980; Okun, 1986). CCRs seek to achieve

these goals through three types of coordination: community intervention projects, criminal justice system reform, and coordinating councils (Shepard, 1999).

Feedback from the field has been positive regarding CCRs and their impact on IPV, and case study findings are encouraging. Specifically, studies have found that CCRs result in: greater coordination of activities, which allows programs to assist survivors more efficiently; more information sharing and victim contact with services; improved victim safety; and, lower rates of offender recidivism (Robinson, 2006; Klevens, et al., 2008; Shepard, Falk, & Elliott, 2002). A more recent study of the impact of CCRs on reports of DV found that women in communities with longer-established CCRs reported fewer instances of DV than those with newer CCRs, but called for better use of more rigorous research design (such as random selection, documentation of interventions, and pre-post intervention analysis) in order to be more confident in results gleaned from evaluation efforts (Post, Klevens, Shelley, & Ingram, 2010).

While CCRs are generally focused on victimization and reducing criminality, the core philosophy—that coordination of multi-disciplinary services improves outcomes—is not unlike other processes used outside the criminal justice field. In the 1980s, for example, wraparound care began as an alternative to institutionalization for youth with complex support needs (VanDenBerg, Bruns, & Burchard, 2003). The wraparound process, according to Suter and Bruns, "is a team-based service planning and coordination process intended to improve outcomes for children and youth with serious emotional and behavioral disorders and support them in their homes, schools, and communities" (2009, p.336). Evaluations on the impact of wraparound care demonstrate a number of positive outcomes including reduced likelihood of incarceration, reduced recidivism, fewer disciplinary actions, more stable living environments, fewer emotional and behavioral problems, less assaultive behavior, and higher grade point averages (e.g., Carney & Buttell, 2003; Clark, Kirisci, & Tarter, 1998; Pullman, Kerbs, Joroloff, Veach-White, Gaylor, & Sieler, 2006; Rast, Bruns, Brown, Peterson, & Mears, 2007; Rauso, Ly, Lee, & Jarosz, 2009).

1.2 Family Justice Centers

The FJC movement, which began in the early 2000s with the opening of the San Diego FJC, is a strategy for communities to take collaboration to the next level by bringing together government and non-government service providers into one centralized location, providing multiple services for survivors of DV under one roof (Gwinn, Strack, Adams, Lovelace, & Norman, 2007). FJCs are designed to foster collaboration between the relevant service sectors, a process that has been somewhat difficult for CCRs to achieve given that service providers are often dispersed (Gwinn & Strack, 2006).

> "*The family justice center model is identified as a best practice in the field of domestic violence intervention and prevention services. The documented and published outcomes have included: reduced homicides; increased victim safety; increased autonomy and empowerment for victims; reduced fear and anxiety for victims and their children; reduced recantation and minimization by victims when wrapped in services and support; increased efficiency in collaborative services to victims among service providers; increased prosecution of offenders; and dramatically increased community support for services to victims and their children through the family justice center model.*"
>
> *- Gwinn and Strack, 2006*

In FY 2004, the PFJCI further institutionalized the movement by providing federal funding to support the implementation of FJCs in 15 communities across the country. The PFJCI attempted to expand on the CCR model by supporting the provision of relevant service providers (medical, law enforcement, prosecution,

social services, community based organizations, etc.) in one location, making it less burdensome on survivors who would otherwise have to travel from location to location to access services.[8] Applicants were required to have strong CCR systems in place to address violence against women and current partnerships with existing victim service providers with a diverse range of services. Additionally, all funded FJCs were required to have a central intake process, VAWA compliant on-site information sharing systems, on-site counseling services, legal services, partnerships with health service providers, basic on-site medical services, child care, emergency transportation assistance, vouchers for public transportation, food vouchers, and mandatory domestic violence training programs for volunteers.

The PFJCI initiative offered a set of guiding principles related to co-location, partnerships, services provided, and a centralized intake system designed to support survivor-authorized on-site information sharing to protect victim confidentiality. Exhibit 1 presents best practices identified through the experiences of communities participating in the PFJCI and promoted by OVW (2007).

Exhibit 1: FJC Best Practices

1. Co-located, multi-disciplinary services for victims of family violence and their children increases safety and support.
2. Pro-arrest/mandatory arrest policies in FJC communities increases accountability for offenders.
3. Policies incidental to arrest/enforcement reduce re-victimization of victims.
4. Victim safety/advocacy must be the highest priority in the FJC service delivery model.
5. Victim confidentiality must be a priority.
6. Offenders must be prohibited from on-site services at centers.
7. Community history of domestic violence specialization increases the success of collaboration in the FJC model.
8. Strong support from local elected officials and other local and state government policymakers increases the effectiveness and sustainability of FJCs.
9. Strategic planning is critical to short-term and long-term success in the FJC service delivery model.
10. Strong/diverse community support increases resources for victims and their children.

Since the PFJCI, many more communities across the country have used public (federal (e.g., from OVW or Bureau of Justice Assistance (BJA), state, or city/county) and/or private funds (e.g., donations) to implement FJCs to serve survivors of family violence and their children in their communities. Demand for communities to continue establishing FJCs has been evident from the number of communities that originally sought to participate in the PFJCI (over 400) and the nearly unanimous survivor feedback supporting the ability to go "one place" for all their needed support (Gwinn & Strack, 2010). As was the case with the centers supported by the PFJCI (Townsend, Hunt, & Rhodes, 2005), not all of the Centers operating today are likely to look the same. While the FJC model has been defined by certain principles like co-location, multi-agency involvement, use of a centralized intake processes, focus on victim safety, and confidentiality, it has been left to communities to determine how best to apply these principles to

[8] If co-location was not possible, off-site partners were acceptable as long as the safety of the survivors was not compromised and the partners were willing to provide services on-site if needed.

serve survivors and their children in their communities. For example, FJCs in dense, urban populations are likely to look profoundly different than FJCs in tribal, rural, or suburban environments.

There has also been no attempt to establish national guidelines through federal legislation for FJCs, as there has been with other similar efforts like CACs.[9] As with the PFJCI, neither BJA nor OVW, the two primary sources of federal funding for FJCs, require applicants to meet a specific definition of a FJC. Partner agencies of FJCs may apply for funding under BJA's Byrne Justice Assistance Grants (JAG) program to support implementation of policies or provisions of services. For example, the Addressing Violence Against Children project is funded through the Byrne JAG program and has provided upgraded recording equipment and a case manager for the Children's Center at the Nampa FJC (Idaho State Police, 2013). Additionally, Byrne JAG funds may be used to fund positions within FJCs, such as site coordinators (Tennessee Department of Finance and Administration, n.d.). Beginning in 2005, when FJCs became established as a purpose area under Title I of the Violence Against Women Reauthorization Act, FJCs became eligible to apply for funds through OVW's Grants to Encourage Arrest and Enforce Protection Orders Improvements.[10] Under this grant program, grantees may apply for funds

> "to plan, develop and establish comprehensive victim service and support centers, such as family justice centers, designed to bring together victim advocates from non-profit, non-governmental victim services organizations, law enforcement officers, prosecutors, probation officers, governmental victim assistants, forensic medical professionals, civil legal attorneys, chaplains, legal advocates, representatives from community based organizations and other relevant public or private agencies or organizations into one centralized location, in order to improve safety, access to services, and confidentiality for victims and families"[11]

More recently, the Alliance has created an affiliation process to promote best practices and the application of guiding principles to FJCs.[12]

A few states have also begun to adopt legislation to define FJCs for the purposes of access to state funding, helping to promote the institutionalization of best practices across Centers within the state. For example, California Penal Code Section 13750 defines FJCs as multiagency, multi-disciplinary centers to "assist victims of domestic violence, officer-involved domestic violence, sexual assault, elder or

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9 CACs are authorized under the Victims of Child Abuse Act 42 U.S.C. Section 13002 and may receive national accreditation through the National Children's Alliance.

10 Prior to 2005, local government agencies could apply for funds to support FJCs under broader purpose areas, e.g., implementation of pro-arrest policies, centralization and coordination of criminal cases, develop policies and procedures preventing dual arrests and prosecutions, as well as through the Rural Sexual Assault, Domestic Violence, Dating Violence and Stalking Assistance Program and Legal Assistance for Victims Grant Program. FJCs also have been and continue to be supported through the STOP Violence Against Women formula grant program, again through purpose areas that are broad enough to reflect the mission of FJCs.

11 See OVW Fiscal year 2018 Improving Criminal Justice Responses to Sexual Assault, Domestic Violence, Dating Violence, and Stalking Grant Program (formerly known as the Grants to Encourage Arrest Policies and Enforcement of Protection Orders), p. 3. Retrieved from https://www.justice.gov/ovw/page/file/1021986/download

12 The Alliance established an affiliation process in 2014 that defines FJCs as those that have a minimum of the following full-time, co-located partners: domestic violence or sexual assault program staff, law enforcement investigators or detectives, a specialized prosecutor or prosecution unit and civil legal services. Many FJCs have additional on-site partners on either a full or part-time basis. FJCs also have established a centralized intake and information sharing process that is HIPPAA and VAWA compliant with their full-time, co-located partner agencies. Centers that do not meet this definition, but have at least three different co-located service providers are referred to as multi-agency Centers. (https://www.familyjusticecenter.org/affiliated-centers/family-justice-centers-2/, downloaded on 11/1/17)

dependent adult abuse, stalking, cyberstalking, cyberbullying, and human trafficking, which ensure that victims of abuse are able to access all needed services in one location and to enhance victim safety, increase offender accountability, and improve access to services for victims of crime."[13] Oklahoma and Louisiana have also added FJC definitional language to state law, but with less specificity than California legislation.[14]

Given the absence of a national model and the need for flexibility to allow communities to tailor application of best practices to their needs, it is not likely that all FJCs in operation today subscribe to the model as established through the experiences of the earlier FJCs (Gwinn & Strack, 2010). As a result, it was important that this scan capture the range of programs operating across the country and collect sufficient information on the elements of each program to identify the different types of programs in operation and the extent to which certain elements of the model are present, if at all.

Capturing the breadth of programs is also important given that preliminary evidence suggests that FJCs can have a positive effect on the number of DV-related homicides, survivor safety, autonomy, empowerment for survivors and professionals, fear and anxiety for survivors and their children with the court system, peer support, witness recanting, and numbers of survivors receiving services, but it is unclear what specific elements contribute to these favorable outcomes (Gwinn & Strack, 2006; Hellman & Gwinn, 2017). Collaboration among multi-disciplinary agency partners, increased hope and resiliency, and high satisfaction levels among clients served has been documented in FJCs and other types of collaborative models (Giacomazzi, Hannah, & Bostaph, 2008; Hoyle & Palmer, 2014; Duke, Schleber, & Ruhland-Petty, 2015; Hellman & Gwinn, 2017). But what is lacking is support through rigorous evaluation to confirm both the impact of these programs and the relationship between specific program elements and outcomes. These challenges are not unique to FJCs. There is a dearth of similar rigorous evaluation in the specific program elements and outcomes produced in community-based DV programs as well (Gwinn & Strack, 2010).

In general, large evaluations of CACs and FJCs have yet to be conducted. Many earlier evaluations were outcome-based but focused mainly on offender outcomes such as recidivism (Babcock & Steiner, 1999; Shepard et al., 2002; Muftic & Bouffard, 2007; Salazar, Emshoff, Baker, & Crowley, 2007). A 2016 meta-analysis by Herbert and Bromfield also concluded that most CAC evaluations are based on offender outcomes and functional program outcomes. The authors call for further evaluations of CACs that focus on victim and family outcomes. In line with that recommendation, two more recent studies of FJCs (DePrince, et al., 2012; Hellman & Gwinn, 2017) examined mental health and emotional well-being among FJC participants. Both studies suggested that survivors' participation in FJCs is associated with greater hope, life satisfaction, emotional well-being, and flourishing (Hellman & Gwinn, 2017), and reduced negative emotional experiences (Hellman & Gwinn, 2017) and mental health symptoms (DePrince et al., 2012). Olson and Parekh (2010) also found support for the ability of FJCs to benefit survivor subpopulations, in this case, refugee and immigrant populations.

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[13] 2014 California Penal Code Part 4 – Prevention of Crimes and Apprehension of Criminals Title 5.3 – Family Justice Centers 13750

[14] See 2015 Oklahoma Statutes Title 22. Criminal Procedure Statute 22-60.31. Family Justice Centers and Chapter 21-D of Title 46 of the Louisiana Revised Statutes of 1950, comprised of 1860 through 1863.

There have only been two multi-site evaluations of FJCs, both conducted in California. The first, which was authorized by the California State Legislature and funded by Blue Shield of California Foundation, evaluated eight FJCs in the state of California. The purpose of the cross-site outcome evaluation was to examine the benefits of co-location of services and agency professionals, and barriers or challenges to the effectiveness of FJCs. The authors only evaluated FJCs that fit the definition identified by legislators under California Penal Code section 13750 (see definition above). The authors used a mixed methods approach, including data collection from clients, professionals, and volunteers working at the FJC, as well as the collection of administrative and criminal justice data. The authors reported positive results with respect to the number of clients served and service needs met, benefits of co-location and multi-agency services, and lack of barriers to access needed services (barriers assessed included immigration status, criminal history, and substance abuse and mental health issues), as well as promising results regarding FJCs' ability to better address offender accountability (EMT Associates, 2013). The second study was conducted in 2016 by the University of Oklahoma's Center of Applied Research for Nonprofit Organizations. The authors evaluated changes in hope and well-being among survivors with significant ACE scores receiving services at seven FJCs located in California. The evaluation assessed the relationship between self-reported measures of hope and wellbeing and survivor-defined success in goal attainment using a pre-test post-test design. The study found statistically significant increases in hope, emotional well-being, and flourishing after 90 days of services in the seven California-based FJCs (Hellman & Gwinn, 2017).

2. Methodology

2.1 Defining Scope of the Scan

As reflected above, the FJC movement has not relied on a prescribed model, but rather a set of guiding principles based on identified best practices and direct survivor feedback. The assumption is that communities will strategize on how best to apply the model to their own unique leadership, infrastructure, partners, population, expressed survivor needs, and funding available to them as they work toward establishing a Center in their own community.

In an effort to capture this range, the scan needed to be broad enough to allow for testing of the variation in programs that fall under the FJC umbrella (both those that call themselves FJCs and other similar multi-agency co-located collaboratives, hereafter referred to as FJCs or "Centers"). In an attempt to capture the range of Centers in operation across the US, while excluding other CCRs, the following four criteria were used to define an FJC for the purposes of the scan: (1) co-located; (2) multi-agency; (3) multi-disciplinary; and (4) targeting provision of services to adult survivors of family violence. In other words, any program that involved *the co-location of multiple agencies representing different disciplines that have come together to provide services to adult survivors of family violence and their families* was included in the inventory, and other types of co-located models (e.g., CACs) were excluded.

Beyond the four core elements identified above, there is potential for variation among identified Centers. Some of this variation may include the population served by the FJC (e.g., DV, sexual assault, child abuse, elder abuse, human trafficking), organizational structure, lead agency, partner agencies, intake process, capacity, services provided, and extent to which services are provided on-site or by referral. Variation may also exist in the agencies involved. For example, the Alliance includes both law enforcement and prosecution involvement as defining elements of an FJC in their affiliation process, but some Centers lack these on-site partnerships and still call themselves FJCs based on the presence of other government partners.[15] In other cases, a Center may include the co-location of community based and government agencies but lack centralized intake, whereas the Alliance and other Centers consider centralized intake to be essential to the coordination of services across agencies in a true FJC model.

Using a limited set of criteria allowed us to be inclusive of the range of Centers in operation and offered the flexibility to narrow our scope later, if necessary. One important note is that CACs meet three out of the four criteria, but, unless they are co-located with an FJC, they were excluded from the inventory because they do not target services to adult survivors of domestic violence. While the general missions of CACs and FJCs in this scan are similar, the target populations and goals are different.[16]

2.1.1 Identification of existing FJCs in the United States

A total of 87 FJCs were identified and included in the study. As described below, the study began with an inventory of 117 Centers, but 30 were excluded through investigations that occurred as part of study activities.

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[15] The Alliance's affiliation process would consider a center that lacks criminal justice partner a "Multi-Agency Center" rather than an FJC, regardless of whether the center refers to itself as a Family Justice Center.

[16] For more information about CACs and evaluation outcomes: https://www.ncjrs.gov/pdffiles1/nij/192825.pdf, https://www.ncjrs.gov/pdffiles1/ojjdp/218530.pdf

Between October 2015 and March 2016, the study team generated an initial inventory of operational FJCs that met the above criteria using three primary sources: (1) a list of Centers known to the Alliance; (2) an intensive on-line search for Centers that provide services to adult survivors of family violence; and (3) a list of recipients of federal funding from OVW.

The Alliance maintains a membership database for all of its program members, which includes members of the Family Justice Center Alliance. From this database, the Alliance provided contact information for 76 centers that met the four criteria established for the study.

The on-line search identified many different types of agencies, but not all fit the criteria outlined above for inclusion in the scan. [17] For example, some agencies were excluded because they did not specifically target adult survivors of family violence and their families, such as the Family Advocacy Center in Deerfield, NY, which provides general services to individuals with developmental or intellectual disabilities (including, but not specific to, domestic violence survivors). Other agencies were excluded because they primarily serve child survivors of abuse, but do not offer similar services for adults and families (i.e., CAC model). Some agencies that were identified in the search provided services to adult survivors of family violence, but focused on a narrow set of services, such as legal guidance or advocacy. For example, the Family Violence Law Center was identified using the search term "Family Violence Center", but it is a single agency operating as a legal clinic. The American Family Advocacy Center was identified using the search term "Family Advocacy Center", but it was found to be an agency that focuses on keeping families intact.

Centers that received federal funding through the OVW were identified through grantee progress reports maintained by the Muskie School of Public Service at the University of Southern Maine, on behalf of OVW. The Muskie School of Public Service provided a list of OVW grantees that marked "Family Justice Center" as a purpose area on their application under the Grants to Encourage Arrest and Enforce Protection Orders Improvement program, and grantees of other grant programs that had FJC as part of their name or mentioned FJC or "justice center" in the narrative provided regarding grant goals and objectives. [18]

From the documents provided by Muskie, 104 unique grantees were identified. Of those, most were already included in our inventory (n=78). Additional on-line research was conducted to determine whether to include the remaining 26 grantees in the inventory. Based on our research, 15 were identified as not meeting the scan criteria for inclusion as an FJC.[19] For example, the Kansas City Family Justice Center was identified through the OVW grantee list, but further research showed that this is the name of the juvenile court in Kansas City, MO. Similarly, the North Dade Justice Center was named in the OVW grantee list, but further research confirmed that this is the name of the courthouse in North Dade, Florida. The remaining 11 grantees were identified as likely to be associated with an FJC.

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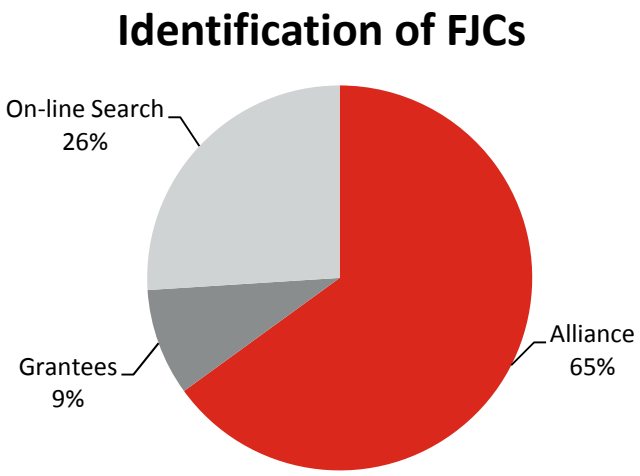
[17] Terms used to search for programs to include in the inventory included: Family Advocacy Center, Family Safety Center, Family Justice Bureau, Center for Domestic Violence Service, Domestic Violence Service Center, One Stop Center, Domestic Violence Resource Center, Family Violence Center, and Presidents Family Justice Center Initiative.

[18] Other grantees include recipients of grants through the Rural Sexual Assault, Domestic Violence, Dating Violence and Stalking Assistance Program, and STOP Violence Against Women formula grant program.

[19] The lack of association with an FJC was determined by reading the grant narrative, as well as follow-up internet searches. It was determined that these 15 grantees were included on the list because the words "justice center" or "family justice center" were included in their grant narratives, but did not meet our minimum criteria for inclusion in the scan.

Using these three sources, 117 FJCs were identified (see Appendix A for a list of all 117 Centers). As reflected in the exhibit below, 65 percent (n=76) of the Centers were identified through the Alliance, nine percent (n=11) as federal grantees, and 26 percent (n=30) through on-line searches (see Exhibit 2).

Exhibit 2: Percent of Eligible FJCs by Identification Method



It is important to note that the Centers that were identified through either the OVW grantee list or on-line research (as described above) were included in the scan based on a review of publicly available information. However, there are limitations to this approach (e.g., co-location is difficult to ascertain from descriptions on a website). Also, due to the sensitive nature of domestic violence survivors seeking services, and the caution and anonymity they may need in order to feel comfortable seeking services, detailed information is not always readily available on-line. If minimal information was available regarding the services provided, but the name of the organization otherwise suggested it should be included, we erred on the side of inclusion. Although this process may have resulted in the inclusion of Centers that did not necessarily meet all four criteria, we felt we would be able to determine this through the scan and could make exclusion decisions based on the additional information collected. The goal of the scan was to collect enough information to confirm that each of the centers identified met the minimum criteria established to consider the organization in the pool of centers for evaluation.

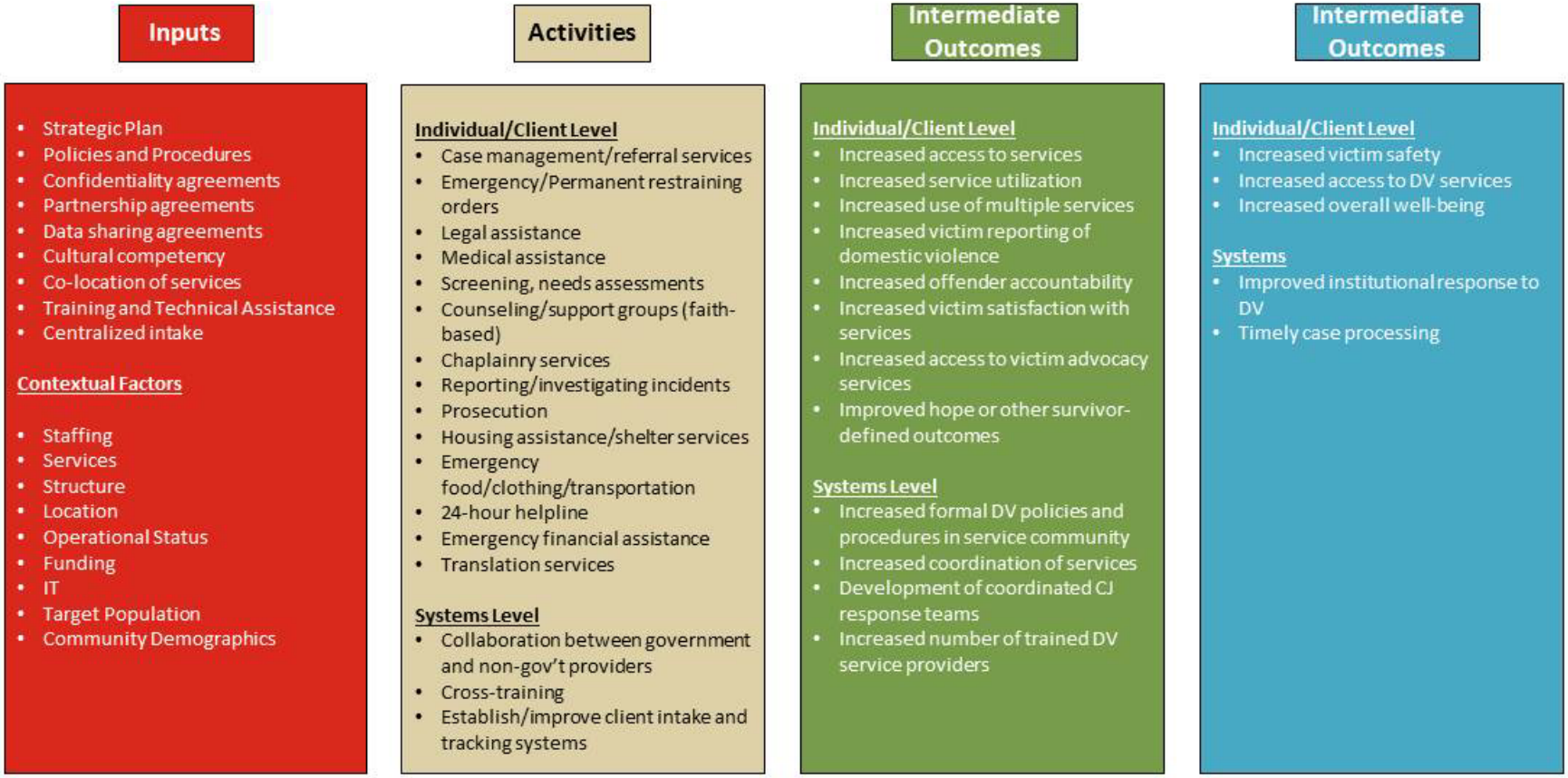
The list of Centers identified also reflects only those that were operational at the time the study team compiled the list in spring of 2016. The Alliance estimates that there are currently 15 to 20 communities nationwide that are actively seeking to develop a Family Justice/Multi-Agency Center. These Centers, and any others that became operational during or after data collection, were not included in the scan.[20]

[20] FJCs that have been identified since the scan are included in Appendix A as a separate list of FJCs that are in the development stage. The list includes three FJCs (Guam, Frenso, and Ventura FJCs) that were included in the 117 that received the scan; none of them responded.

2.2 Instrumentation

Before designing the instrument, the study team generated a logic model to depict the relationship between inputs, activities, outcomes, and impacts based on the guiding principles promoted through the PFJCI and our review of the literature (see Exhibit 3).

Exhibit 3: Program Logic Model



Using the logic model as a guide, the project team developed a survey instrument to collect data on inputs and activities to measure variation across FJCs and the extent to which outputs were collected and maintained, as part of an assessment of evaluability. The survey was designed to support the two primary research questions: (1) What do FJCs look like? and (2) Can they support formal evaluation efforts?

To address the first research question, the survey gathered information in the following areas:

- Mission of the Center
- Governance structure
- Partner agencies
- Policies and procedures
- Demographics of the community in which the Center is located
- Target populations
- Operational status
- Capacity
- Demographics of the population served
- Services provided

To support the second question, the survey collected information on the following topics:

- Intake procedures
- Collection of client-level data
- Collection of data on services received
- Storage of client-level data
- Ability to provide data to support evaluation

To support consistent data collection, the environmental scan was guided by the data collection protocol, which included a brief consent process followed by a questionnaire that could be completed electronically or in hard copy. The instrument was also designed to collect information as efficiently as possible to encourage high response rates.

2.3 Data Collection

2.3.1 Instrument deployment

Pre-test

On June 7, 2016, the project team deployed a pilot version of the instrument to five FJCs who were identified by the Alliance as likely to assist in a pre-test. Four out of the five FJCs responded to the pre-test, three electronically and one in hard copy. [21] The survey instrument was revised slightly based on feedback from the pre-test, i.e., the survey was shortened slightly, clarifying language was added where questions were unclear, and a question was added to capture total staff counts in case respondents could

[21] Pre-test respondents included: Nampa Family Justice Center, One Safe Place FJC, Alameda County FJC, and New Orleans Family Justice Center

not provide staffing information broken out by partner agencies. Pre-test respondents received a small stipend ($25) to reimburse them for their participation.

Full Deployment

The project team at Abt mailed and emailed the survey on August 23, 2016 to all FJCs with a valid email and/or mailing address. [22] The introductory email introduced the study and the intended goals, and included contact information, a participant-specific link to the instrument (meaning the link could only be accessed by the emailed recipient), and a link to a letter of support for the project provided by the OVW (see Appendices C, D, and E for consent language, survey, and letter of support from OVW). A link to the PDF version of the instrument was also included in the e-mail, giving participants the option of completing the survey by hand and either scanning or mailing it back to the Abt team.

The mailing included an introductory letter explaining the project, intended goals, and project contact information, as well as a copy of the instrument, a copy of the OVW letter of support, and a self-addressed stamped return envelope.

Scan respondents received a small stipend ($50) to reimburse them for their participation.

2.3.2 Reminders and technical assistance

The first reminder email was sent to all non-respondents with a valid email address on September 20, 2016. The project team began calling non-respondents (including those who received hard copy versions of the survey in the mail) to encourage participation and/or offer assistance with completing the instrument on October 6, 2016. The project team made multiple rounds of follow-up contacts to offer technical assistance in completing the instrument. As part of this process, Abt confirmed points of contact and their email addresses (or asked for email addresses where one had not been provided previously). The second reminder email, which included all updated points of contacts/emails, was sent to non-respondents on October 26, 2016. This email included participants for whom Abt did not previously have e-mail addresses. Representatives from the Alliance also began reaching out to non-respondents on November 7, 2016 to encourage participation. The last recruitment reminder email was sent to non-respondents on November 30, 2016, alerting non-respondents of the data collection end date of December 12, 2016.

During the technical assistance phase, based on conversations with non-respondents, it was determined that 20 Centers should be removed from the list for the following reasons:

- Duplicate (n=3)
  - Center listed was a duplicate of another Center already in the list (satellite location or lead partnering agency)
- Community-based Organization (n=8)
  - Center was not multi-agency
- Child Advocacy Center (n=3)
  - Center did not have CAC in the title, but upon speaking to someone from the center, it was determined it did not serve adult survivors

[22] The team did not re-survey the four centers who participated in the pre-test.

- Multi-disciplinary team (n=4)
  - Teams are multi-agency, but are not co-located
- Center was still in development stage at the time of the scan (n=1)
- Respondent self-identified that their Center did not meet the inclusion criteria (n=1)

Once removed, the total universe of Centers was reduced from the original 117 to 97 centers. The Abt project team received a total of 63 responses.

2.3.3 Data cleaning and follow-up

On December 13, 2016, Abt began reviewing survey responses to check for completeness, and to see if any follow-up with individual participants was necessary. A substantive review of the on-line version of the survey was completed on December 28, 2016, and review of the PDF and hard copy versions of the survey was completed on January 12, 2017. Abt determined that one response should be removed from the sample because it was a duplicate of a response already received, and clarification was needed for responses in 19 (of the remaining 62) surveys. Abt contacted survey respondents for clarification on the following:

- Confusion about partner location at satellite locations or off-site
- Confusion over other information provided (e.g., respondent indicated that 98% of clients are men and 2% are women)
- Surveys that were mostly complete, but had a few of missing questions

Abt began contacting survey participants with follow-up questions on January 12, 2017. Participants were contacted initially by phone or e-mail. Participants were contacted once, and if they were non-responsive, Abt did not attempt to follow up with them again. Follow-up with participants was completed on January 30, 2017.

Once initial data cleaning was completed, an Abt data analyst synthesized all of the surveys into a single electronic database for analysis.

Upon beginning data analysis, the project team recognized a need for greater clarification from a number of Centers on their structure and partnerships. Specifically, the team was interested in learning more about the relationship between primary sites and their satellites regarding how staff are allocated, how clients are served, and how the primary and satellite sites interact. The team had similar questions for respondents who indicated that their Center is part of FJC/CAC coordinated model. Finally, the team conducted follow up with the Centers with fewer than six partner agencies regarding service provision.

The second phase of follow-up began in late spring of 2017. Based on the findings from the second phase of follow-up, revisions were made to both the overall dataset (10 Centers were removed from the dataset because it was determined that they did not meet the inclusion criteria, see Appendix A for full list of Centers) and to add context to specific responses (e.g., the number of FJCs/CACs and Centers with satellite locations).

2.3.4 Number of respondents

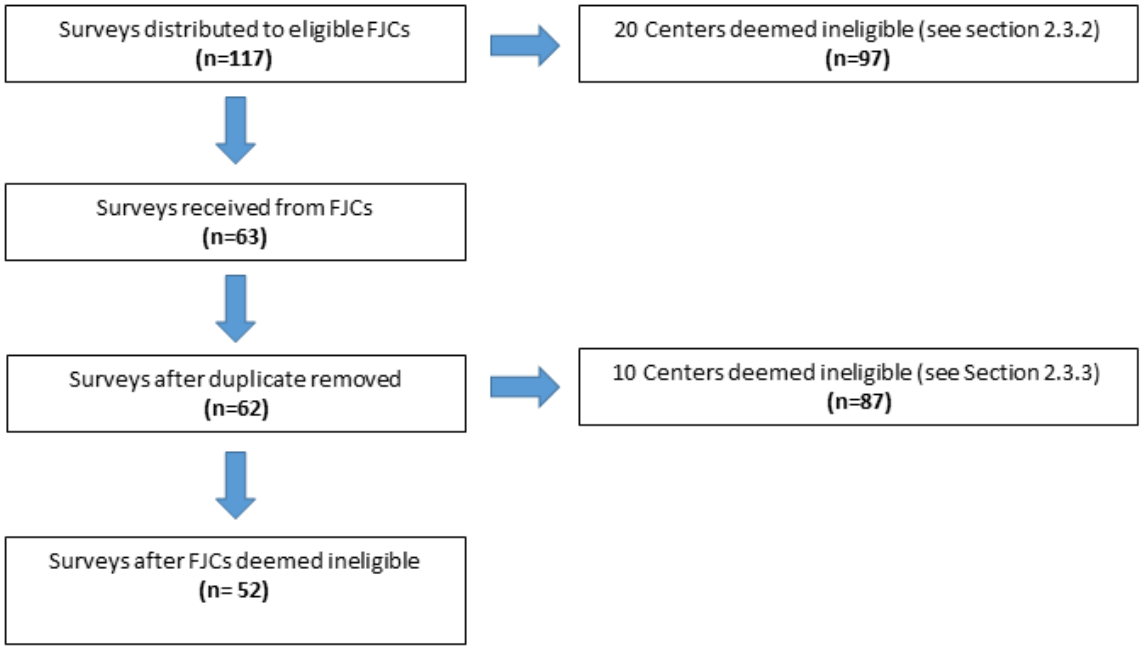
Surveys were distributed to a total of 117 Centers for inclusion in the study (117 in hard copy, 90 electronically, including the four centers who pre-tested the instrument). During the technical assistance phase of the project, 20 Centers (who had not yet responded to the instrument) were removed from the list

for various reasons (see section 2.3.2). This reduced the total number of centers included in the study from 117 to 97 Centers. Of those 97 Centers, we received a total of 63 responses.

During the first phase of follow-up, one response was removed because it was determined to be a duplicate of a previously received response. During the second follow-up period, an additional 10 responses were excluded because the centers were determined to not meet the inclusion criteria (based on their self-report). This further reduced the total number of centers meeting the study criteria to 87 FJCs and reduced the final number of valid scan responses to 52.

Of the 52 total responses, 44 respondents fully progressed through the survey (meaning the respondent "completed" the survey, but did not necessarily answer all questions) and eight responses were incomplete (respondent did not "complete" or progress to the end of the survey), but all contained some information useful in analysis. Thirty-five respondents responded via the electronic survey, 16 respondents participated via hard copy, and one respondent preferred to walk through the instrument over the phone.

Exhibit 4: Data Collection Flow Chart



2.4 Data Limitations

2.4.1 Low response rate

Of the 87 Centers included in the scan, 52 responses were received, representing a response rate of 60 percent. This is lower than the anticipated (and preferred) response rate of 75 percent. Appendix A presents the list of all Centers included in the scan, whether the Center responded to the scan, and key characteristics. For those Centers that were excluded (i.e., 30 Centers from the original 117 identified) we provide reasons they were excluded from the analysis.

Given the low response rate, findings cannot be generalized to Centers nationwide because we cannot predict responses for those that did not respond to the scan. Therefore, the results will need to be interpreted with the caveat that they may not be reflective of all FJCs nationwide.

2.4.2 Response bias

The survey instrument required respondents to provide information on behalf of their Centers. As such, the analyses presented throughout this report are dependent upon self-reported data. Response bias (also called survey bias) is a term for a number of factors that may influence respondents' tendency to provide false or misleading answers (e.g., Lavrakas, 2008). One common type of response bias, known as social desirability bias, occurs when respondents attempt to answer survey questions in the way they believe the administrators want them to answer—in other words, they may over-report desirable program characteristics and under-report less desirable ones. Given the stated objectives of the scan, responses may be biased toward FJCs that are more established, more likely to adhere to principals promoted through the PFJCI, and more likely to be interested in participating in an evaluation. There may also be Centers that fit the criteria but do not identify themselves as a FJC or multi-agency center and therefore did not respond to the scan.

In addition, the initial correspondence letter/consent language that accompanied the electronic and hard copy survey explained that the study was being conducted in partnership with the Alliance. As administers of the Family Justice Center Alliance and FJC affiliation process, it is likely that many of the Centers are aware of the Alliance and its efforts to affiliate centers as FJCs or multi-agency Centers. As such, it is reasonable to assume that some Centers may have been more or less inclined to participate due to the connection with the Alliance. It is also possible that the involvement of the Alliance biased responses toward best practices supported by the Alliance.

3. Facility Characteristics

The following section provides descriptive facility characteristics for the 52 Centers who participated in the FJC Scan. The purpose of this section is to support a better understanding of the landscape of Centers that exist nationwide and their commonalities and differences. Information is presented in six categories: operational status, program governance, funding status, geographic location, client population, and service provision.

3.1 Operational Status

3.1.1 Implementation status

Respondents were asked to indicate, on a scale, where the Center is in the implementation process (n=52). Eighty-eight percent of respondents indicated that their Center is "fully operational," meaning the center is open, operating, and serving clients as intended. Four Centers identified themselves as being open, but only "partially operational" (e.g., space is not completed, partners are not all co-located, etc.). Only two Centers identified themselves as being in the "planning" stages (e.g., Center is no longer in the development phase).

3.1.2 Years in operation

While the implementation of CCRs dates back to the 1990s, the FJC movement did not become prevalent until the early 2000s. As expected, of the 52 scan participants who responded to the question, all but one of the Centers became/planned to become fully operational after 2001. As shown in Exhibit 7, 60 percent of the Centers in the scan became fully operational between 2006 and 2015. Of the Centers in the scan, the average time in operation (as of Fall 2016) was approximately six years.

Exhibit 7: Year Center Became/Planned to Become Fully Operational

What date did you become/plan to become fully operational?		
	#	%
Before 2001	1	2%
2001-2005	8	15%
2006-2010	16	31%
2011-2015	15	29%
2016-Present	12	23%
Total	**52**	**100%**

3.1.3 Coordinated FJC/CAC model

The survey asked respondents if their Center is part of an FJC/CAC coordinated model. Of the 49 respondents who answered, nearly half (49%) selected "Yes." In an effort to better understand the FJC/CAC coordinated model, the project team attempted to follow up with all 24 Centers who answered in the affirmative. The project team was able to speak with a representative from all but four of those Centers about FJC/CAC coordination. Through those conversations the project team was able to identify response errors (i.e., Centers that responded as being part of the FJC/CAC model, but are not) and types of coordinated FJC/CAC models. Of the 20 Centers who participated in the follow-up, 10 confirmed that they are not part of an FJC/CAC coordinated model, reducing the total number of Centers with a

coordinated FJC/CAC model from 24 to 14 or 27% (including the four Centers who did not respond to follow-up).

An example of the coordinated FJC/CAC model is that of the Nampa Family Justice Center. The FJC and CAC are co-located, share one centralized intake process, and store data in a single database. The intake staff are the same for both the FJC and CAC, but the service providers are different, given the nature of the survivors. Two other Centers operate similarly. Seven other Centers that participated in the follow-up discussions are physically co-located with the CAC or located adjacent to and partner with the CAC, but have separate intake processes, databases, and otherwise function completely autonomously and are, therefore, not part of a FJC/CAC coordinated model.

3.1.4 Employees and volunteers

The unique structure of FJCs and similar multi-agency co-located collaboratives makes it difficult to accurately capture the total number of staff assigned to the Center on a yearly basis. Most Centers employ an administrative team (although sometimes that "team" consists of only the Director and an administrative assistant) and have an agreement with their partner agencies to assign staff to the Centers. However, the rotation of partner agency staff may vary not only from Center to Center, but often from month to month within Centers. Some staff may be assigned to the FJC full time, some may be part-time and assigned a set number of days a week, and some may rotate through less frequently, e.g., once a month. Many Centers also have volunteers who may provide services on a set schedule or on an ad hoc basis. The survey asked respondents a number of questions about the total number of staff assigned to the Center (both full- and part-time). Only a small number of respondents provided information on the total number of staff. Of those who answered the question, the average number of full-time staff assigned to the Center was 25 (n=13) and the average number of part-time staff was 11 (n=11). The maximum number of full-time staff assigned was 47 and the maximum number of part-time staff was 133.

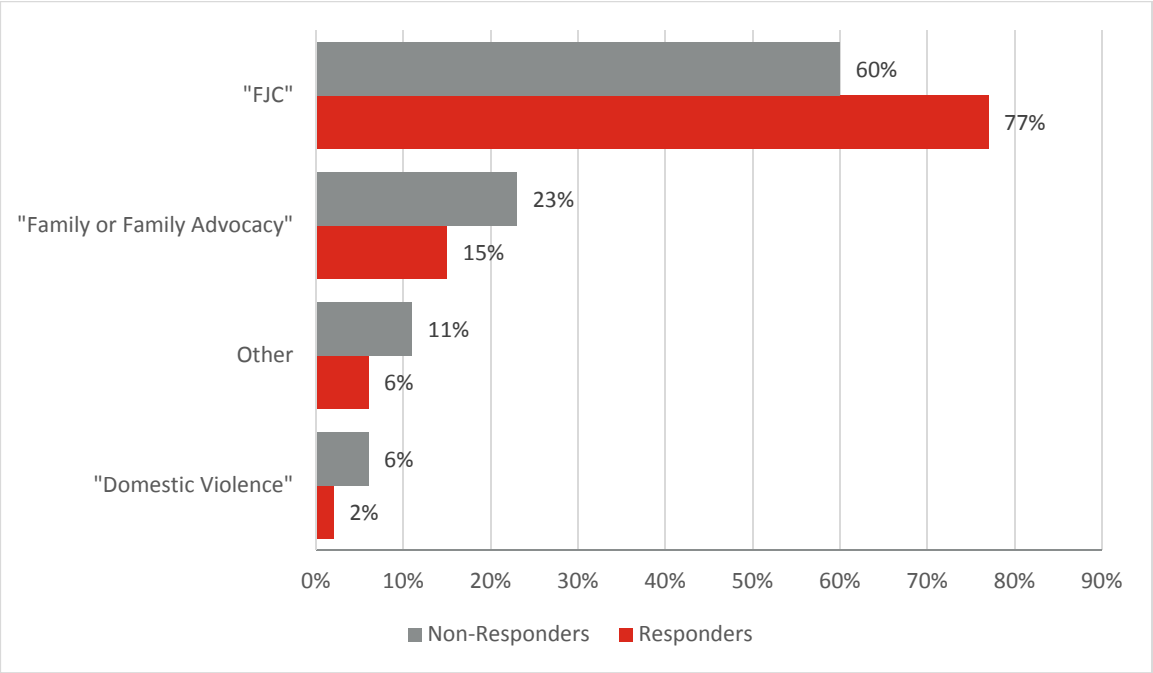
A greater number of respondents provided information on the number of volunteers at their Center. Of those Centers who provided the number of volunteers at the *primary* Center (n = 47), the average number of volunteers was nine, with a maximum of 50 volunteers.

3.2 Naming Convention and Program Governance

3.2.1 Naming conventions of Centers that participated in the scan

Of the 52 Centers that participated in the scan, more than three-quarters (77%) use the term "Family Justice Center" in their name. Fifteen percent that do not otherwise call themselves an FJC have the word "family" in the name of the Center. The name of one Center includes the term "domestic violence," and three Centers have unique names, including the names of specific individuals. As shown in Exhibit 8 below, Centers that participated in the scan more commonly have "Family Justice Center" in their title, as compared with non-respondents. Conversely, non-respondents more commonly have "Family" or "Family Advocacy" in their title, as compared to Centers who responded to the scan.

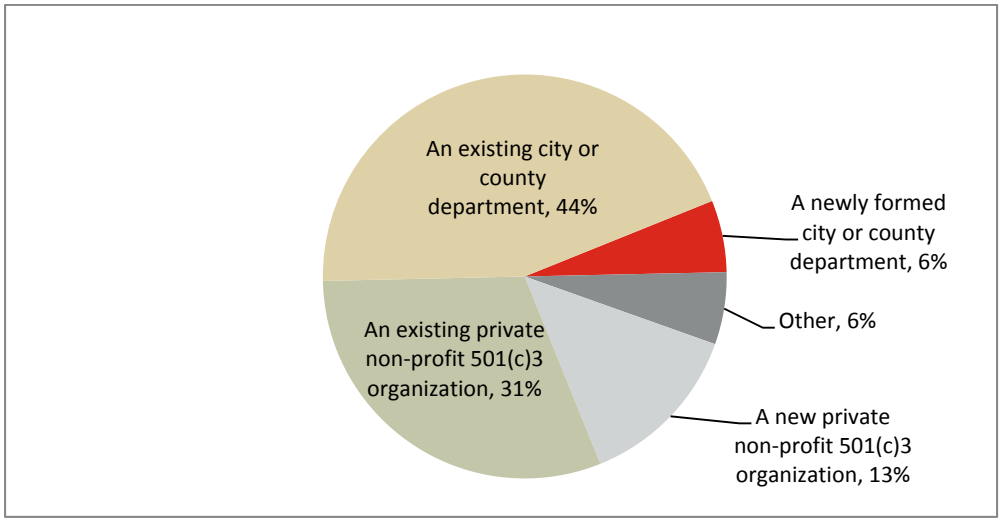
Exhibit 8: Naming Conventions of Centers: Non-respondents vs. Respondents



3.2.2 Governance structure

Respondents were asked to identify the name of the agency or agencies that lead(s) the Center and then asked to indicate the type of agency/agencies (n=52). As shown in Exhibit 9, the most commonly selected agency types were an existing city or county department (44%) and an existing private non-profit 501(c)3 organization (31%). The least common agency type identified was a newly formed city or county department (6%).

Exhibit 9: Types of Agency or Agencies Who Lead(s) the Center (n=52)



When asked about who provides oversight or governs the operations of the center (i.e., to whom does [the] Director report?), of the 52 Centers who responded, the most commonly selected response was nonprofit board of directors (33%), followed by city/county department head only (26%). The least commonly selected option was board of supervisors only (3%). While there is no right or wrong organizational model, as communities have to decide what model works best for them, the strengths and weaknesses are different depending on whether the Center sits within an existing or new government agency or an independent non-profit organization (see Wilson, Gwinn, & Strack, 2005).

3.2.3 Guiding principles and policies

The majority of respondents (81% of the 48 that responded) indicated that their Center has (or subscribes to) guiding principles.[23] Respondents were also asked to identify, from a list provided, which documents have been developed by the Center and/or its partners. As Exhibit 10 illustrates, all of the respondents (n=49) have a mission statement and the majority of respondents have developed documents such as confidentiality agreements (96%), partnership agreements, and intake procedures (94% each).

Exhibit 10: Policies Developed

Which of the following documents have been developed by the Center and/or its partners (*select all that apply*)? *(n=49)*		
Policy type	**#**	**%**
Mission Statement	49	100%
Confidentiality Agreements	47	96%
Partnership Agreements	46	94%
Intake Procedures	46	94%
Operations Manual/Policy and Procedures	45	92%
Safety and Security Protocol	43	88%
Information Sharing Agreements	40	82%
Strategic Plan	36	73%

3.2.4 Centralization

Where FJC staff and their allied agencies provide services is critical to the success of the FJC model. Ideally, to enhance collaboration, trust, and awareness of partner staff capabilities, partner agency staff must be co-located. As previously mentioned, co-location was one of the four criteria used to select Centers for the scan. Whereas 83 percent of respondents (n=44) initially indicated that their Center is centralized at a single location, eight respondents indicated that their Center is centralized at a single location *and* has at least one satellite location (average n=3).

In an effort to both better understand how Centers with satellite locations operate and ensure that Centers did not misunderstand or misinterpret the term "satellite," the project team attempted to follow up with the eight Centers that indicated that they had satellite locations. The project team asked those Centers who responded to our follow-up request (n=5) if the satellites functioned differently from the main Center. We learned that there are two types of satellite locations: those that could function independently of each

[23] Respondents were not asked to provide the Center's guiding principle(s).

other, but share qualities such as the client database and Executive Board, and those that consist of a main Center with additional locations that could not function autonomously.

California's Contra Costa Family Justice Alliance, for example, has two locations, one in Concord, and one in Richmond. The two Centers function as one in terms of administration: They share an Executive Director, accounting department, procedures, intake policies, and client database, and have a monthly meeting with all staff involved at each center, but otherwise operate autonomously. The center in Richmond was opened first, but both FJCs function similarly in regards to service provision.

Alternatively, the Sweetwater FJC's main center is located in Rock Springs, WY, but they have an additional center located in Green River, WY. The Green River Center is not staffed full time; instead, a rotation of staff from the Rock Springs center operates out of that location. The intake process is the same for the main office and the satellite office, but the satellite office could not function on its own separate from the main office.

Two of the five respondents that participated in the follow up were confused by the term "satellite." The New Orleans FJC, for example, indicated that they had a satellite location, but during follow-up the representative clarified that they were considering their co-located CAC a satellite location to the CAC's main center (which is located at a children's hospital elsewhere in the city). Similarly, the Sojourner Family Peace Center misunderstood the question and considered their co-located partners' home offices as satellites.

Once the Centers' erroneous responses regarding satellites were removed (n=2), the number of Centers that are centralized at a single location and have no satellite locations was revised to 45 and the number of Centers with satellites was revised to 6 (12%).[24]

3.2.5 Partner agencies

The number and variety of partner agencies are vital to the success of any Center. If there are too few partner agencies or partner agency staff then the success of an "under one roof" model is limited; clients may experience lengthy wait times, limited service provision, services that are not tailored to their specific needs, and may ultimately have to seek additional services elsewhere. Too many partner agencies/partner agency staff can also be a challenge both in terms of logistics (e.g., space availability and management/supervision of staff) and in building and maintaining strong partner relationships (e.g., staff frequently rotating in and out of the Center, diminished staff interactions/limited trust, unclear staff roles/expertise). As mentioned previously, multi-agency collaboration was also one of the four criteria used to select Centers for the scan.

Number of partner agencies

As shown in Exhibit 11, of the 47 respondents who answered this question, 40 percent indicated that their Center maintains between 6 and 10 partner agencies. On the low end, 12 percent of Centers maintain between 3 and 5 partner agencies, whereas just over 15 percent of respondents indicated that their Centers have more than 20 partnering agencies.

[24] One Center responded that it was not centralized because it operated Centers at two different locations; it did not consider either a satellite.

Exhibit 11: Number of Partner Agencies

How many partnerships does the Center maintain?		
	#	%
3 to 5	4	12%
6 to 10	19	40%
11 to 15	7	15%
16 to 20	9	17%
over 20	8	15%

Types of partner agencies

The types of agencies that FJCs partner with are as important as the number of agencies providing services (and the number of staff available). To effectively and efficiently meet the diverse needs of DV survivors, it is important that Centers provide a robust and comprehensive array of services. As a reminder, two of the four elements used to define an FJC for the purposes of the scan were "multi-agency" and "multi-disciplinary." As such, the instrument asked respondents to identify, among other things, the Centers' partners by name and type of agency (i.e., Community Based Organization, Local/State Government, Legal Advocacy/Court, Criminal Justice Agency, Victim Service Agency, Civil Legal Services, and Other). Of those respondents who provided information about their partner agencies (n=48), a quarter identified a partner agency in all agency types, excluding "other". The most commonly reported partner agency types were "Victim Service Agency" (94%), "Community Based Organization" (85%), and "Criminal Justice Agency" (85%). The least common partner agency type was "Legal Advocacy/Court" (46%).[25]

Exhibit 12: Partner Agency Types

What type of agency is the partner (*select all that apply*)? (n=48)		
FJCs with a partner type of one or more…	**n**	**%**
Victim Service Agency	45	94%
Community Based Organization	41	85%
Criminal Justice Agency	41	85%
Local/State Government	36	75%
Civil Legal Services	32	67%
Other, please specify	26	54%
Legal Advocacy/ Court	22	46%

The combination of partner agency types varied considerably among the Centers who participated in the scan. For example, of those respondents who identified at least one partner agency as a community-based organization *and* at least one partner agency as a victim service agency, four did not identify any partners

[25] Partner agency types include partner agencies located on-site, off-site, and/or at a satellite.

as a criminal justice agency.[26] Forty percent of respondents who identified at least one partner agency as a criminal justice agency (n=48) also identified at least one partner as a legal advocacy/court agency.

3.3 Funding Status

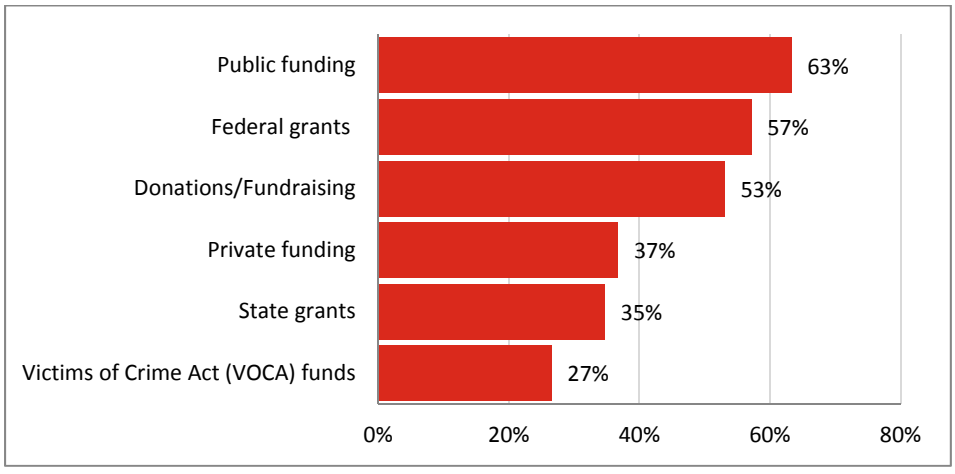
3.3.1 Annual budget

Funding status was one of the seven main categories of interest when the survey was developed. As such, a number of the questions asked respondents about their Center's annual operating budget, whether their Center exceeded, met, or did not meet that budget, and their three primary sources of funding. The average annual operating budget of the 46 Centers who provided this information was approximately $635,000 (respondents were asked to include expenses/costs for ONLY Center staff, programs/services, and facilities, but exclude any budgets or contributions from partner agencies). The minimum annual operating budget was $64,000 and the maximum operating budget was $2.8 million. Generally, the larger budgets (above $1 million) were for Centers serving larger metropolitan areas (e.g., New York City, Oakland, Nashville, and Memphis). Of the 48 respondents who answered the question regarding whether their Center exceeded, met, or did not meet their annual operating budget in the last fiscal year, the majority indicated that their Center *met* the operating budget (69%). Seventeen percent of Centers *exceeded* their operating budget and 15 percent *did not meet* their budget.

3.3.2 Primary sources of funding

The three most common primary sources of funding for the responding Centers (n=49) were public funding (63%), federal grants (57%), and donations/fundraising (53%). The least commonly selected primary source of funding was Victims of Crime Act (VOCA) funds (27%). See Exhibit 13 for the full range of funding sources (these categories are not mutually exclusive; respondents could select all that applied).

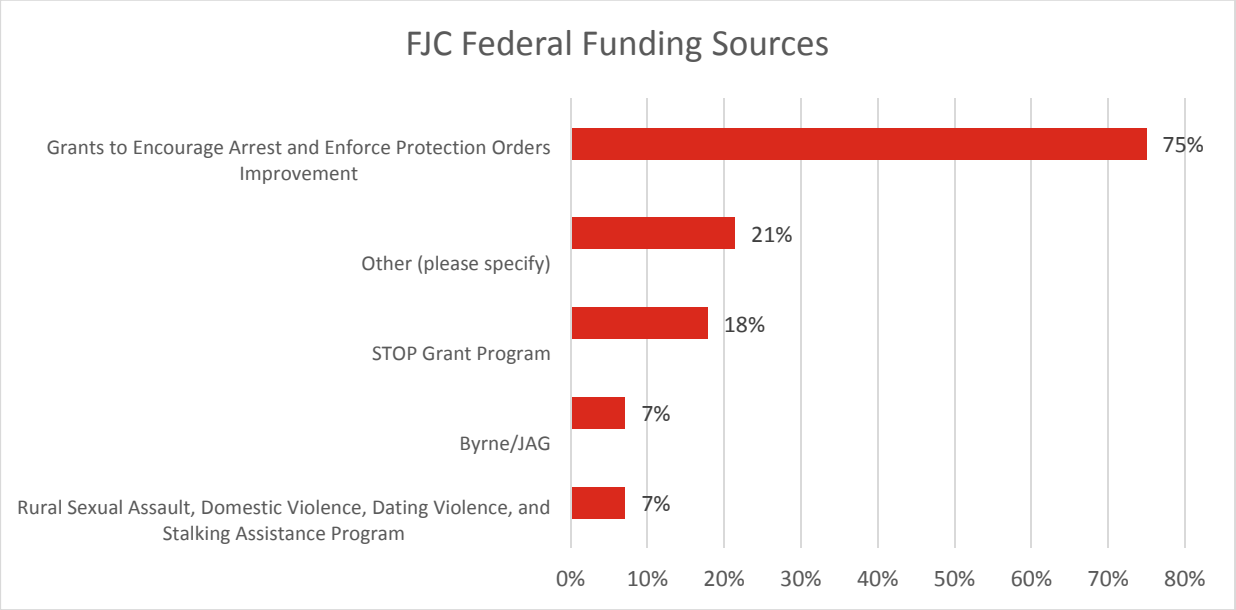
Exhibit 13: Funding Sources (n=49)



[26] Of those Centers whose respondents did not identify at least one partner agency as a criminal justice agency, only one did not identify any community based organizations or victim service agencies as partners. However, the respondent did identify peer counselors and mental health providers as partner agencies.

Respondents who selected federal grants as a primary source of funding (n= 28) were asked to identify the specific types of grants that the Center receives. The most commonly selected federal grant was "Grants to Encourage Arrest and Enforce Protection Orders Improvement" (75%). The second most common federal grant was the "STOP Grant Program" (18%). Only two respondents selected "Rural Sexual Assault, Domestic Violence, Dating Violence, and Stalking Assistance Program" as a funding source (7%). See Exhibit 14 for breakdown of federal funding sources.

Exhibit 14: Federal Funding Sources (n=28)

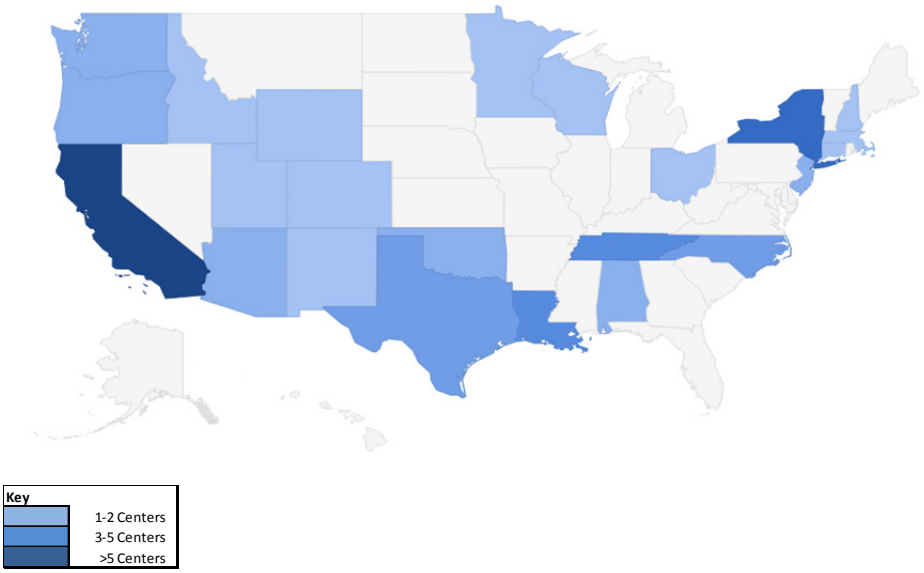


3.4 Geographic Location

3.4.1 Geographic spread of respondents

The scan collected data from Centers serving clients in twenty-four states throughout the United States (49 respondents answered the question about where the Center serves clients). As the exhibit below reflects, a plurality of responses came from Centers serving clients in the Western region of the country (39%), followed by the South (37%), and the Northeast (20%). Only a small percentage of respondents reported serving clients in the Midwest (6%). Responding Centers reflected a slightly different geographic spread than the full list of 87 Centers, which were more concentrated in the West (47%) and Midwest (11%) and less concentrated in the South (28%) and Northeast (14%) than the respondents.

Exhibit 15: Geographic Distribution of Responding Centers



3.4.2 Location type

Respondents were also asked to select the "location type" that best describes the location where the Center is primarily located. Of those who responded (n=51), the overwhelming majority selected "urban" (82%), followed distantly by "large town" (12%). Only six percent of the respondents selected "suburban" or "rural."[27]

3.5 Client Population

3.5.1 Total number of clients

Respondents were asked to define "client," as well as "new" versus "returning" client. Although the actual wording varied, most Centers defined "clients" similarly. Examples of "client" definitions include:

- "Individuals for whom an intake assessment has been completed"
- "Individuals who walk into the Center requesting services"
- "Individuals who filled out a [form] when they first contacted [the Center]"
- "Any individual who obtained services from the District Attorney's unit that assists domestic violence victims or one of the other partners at the Family Justice Center"

[27] "Urban" was defined as a continuously built up area of 50,000 residents or more. "Large town" was defined as population between 10,000 and 50,000. "Suburban" was defined as area with a committing relationship with an urban center. "Rural" was defined as population under 2,500, not within a greater metropolitan area.

The instrument asked respondents about the total number of clients served by the Center in the last 30 days. While 43 Centers responded to this question, only 36 provided specific counts. 28 Among those, 16 percent of respondents that provided counts indicated that their Center served between 1 and 75 clients in the last month; another 16 percent of respondents indicated that their Center served over 600 clients in the last 30 days. See Exhibit 16 for the full distribution of numbers of clients served.

Exhibit 16: Total Number of Clients Served in the Past 30 Days

In total, how many clients did the Center serve in the last 30 days? (n=43)	#	%
1-75	7	16%
76-150	8	19%
151-225	4	9%
226-300	4	9%
301-375	1	2%
376-450	1	2%
451-525	2	5%
526-600	2	5%
Over 600	7	16%
Missing	7	16%

Of those Centers that provided a number (n=36; excludes the 7 Centers who did not provide the information above), the average number of clients served per month was approximately 329 clients. The minimum number of clients served per month, as reported by participants, was 22, whereas the maximum was 1,685.

As Exhibit 17 shows, the average total number of clients served from 2011 to 2015 varied only slightly from year to year, except for 2013 to 2014, when the minimum number of clients increased dramatically. Of note, client counts may include children, as respondents were not asked to limit counts to adults.

Exhibit 17: Total Number of Clients Served by Year, 2011 – 2015

	2011	2012	2013	2014	2015
n	22	22	27	29	37
Mean	4,316	3,629	3,505	3,952	3,705
Median	2,258	2,201	2,112	2,255	1,900
Max	20,175	19,097	19,663	19,957	20,024
Min	15	17	15	200	200

[28] The seven "missing" respondents indicated that they could provide the number of clients served by their Center, but did not provide how many clients were served in the last 30 days.

New clients

The majority of Centers define "new client" as "first visit to the FJC." Other Centers define "new client" as those clients who may have received services previously, but who have not returned to the Center within a set time (e.g., one year) or are returning for a different case than the one that originally brought them to the Center.[29]

Examples of responses included:

- "First/initial visit to the FJC"
- "Has never been to the Justice Center or it has been over a year since the client received any services"
- "First visit to the FJC in the calendar year"
- "First visit or returning regarding a "new crime"

Respondents were asked how many *new* clients the Center served in the last 30 days (n=43). The average number of new clients served in the last month was 125, the minimum was 10 and the maximum was 382. When asked what proportion of clients were new clients, the average was just under half (49%). The most commonly indicated percentage of new clients was 21-40 percent.

Returning clients

Finally, respondents were asked to define "returning" client. Examples of responses included:

- "Return for continued services"
- "Clients being seen for ongoing services"
- "Clients who are not currently receiving services and have previously received services/been to the Center"
- "Clients who are receiving ongoing services or have returned in less than one year"
- "Any client who has obtained services at any point in the past since the Family Justice Center opened in July 2008 from the District Attorney's unit that assists domestic violence victims or one of the other partners at the Family Justice Center"

As above, respondents were asked how many *returning* clients the Center served in the last 30 days (n=39). The average number of returning clients served in the last month was 275, the minimum was three and the maximum was 1,294. Approximately 53 percent of the total client population were returning clients; the most commonly indicated percentage of returning clients was 61-80 percent.

While information presented above is encouraging in that Centers' throughput is likely sufficient to support evaluation efforts, the findings also suggest the importance of confirming and ensuring consistent definitions and data collection processes, particularly for cross-site comparisons.

3.5.2 Demographics of clients served

The survey asked respondents to provide information on demographic characteristics (e.g., gender, age, race, and ethnicity) of their Center's client population in the past year. According to the respondents providing this information (see Exhibit 18 for response rate), clients served in the last year were most

[29] This is common practice. For example, OVW allows counting clients each reporting period if they receive a service during that period, regardless of whether or not it is a new victimization.

commonly white (45%), female (84%), and/or between the ages of 30 and 50 (51%). On average, 25 percent of the clients served were identified as Hispanic.

It is important to note that while the majority of domestic violence survivors are female, as evidenced by many sources including crime statistics, literature and research on DV/IPV, and clients served by Centers in the survey, men experience domestic violence as well. Just over 13 percent of clients served in the past year by Centers who responded to the survey (and who provided information on client gender; n=41) were male. In addition, while the percentage of clients served by the Centers who identified as transgender was low,[30] research suggests that the transgender community is victimized at much higher rates than the general population (National Council of Anti-Violence Programs, 2010).

Exhibit 18: Client Population in the Past Year[31]

Please describe characteristics of your Center's client population in the past year:							
		Count of Center respondents					
Demographic Category	Average %	0-10%	11-30%	31-50%	51-70%	71-90%	91-100%
Gender							
% Male (n=41)	13	22	16	1	1	1	0
% Female (n=41)	84	0	1	1	3	18	18
% Transgender (n=20)	0.4	20	0	0	0	0	0
% Other (n=19)	2	17	2	0	0	0	0
% Unknown (n=18)	3	17	1	0	0	0	0
Age Range							
% 0-17 (n=33)	10	23	8	1	0	0	1
% 18-30 (n=35)	24	4	20	11	0	0	0
% 30-50 (n=35)	51	1	3	14	11	6	0
% 50 and older (n=35)	10	22	13	0	0	0	0
% unknown (n=23)	6	19	3	1	0	0	0
Race							
% White (n=38)	45	3	11	11	5	5	3
% Black/African American (n=37)	26	9	16	7	4	1	0
% Asian (n=34)	4	31	3	0	0	0	0
% American Indian / Alaska Native (n=32)	1	31	0	1	0	0	0
% Hawaiian / Pacific Islander (n=26)	1	26	0	0	0	0	0
% unknown (n=29)	13	20	6	1	1	0	1
Ethnicity							
% Hispanic (n=39)	25	13	8	15	2	0	1

[30] This may be the result of transgender clients choosing to identify as "male" or "female" rather than "transgender" or not reporting any gender orientation during the intake process.

[31] The percentages included in this table were provided from the Centers. No weighting calculations have been applied.

3.6 Service Provision

As service provision is the cornerstone of all FJCs, the scan was developed to help clearly identify the types of services provided by the Center, including where those services are provided: on-site, at a satellite, offsite, or through referral (i.e., not through partner agencies), and whether they target services to types of violence or specific populations. Respondents were not provided specific definitions of "on-site," "at a satellite," or "off-site."[32] As such, these definitions may vary slightly by Center (e.g., some Centers define "off-site" as services provided by a partner agency located in the community, while others may consider "off-site" to be services provided by other agencies who are not necessarily partners). As a result, any further exploration into the differences between service provision locations would need to acknowledge variation in definitions that are likely to exist across centers and/or narrow the terminology for cross-site comparison.

Forty-four respondents reported the types of services provided on-site, at a satellite, offsite, or through referral. Overall, the most commonly reported types of services provided by the Centers (regardless of *where* they are provided) are advocacy, legal assistance (criminal justice legal assistance), safety planning, and transportation; all of the Centers that responded to the question provide these services in some capacity. In fact, the vast majority of Centers indicated that they provide nearly all of the services on the list to some extent. The least commonly reported types of services provided by the Centers (again, regardless of *where* they are provided) are military assistance (73%), blind/sight impaired victims assistance (68%), VOICES Committee (survivor-led advocacy for the Center) (50%), and "other services" (18%).

There are variations, however, in the types of services provided *by location.* For example, while the most common services provided on-site are safety planning and advocacy, the most common off-site services are sexual assault forensic exams and child protective services/child welfare services.

3.6.1 Types of services provided by location: On-site

Exhibit 19 presents those services provided *on-site* that were identified by at least three-quarters of the Centers providing information (n=44). As the table shows, the most common services provided on-site are safety planning and advocacy (both 100%).

[32] The only clarification, as reflected in the text, is that services provided through referral were defined as those provided "not through partner agencies."

Exhibit 19: Type of Services Provided by Location, On-site

	ON SITE (n=44)	
Services Provided	**#**	**%**
Advocacy	44	100%
Safety Planning	44	100%
Legal assistance – restraining orders	40	91%
Community Outreach and Education	38	86%
Interpretation/Translation Services	38	86%
Legal assistance – criminal justice legal assistance (e.g. victim's rights)	36	82%
Legal advocacy/court accompaniment	35	80%
Food Assistance	34	77%
Sexual Assault Services	34	77%
Transportation	33	75%
Support Groups for Adults	33	75%
Counseling for Adults	33	75%
Law Enforcement Investigation	33	75%

3.6.2 Types of services provided by location: Satellite

Exhibit 20 presents those services provided *at a satellite location* that were identified by at least 11 percent of the 44 Centers responding to the question about which services are provided by the Center on-site, at a satellite, off-site, or through referral.[33] As a reminder, only six Centers out of the total population of scan respondents reported having satellite locations. The most common services provided at a satellite location are advocacy, food assistance, counseling for adults, sexual assault services and emergency housing (approximately 14% each).

Exhibit 20: Type of Services Provided by Location, Satellite

	SATELLITE (n=44)	
Services Provided	**#**	**%**
Advocacy	6	14%
Food Assistance	6	14%
Counseling for Adults	6	14%
Sexual Assault Services	6	14%
Housing – Emergency	6	14%
Safety Planning	5	11%
Community Outreach and Education	5	11%
Self-Sufficiency Programs (Life Skills Counseling and Development)	5	11%
Support Groups for Adults	5	11%
Housing – Transitional	5	11%
Legal advocacy/court accompaniment	5	11%
Primary Prevention Work	5	11%

[33] This includes seven Centers who answered "no" to having a satellite on Q9, but indicated in this question that services are provided at a satellite.

3.6.3 Types of services provided by location: Off-site

Exhibit 21 presents those services provided *off-site* that were identified by at least a quarter of the 44 Centers responding to the question. The most common service provided off-site is sexual assault forensic exams (39%), followed by community outreach and education (34%), and child protective services/child welfare services (32%).

Exhibit 21: Type of Services Provided by Location, Off-site

	OFF-SITE (n=44)	
Services Provided	**#**	**%**
Forensic Exam – Sexual Assault	17	39%
Community Outreach and Education	15	34%
Child Protective Services/Child Welfare Services	14	32%
Housing – Emergency	13	30%
Housing – Transitional	13	30%
Primary Prevention Work	13	30%
Employment Assistance	12	27%
Forensic Exam – Domestic Violence	12	27%
Human Trafficking Specialized Services	12	27%
Counseling for Children	11	25%
Forensic Documentation of Injuries	11	25%
Support Groups for Adults	11	25%
Teen & Youth Services	11	39%

3.6.4 Types of services provided by location: Referral

Finally, Exhibit 22 presents those services provided *by referral* that were identified by at least a half of the Centers responding to the question. The most common referrals are for substance abuse services (77%), followed by medical services and probation/parole services (68% each).

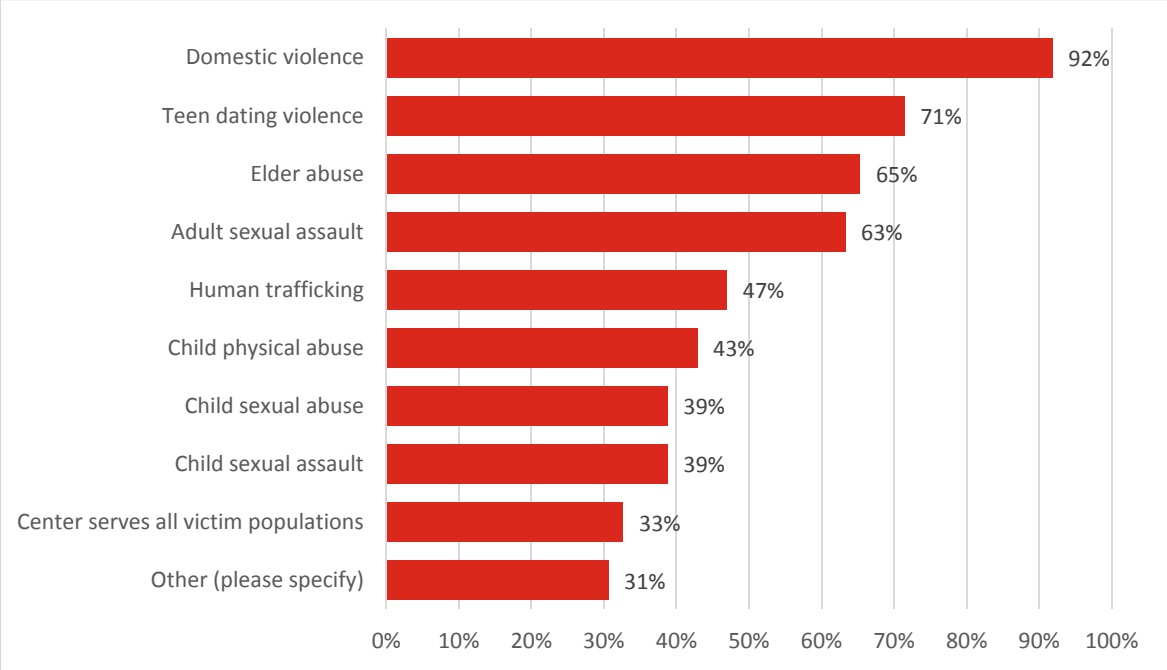
Exhibit 22: Types of Services Provided by Location, Referral

	REFERRAL (n=44)	
Services Provided	**#**	**%**
Substance Abuse Services	34	77%
Probation/Parole Services	30	68%
Medical Services	30	68%
Supervised visitation and/or safe exchange services	29	66%
Dental Assistance	28	64%
Military Assistance	28	64%
Housing – Long-term Affordable	26	59%
Parenting Classes	26	59%
Mental Health Treatment Services	25	57%
Career Counseling/Job Training	23	52%
Mentoring	23	52%

3.6.5 Types of violence targeted for services

The most common types of violence currently being targeted for services as reported by respondents (n=49) include domestic violence (92%), teen dating violence (71%), elder abuse (65%), and adult sexual assault (63%). Approximately 33% of respondents indicated that their Center serves all victim populations. See Exhibit 23 for the full range of types of violence targeted.

Exhibit 23: Target Populations: Type of Violence

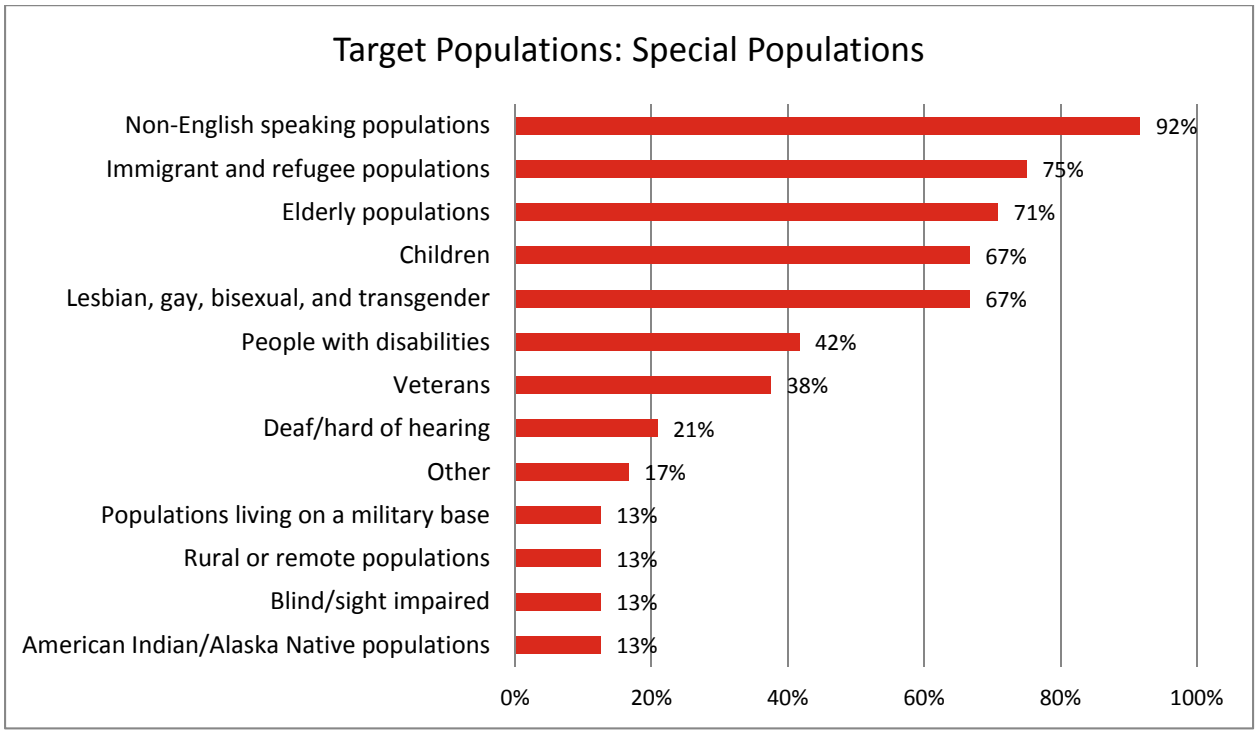


3.6.6 Types of special populations targeted for services

Just over half of respondents (n=47) indicated that their Centers target services to special populations (51%). Of those respondents who selected special populations targeted by their Centers (n= 22), the most commonly identified special population was non-English speakers (92%). The least commonly selected were American Indian/Alaska Native populations, blind/sight impaired, rural or remote populations, and populations living on a military base (3% each). Exhibit 24 presents the full range of special populations targeted. [34]

[34] None of the Centers reported targeting or serving perpetrators.

Exhibit 24: Target Populations: Special Populations



4. Evaluability Assessment

Beyond describing Centers currently in existence across the nation, we also sought to understand their potential for future evaluation. We collected information regarding Center practices and administrative data collection activities to understand how these might be utilized in a potential evaluation design. The extent to which data exists and is accessible is one gauge of evaluability. The other is willingness, which we explored by asking questions about concerns associated with participating in formal evaluation efforts, as well as experience participating in these types of efforts in the past. Lastly, we asked about support the center may need to participate in a formal evaluation.

For these purposes, we surveyed Centers across five broad categories of interest:

- Intake procedures
- Collection of client-level data
- Collection of data on services-received
- Storage and retention of collected data
- Willingness to participate in evaluation activities

On average, over two-thirds of the 52 responding Centers responded to individual survey questions regarding the above areas of interest. The subsequent sections of this chapter describe the evaluability areas of interest we explored, our rationale for asking about these elements, and descriptive statistics characterizing Center responses.

4.1 Collection of Client-Level Data

To assess their evaluation potential, Centers were surveyed about their capacities to collect and provide client-level data. Of primary interest, we wanted an understanding of client intake procedures and data collection practices. Centers' intake procedures are an important component of any potential evaluation because they represent the first point of contact between the Center service umbrella and clients in need. With a better understanding of the intake procedures and the types of information gathered upon intake, we can gauge the comparability of intake practices and potential for standardization across Centers. Any client experience and services delivered following the initial intake are likely to be heterogeneous as a result of multiple factors, including but not limited to individual client circumstances, varying service types provided among partners, and regional variation. Assessing intake procedures allows us to compare how similar the first point of engagement between Centers and clients may be, and how useful intake policies and information may be in potential evaluations.

4.1.1 Centralized intake and use of intake forms

An overwhelming majority of Centers responding to these survey questions (87%; n=46) reported using a centralized intake procedure. As a result, any sample of intake-based client-level data among these 40 Centers would be inclusive of all clients who receive services (excluding those who "opt out"). This benefits future evaluations, as it lessens the burden of collecting client intake information. When a de-centralized intake process is used, as is the case in six Centers, intake data would need to be collected across the various participating partners for the Center to be evaluated. The use of centralized intake processes did not appear to vary significantly by how long the Center has been in operation.

An even larger majority of Centers (94%, n= 47) use an intake form to collect client-level intake data. All of the Centers that have centralized intake reported using an intake form, and an additional three Centers that do not have centralized intake also reported using an intake form to collect client-level data (three Centers reported using neither centralized intake *nor* an intake form). The use of an intake form can be beneficial for any evaluation, as any record of the initial client contact can be converted into analyzable data, so long as these records are maintained and made available. The large number of respondents utilizing an intake form suggests that most Centers participating in an evaluation are likely to be able to provide some record of initial client contact.

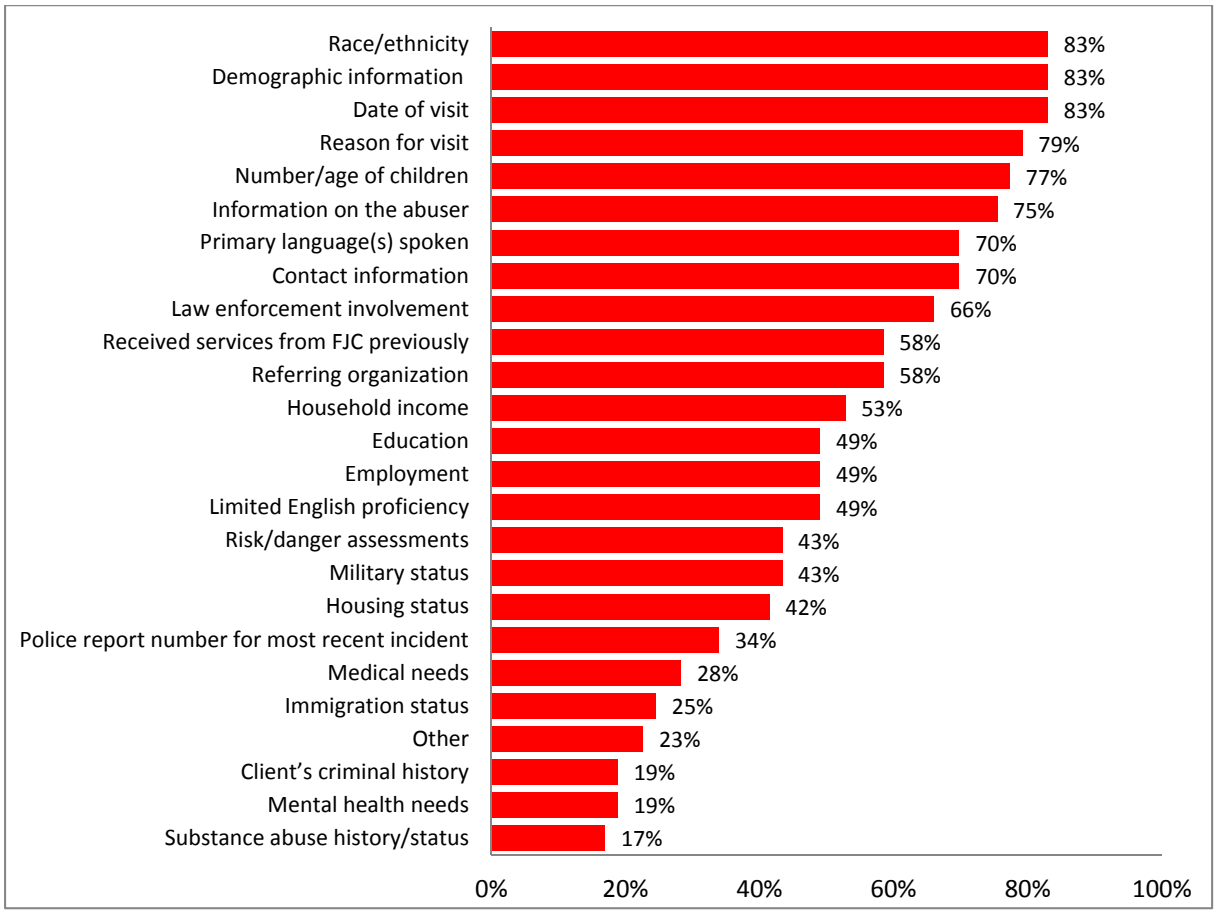
As part of the scan, we requested copies of intake forms to analyze the information of interest to Centers during intake (we received 16 forms electronically and five in hard copy). Our review of the documents provided suggests consistency in the information collected at intake, consisting of:

- Client contact information
- Demographic characteristics
- Family information
- Incident/abuse information and any law enforcement involvement
- Referring organizations

4.1.2 Types of client-level data collected

Survey respondents were also asked to provide details about the types of client data collected during intake. Forty-six respondents provided at least some detail about the intake data captured. As illustrated in Exhibit 25, the majority of respondents (75% or greater) collect data on visit dates, client demographic information, number/age of children, reason for visit, and information on the perpetrator. Substance abuse history/status (17%), mental health needs (19%), and client's criminal history (19%) were the least common types of client-level data collected at intake.

Exhibit 25: Types of Client-level Data Collected as Part of the Intake Process



4.1.3 Client-level data storage

Exhibit 26 presents a breakdown of client information collected at intake by the storage means (electronic vs. paper forms) (n=46). In almost every case, Centers stored client information collected at intake electronically, regardless of the type of information collected. Again, these responses suggest that future evaluators should be able to collect robust data about intakes from participating Centers, with a majority likely maintaining these data electronically.

Exhibit 26: Information Collection and Storage

Which information is collected as part of the intake process and how that information is stored (select all that apply)? (n=46)								
	Yes		Electronic		Paper		Not Stored	
Information collected	#	%	#	%	#	%	#	%
Date of visit	44	96	35	80	6	14	1	2
Contact information	37	80	27	73	7	19	1	3
Demographic information	44	96	37	84	5	11	0	0
Race/ethnicity	44	96	35	80	5	11	0	0
Primary language(s) spoken	37	80	29	78	4	11	0	0
Limited English proficiency	26	57	20	77	3	12	1	4
Immigration status	13	28	10	77	2	15	0	0
Housing status	22	48	14	77	3	14	0	0
Employment	26	57	20	77	4	15	0	0
Education	26	57	20	77	3	12	0	0
Number/age of children	41	89	32	78	3	15	0	0
Military status	23	50	18	78	3	13	0	0
Household income	28	61	21	75	5	18	0	0
Reason for visit	42	91	31	74	6	14	1	2
Medical needs	15	33	9	60	3	20	0	0
Mental health needs	10	22	5	50	3	30	0	0
Substance abuse history/status	9	20	6	67	2	22	0	0
Risk/dangers assessments	23	50	15	65	6	26	0	0
Clients criminal history	10	22	5	50	3	30	1	10
Information on the abuser	40	87	29	73	6	15	1	3
Law enforcement involvement in the current situation	35	76	23	66	9	26	1	3
Police report number for most recent incident	18	39	9	50	7	39	0	0
Referring organization	31	67	24	77	4	13	0	0
Received services from FJC previously	31	67	23	74	3	10	1	3
Other (please specify)	12	26	9	75	1	8	0	0

*Some respondents responded, “Yes” to collecting a specific variable, but did not respond to the follow up questions asking how the information is stored.

Exhibit 27 below presents further detail on the data storage types for the electronically stored client-level data from intake (n=46). Of the four electronic storage options provided to respondents (Efforts to Outcomes (ETO), ARJIS, Excel, or Access), the information collected electronically is most commonly stored in an ETO case management database (n=11).[35] Many Centers reported using an "other" type of electronic data storage. Examples of other electronic data storage include case management software for non-profits such as Apricot and CAP60, as well as other data management software such as SQL, and Infonet.

Exhibit 27: Data storage types

If electronic database, type of database?									
		ETO		Excel		Access		Other	
Information collected	n	#	%	#	%	#	%	#	%
Date of visit	35	11	31	4	11	3	9	16	46
Contact information	27	11	41	2	7	2	7	8	30
Demographic information	37	10	27	5	14	3	8	14	38
Race/ethnicity	35	10	29	5	14	3	9	13	37
Primary language(s) spoken	29	8	28	4	14	3	10	11	38
Limited English proficiency	20	9	45	2	10	3	15	4	20
Immigration status	10	6	60	0	0	1	10	2	20
Housing status	17	6	35	1	6	2	12	7	41
Employment	20	5	25	1	5	3	15	9	45
Education	20	5	25	0	0	2	10	10	50
Number/age of children	32	7	22	4	13	3	9	13	41
Military status	18	6	33	2	11	2	11	4	22
Household income	21	5	24	2	10	3	14	7	33
Reason for visit	31	8	26	4	13	3	10	13	42
Medical needs	9	4	44	0	0		0	5	23
Mental health needs	5		0	1	20	1	20	3	60
Substance abuse history/status	6	2	33	0	0		0	3	50
Risk/dangers assessments	15	6	40	0	0	2	13	6	40
Clients criminal history	5	3	60	1	20		0	1	20
Information on the abuser	29	9	31	3	10	1	3	13	45
Law enforcement involvement in the current situation	23	8	35	2	9	2	9	8	35
Police report number for most recent incident	9	4	44	1	11		0	3	33
Referring organization	24	7	29	4	17	2	8	9	38
Received services from FJC previously	23	5	22	5	22	2	9	11	48
Other (please specify)	9	2	22	1	11	1	11	5	56

[35] ETO is a "comprehensive outcomes and case management tool for large nonprofits, government agencies, and community collaboratives." Retrieved from https://www.socialsolutions.com/software/eto/)

4.1.4 Client-level data linkages

As shown in Exhibit 28 below, 31 of 36 responding Centers (86%) link their electronic database data to clients by name. Nineteen (53%) report linking by a unique database identifier. Nineteen Centers link to clients by name only, while six solely use unique identifiers. The remaining 17 have both name data and identifiers that enable linking to clients.

Exhibit 28: Linkages of Electronic Data to Clients

Is information in the Center's electronic database linked to the client by name or identifier? (n=36)		
	#	%
Electronic database linked to client by NAME	31	86%
Electronic database linked to client by IDENTIFIER	19	53%

Based upon these responses, it is clear that Centers maintain sufficiently detailed, and comparable, sources of client data at intake. We are encouraged by the ability of Centers to provide client-linked data across a wide range of client characteristics collected at intake. The near unanimous use of intake forms indicates that most centers participating in any evaluation would be able to provide a standardized record of this intake data. Most are collected electronically, using comparable systems, and if not electronically, can be aggregated from records of the intake forms.

4.2 Collection of Data on Services Received

Beyond identifying what client information centers collect, and how these data are stored, data regarding interventions (in the form of services provided) is another important set of data to support future evaluation activities. Centers were surveyed about limitations to service data (in regards to client anonymity), the types of service data collected, how this information is stored, and lastly, the length of time these data are available. Each of these areas is discussed in the following subsections.

4.2.1 Client anonymity and data collection

When analyzing client-level data and service provisions, evaluators must also be cognizant of the procedures governing service delivery in relation to this information. For example, if an individual visits a Center seeking service, must they provide personal information in order to receive services? Even if they provide personal information, do clients have the ability to opt out of this information being recorded? If so, does this have any impact upon service provision? Such questions are important to consider, because they highlight potential discontinuity between client data and service data available for use in evaluation.

To gauge the potential impacts of this on data sources, we surveyed Centers about:

- The ability of clients to receive services anonymously,
- The ability of clients to opt out of electronic storage of intake information, and
- Whether Centers limit services for opting out of providing intake information.

Exhibit 29 summarize Centers responses to these questions. Twenty-eight Centers out of the 44 who answered the question (64%) allow clients to opt out of providing personal information at intake, an additional seven Centers (16%) *sometimes* allow clients to opt out of providing data. Respondents who selected that clients are *sometimes* allowed to opt-out of providing personal information at intake were asked to *explain,* responses include:

- "Crisis calls do not require any information"
- "This is handled on a case by case basis with the final decision being made by the director, assistant director, or victim services supervisor"
- "Some services, like civil legal cannot be anonymous"
- "Mandated reporting concerns may inhibit our ability to assist clients who wish to remain anonymous"

Twenty-eight Centers allow clients who are providing information to opt out of having their information inputted into a statistical database (an additional five Centers *sometimes* allow clients providing information to opt out of having their data stored electronically).

Respondents were also asked if services are limited or refused if clients opt-out of providing information at intake.[36] Eleven Centers indicated that it may limit or refuse services if clients opt-out of providing intake information, but 10 of these 11 Centers indicated that these services were only *sometimes* limited or refused. Respondents who selected that services were only *sometimes* limited or refused were asked to *explain*, examples include:

- "It depends on the information that is opted-out. Some legal documents require that the client have ID and provide their contact information. If a client chooses to withhold information, we can safety plan and discuss other resources, but we may not be able to file for protection order or do other court-based interventions"
- "The majority of services are still provided, however the client could not access the video-court services anonymously"
- "Some partner services cannot be accessed without a name"

As anticipated, some services offered by the FJCs, particularly law enforcement investigation and prosecution-related services, may require initial information disclosure before they can be offered.[37]

Exhibit 29: Client Anonymity and Data Collection

	Clients can opt out of providing information	Clients can opt out of information stored in statistical database	Services are limited/refused if clients opt out
	n=44	n=44	n=34
Yes	28 (64%)	28 (64%)	1 (3%)
No	9 (20%)	11 (25%)	23 (68%)
Sometimes	7 (16%)	5 (11%)	10 (29%)

[36] Although all respondents were asked if clients can opt out of providing information at intake (Q35), only those that responded in the affirmative were supposed to answer whether services are limited or refused as a result (Q36). However, one respondent who indicated "No" on Q35 *also* responded to Q36. And one respondent that answered "Yes" and one that responded "Sometimes" did not answer Q36.

[37] The Alliance recommends that Centers provide services regardless of whether clients provide all intake information.

As a byproduct of allowing clients to receive services after opting out of providing or recording information at intake, evaluators may encounter the following scenarios when utilizing service data from the Centers:

- Services may be recorded without any corresponding client information
- Recorded service data may be limited only to those clients providing intake information
- Certain types of services may be underrepresented in the data due to anonymous clients utilizing these services
- Certain types of clients may be excluded from an evaluation, introducing an unknown bias

Any evaluation must take into account the potential impacts of these scenarios, and incorporate designs that account for potential systemic bias introduced by these procedures.

4.2.2 Collection of service data

Beyond characterizing potential limitations in tracking services as a result of client anonymity, we also surveyed Centers about their ability to track services overall, by type, and individually. Exhibit 30, below, characterizes the overall ability of surveyed Centers to track and provide data on services requested by clients. Of the 38 Centers that responded to this question, the majority track services **requested** by clients at the Center in their electronic databases (32 or 84%).[38] Of the 32 Centers who track services requested, 23 (72%) and 27 (84%) confirmed being able to provide these data both at the de-identified individual level and at the aggregate level, respectively.

Exhibit 30: Collection of Service Data, Services Requested

If clients are tracked using names or identifiers, does the electronic (statistical) database also track service *requested* by clients at the Center? (n=38)						
	#	%				
Yes	32	84%				
No	5	13%				
Don't Know	1	3%				
If yes, can the data be provided at the:	**Yes**		**No**		**Don't Know**	
	#	%	#	%	#	%
De-identified individual level?*	23	72%	3	9%	5	16%
Aggregate level?	27	84%	0	0%	5	16%

*One Center who said "Yes" to tracking services requested by clients did not provide an answer to de-identified level.

As shown in Exhibit 31, over 90 percent (34 out of 37) of Centers who responded to the question track services **received** at the center, and 30 percent additionally track services received by clients outside of the center. The majority of Centers can report these data at both the de-identified individual level (65%) as well as aggregate (82%).

[38] All respondents were asked the questions related to tracking services requested and received, regardless of how they answered if the information in the Center's electronic database is linked to client name or identifier.

Exhibit 31: Collection of Service Data, Services Received

If clients are tracked using names or identifiers, does the electronic (statistical) database also track services *received* by client (*select all that apply*)? (n=37)						
	#	%				
At the Center	34	92%				
Outside the Center	11	30%				
If yes, (at or outside the Center) can the data be provided at the:	**Yes**		**No**		**Don't Know**	
	#	%	#	%	#	%
De-identified individual level?	22	65%	2	5.9%	8	24%
Aggregate level?	28	82%	0	0.0%	6	18%

*Two Centers that said "Yes" to tracking services received by clients did not provide an answer to de-identified level.

Taken together, these results suggest that a majority of Centers electronically track client service data, especially when those services are received at the center itself. Potential evaluations should have sufficient sources of client service data for both services requested and services received, bolstered particularly by those that also track services received beyond the Center. The ability of these database systems to provide these data at both de-identified individual and aggregate levels is critical for evaluators in formulating evaluation designs that more easily meet human subject protections criteria.

4.2.3 Types of client service data collected

Of the client service data tracked, the Centers surveyed report a variety of data types collected. Exhibit 32 below summarizes both types of data respondents collect, as well as the method used to collect it. Thirty-nine (87%) of the 45 responding Centers track services received by clients, most of which do so via case management/intake related systems (answered via "other"). Over half also collect data on services partially received, and over two-thirds collect data on satisfaction with services. Nearly half of Centers also collect information about services partially or not received. Most data on service satisfaction and perception of access to services comes via exit surveys with clients.

Exhibit 32: Client Information Collected and Methods for Collecting

Specify the type of information collected from clients and the method used to collect the information (*select all that apply*) (n=45)											
	Collected		Exit Survey		Focus Groups		Follow Up Calls		Other		Method Not Specified
Types of Information	#	%	#	%	#	%	#	%	#	%	#
Services received	39	87%	11	28%	0	0%	6	15%	16	41%	6
Services partially received	24	53%	6	25%	2	8%	3	13%	9	38%	4
Services not received	22	49%	7	32%	1	5%	2	9%	9	41%	3
Reasons services partially/not received	21	47%	8	38%	1	5%	1	5%	6	29%	5
Satisfaction with services	29	64%	20	69%	1	3%	1	3%	3	10%	5
Perception of access to services	19	42%	9	47%	5	26%	1	5%	2	11%	3
Other	6	13%	1	17%	1	17%	1	17%	1	17%	2

A majority of Centers also reported an ability to provide multiple types of data on outcomes for clients, as shown in Exhibit 33. Almost all reported an ability to provide outcome data on clients seeking and receiving services, as well as data on new and returning clients seeking services. A majority can also provide outcome data on sources referring clients to the Center, services sought, reasons for seeking service, and the services received on-site. To a lesser extent, a small number of Centers can also provide data on services received at satellite locations, offsite entirely (including those based on a referral), and services *not* received and why. Researchers therefore should be mindful that these data may not regularly be available for use in future outcome-focused evaluations.

Exhibit 33: Ability to Provide Outcome Data

Please confirm the extent to which you can provide the following outcome data (*select all that apply*): (n=41)		
Outcomes	**#**	**%**
Number of clients receiving services	38	93%
Number of clients seeking services	38	93%
Number of new clients seeking services	37	90%
Number of returning clients seeking services	33	81%
Sources referring clients	31	76%
Services sought by client	33	81%
Reasons for seeking services	26	63%
Services received on-site	34	83%
Services received at a satellite	8	20%
Services received offsite	7	17%
Services received based on referral	8	20%
Services not received	16	39%
Reason services not received	11	27%

As shown in Exhibit 34, 34 (79%) of 43 respondents perform some degree of client follow-up, with the majority occurring upon exiting the center. Exhibit 35 describes how Centers utilize this follow up data, with almost all (86%) of Centers using data for administrative purposes. Most frequently, Centers reported using these data for internal analysis/staff feedback as well as for funding justifications, but improving service delivery and satisfying grantee funding requirements were commonly cited uses as well.

Exhibit 34. Follow-up Activities with Clients

Does the Center follow-up with clients (e.g., asking clients to fill out an exit survey, participate in a focus group, calling to follow-up, etc.? (n=43)		
	#	**%**
Yes	34	79%
No	9	21%
If yes, at what intervals (*select all that apply*)?	**#**	**%**
Upon exiting the center	22	65%
As part of follow-up	17	50%
At/on a certain time period after visiting the center	8	24%
Other	9	27%

Exhibit 35: Use of Data Collected

Does the Center use the data collected for any purpose? (n=44)		
	#	%
Yes	43	98%
No	1	2%
If yes, purpose(s) for collecting data (*select all that apply*)	**#**	**%**
Internal analysis (e.g., feedback to staff)	41	95%
Improve service delivery	40	93%
Center annual reports	33	77%
Justification for funding	42	98%
Grantee funding requirement	39	91%
Evaluations	31	72%
Other	2	5%

These responses indicate that for a majority of Centers, client-level service timelines could be analyzed from intake to exit. The client service data collected could support robust evaluation designs examining service utilization and outcomes, beginning with intake and following through the receipt of services.

4.3 Storage of Client-level Data

The retention of relevant data is an overarching factor influencing any potential evaluation approach. With sufficient availability of data over years, researchers may be able to consider time-series evaluations.[39] Using client data from multiple years, potential evaluations may also achieve greater accuracy in estimating rates of return to the Center. Centers were surveyed about their data storage practices in order to assess the typical period of data retention, and account for practices that might result in incomplete service data.

As shown in Exhibit 36, among the 37 Centers who responded to this question, all but four maintained electronic records from their databases for over a year. However, all four Centers with less than one year of data had only recently begun operations at the time of the survey, and presumably will retain data beyond this immediate time frame. Centers had data available on average for approximately four years. Exhibit 37 shows that nearly 75 percent of Centers reported that they did not purge data. Eight Centers did not know, and less than 10 percent of Centers reported purging their data at specific intervals (none of the intervals were less than 3 years). These results suggest that future evaluations will likely have multiple years of comprehensive client and service data available for analysis, which can support a wider range of quasi-experimental research design options.

[39] "A time series evaluation is a collection of observations of well-defined data items obtained through repeated measurements over time. ... identifying the nature of the phenomenon represented by the sequence of observations, and forecasting (predicting future values of the time series variable)." Retrieved from http://www.betterevaluation.org/en/evaluation-options/timeseriesanalysis.

Exhibit 36: Years of Data Available

Of the information stored in an electronic database, how long have you maintained these electronic records? (n=37)		
	#	%
Less than 1 year	4	11%
1-3 years	14	38%
4-6 years	9	24%
7-9 years	4	11%
10-12 years	6	16%

Exhibit 37: Data Purging

Is the data purged at specific intervals? (n=40)		
	#	%
Yes	3	8%
No	29	73%
Don't Know	8	20%

4.4 Evaluation Willingness

Lastly, we surveyed Centers about their willingness and ability to participate in future evaluations. We asked a series of questions about their participation interest, as well as other factors like types of support needed, participation in prior evaluations, etc.

Of 41 responding Centers, 33 (or about 80 percent) expressed willingness to participate in a formal evaluation. Exhibit 38 summarizes the types of support needed for participation in a formal evaluation, as indicated by respondents. Funding and staffing support were each indicated by roughly two-thirds of respondents as needed for participation. Those respondents that selected "funding" or "staff" were asked to clarify how much of each would be needed. Respondents indicated that they would need an average of $15,000 and/or 30 hours per week in staff support. Just under half of Centers indicated that support would be needed in the form of training and technical assistance, most commonly regarding extracting data.

Exhibit 38: Needs for Participating in Formal Evaluation

If you were to participate in a formal evaluation, what types of support do you think you would need to participate (*select all that apply*) (n= 38)		
Type	**#**	**%**
Funding	26	68%
Staff	25	66%
Other	10	26%
Training & Technical Assistance	16	42%
Extracting data	13	81%
Interpreting confidentiality guidelines	9	56%
Other	4	25%

About a third of Centers indicated that they had some involvement in a current or prior evaluation, as shown in Exhibit 39. Five Centers were uncertain about any involvement in evaluations to date. Twelve (80%) of the 15 Centers involved in evaluations to date were involved in process evaluations. Only three Centers also had any involvement in outcome or impact evaluations. Most evaluations have been conducted by an independent evaluator, as shown in Exhibit 40. Eight of the Centers provided data electronically to these evaluators.

Exhibit 39: Evaluation of the Center

Is the Center currently being evaluated or has it been evaluated in the past? (n= 43)		
	#	**%**
Yes	15	35%
No	23	53%
Don't Know	5	12%
If Yes, evaluation type (*select all that apply*)		
Needs Assessment	6	40%
Process Evaluation	12	80%
Outcome Evaluation	3	20%
Impact Assessment	3	20%
Not sure	2	13%

Exhibit 40: Current Evaluator

Who is conducting/conducted the evaluation (*select all that apply*)? (n=15)		
	#	**er**
Internal Staff	4	27%
Independent evaluator	12	80%
Did you provide electronic data?		
Yes	8	
No	0	
Don't know	3	
Unknown	1	
Others	1	7%

These responses indicate a willingness among Centers to participate in formal evaluation. The responses to questions regarding data collection, storage, and retention provided by our sample, suggests that data on client throughput and services received are likely to be available for most Centers. The biggest hurdle seemingly facing future evaluations will be incentivizing and supporting Centers for their participation. Funding and additional staff are needed to offset burdens and disruptions potentially imposed by data collection activities, which future evaluation designs should take into consideration at the outset.

5. Proposed Research Designs for National Evaluation

While the findings in this report are not reflective of all FJCs in operation across the US, they suggest that there are variations in center structure and operation that should be explored through evaluation efforts. The results also suggest that there is available of data and adequate interest in evaluation among FJCs. This section presents recommendations regarding how FJCs might be evaluated. We start by revisiting the logic model to review anticipated outcomes among FJCs and follow with recommendations on how a national cross-site evaluation may be designed. While the scan did not include all Centers in operation across the United States, the findings support the presence of variations in center structure and operations that should be explored through evaluation efforts, as well as provide confidence in the ability of Centers to participate in formal evaluation efforts.

5.1 Design for Cross-site Evaluation of FJCs

The critical goals of FJCs are to increase safety for domestic violence survivors through collaboration and coordination that increases access to and utilization of a range of services. The co-location of services is intended to offer and encourage utilization of a range of needed services, minimize travel to multiple agencies, reduce the number of times a client has to repeat her story, reduce case processing time, and, in general, improve the efficiency and capacity of service providers and reduce victimization in an area. As presented earlier, the logic of how Centers may achieve these goals is depicted in Figure 1. The model links the organization of the Center and its resources or inputs to planned activities to the outputs of those activities, and ultimately to intermediate and ultimate outcomes that derive from those outputs. The outcomes may be realized at the individual client level and at the systems level.

As discussed earlier, the PFJCI played an important role in institutionalizing the FJC movement by providing federal funds to establish FJCs in communities across the country, and establishing, through grant requirements, core program elements that include co-location, centralized intake, and a multi-disciplinary focus on providing specific services to survivors of domestic violence. The extent to which these and other program elements, as depicted in the logic model, have been implemented across Centers nationwide was explored through the scan. The goal of the scan was to identify and include all Centers that involve the co-location of a multiple agencies that support a multi-disciplinary team to provide services to adult survivors of family violence. Using a broader concept than prescribed through the PFJCI and supported by organizations like the Alliance offered both the opportunity to identify the range of Centers operating across the country and collect sufficient information to identify specific elements that could cause a differential impact on outcomes.

Through the scan we confirmed that there are variations across the Centers, all of whom provide a wide range of services under the overarching goal of placing comprehensive victim services and advocacy in one physical location. There are variations in governance structure, organizational configuration, size and number of partners, services provided, and data infrastructure. For example, 27 percent scanned are part of a coordinated FJC/CAC model and 12 percent host satellite locations. They also vary in how services are provided---on site, off site with a partner agency or by referral out. And, the majority, but not all, use a centralized intake procedure even if services are provided elsewhere. This variation provides the basis for examination of comparative effectiveness of different configurations of services and programming.

The second objective of the scan was to inform the development of a plan to formally evaluate Centers in terms of their effectiveness: 1) in implementing the model; and 2) in producing real change in the outcomes of interest, and 3) in which variations in programming work best in reaching common outcomes. The basic questions are whether the program works as intended and whether the effect of the Centers programming can be isolated from other factors that may produce those effects. This involves logically linking the activities of the program as displayed in a program's logic model to the outcomes they are intended to produce. To answer these questions, we looked at two aspects of the Center programs—did the program get implemented as planned and with fidelity, and did it make a difference in the outcomes at the client and service levels?

5.1.1 Measuring processes and impacts

Our cross-site evaluation plan is based on the following assumptions. We understand that these assumptions may be different once final budgetary and programmatic decisions are made, but they are offered to provide a common basis for the presentation.

- Programs will be selected for the evaluation from a group of either new or legacy Centers.
- Programs may be excluded by asking participants to meet some minimum requirement of what constitutes a FJC in the government's eyes, e.g., centralized intake, criminal justice partnerships.
- Due to budget restrictions, a finite number of Centers will be included in the evaluation rather than an attempt to cover the universe of centers in operation.
- Centers will volunteer or opt into the evaluation.

The basic research questions for a multi-site evaluation of the Centers can be divided into questions regarding ***program processes*** and questions regarding ***outcomes or impacts***. Answers to the first set of questions on how a program was implemented are critical for understanding how the program achieved the answers to the second set of questions.

Describing Program Processes

- What are the specific resources, activities, organizational configurations governing the Centers under evaluation?
- What are the specific outputs of the resources and activities?
- What characteristics in the program's setting that could affect client and system level outcomes, e.g., physical location, available resources, funding?
- What characteristics of the program operations could be related to client and system level outcomes, e.g., staffing, training, partnerships, use of central intake?
- Was the program implemented with fidelity to the basic Center model?
- What were the barriers or challenges to program implementation?

This part of the evaluation serves two purposes. The first is to provide a full description of the programs, how they operate, and any issues with how they execute their models. The second is to gather data on what individual program-level characteristics are potential predictors of client level outcomes. The data elements used in the process and implementation portion of the evaluation are those in the first two columns of the logic model, i.e., program inputs and activities. Data are collected through interviews with staff and partners, review of organizational and administrative materials, program policy manuals,

training records, minutes of collaborative meetings, review of referral networks, and observations of program operations and spatial arrangement.

This part of the evaluation would also include monitoring program implementation by collecting data on what the program produces, i.e., program outputs. For Centers, this might include the number of partnership agreements or MOUs signed, the number of service providers trained, the number of services provided, caseloads, physical layout, intake procedures, number of new clients served, number of services provided, etc. Most of the data is likely to be maintained in the Center's data management system, but may also be collected through document review or interviews with program administrators.

Describing Program Outcomes across Center Programs

Given the variation observed in the scan, an important question for the larger evaluation is whether there are significant differences in the outcomes related to these characteristics in producing the common goals of increasing victim safety, increasing service access, and improving institutional response to DV. Both the data on program inputs and activities and the data from monitoring implementation (the outputs) can be codified for cross program analyses of the effectiveness of systems development as well as the contribution those program elements have on victim and systems level outcomes.

We offer two possible designs for looking at center outcomes and impacts:

- Determine the *comparative effectiveness* of different configurations of programming confining the comparisons to implemented Centers in a cross-site evaluation of sampled Centers
- Determine the *impact* of the Centers by looking at a control condition

We describe each below.

As stated in the initial assumptions for this evaluation plan, for either design we suggest sampling across the Centers given that there may be close to 100 possible Centers that make up the universe of programs in operation. If NIJ restricts the number of programs through a selection process, i.e., limiting to presence of certain program elements (e.g., centralized intake, criminal justice partners), sampling may not be needed. However, we suggest a possible scenario that includes a simple sampling plan that assures the inclusion of enough Centers that either include or do not include a core element of the model prescribed through PFJCI.

The intent of the scan was to include both Centers that call themselves FJCs and similar multi-agency co-located collaboratives. While all share some common elements (i.e., co-location, multi-agency), they are likely to vary in terms of structure, the intake process, and services provided. However, there is one element, the presence of a criminal justice partner, which is an important area of exploration for any formal evaluation effort that includes the range of collaboratives included in the scan.

We have chosen this feature of variation because 1) it is a program element that may have an important association with critical outcomes (victim safety, reduced case processing time, repeat DV events), and 2) the environmental scan found that of the 52 centers responding to the scan survey, 25 percent had no criminal justice or district attorney partner *on-site*. While this choice should be discussed and approved by NIJ, it appears to be a program element that is important to explore through evaluation and one that may not be possible if a simple random sample or sample proportionate to size were employed.

We suggest that Centers interested in participating in the cross-site evaluation fill out a simple checklist of features to explore through evaluation, including whether they have criminal justice partners on site, as

well as other requirements, e.g., minimum data needs for the evaluation, implementation status, willingness. From the pool of Centers, we would divide the list of those interested into those with criminal justice partners and those without, making sure we have an adequate number of programs in each group. Depending on the resources available and the number of interested programs, we suggest either taking all of the programs in each group or sampling randomly within each group to obtain an adequate number for comparisons. As detailed below, one of the limitations of large program numbers lies in the need for a counterfactual condition to determine impact; that is, comparison data on what happens without a Center in terms of the outcomes of interest. Gathering data for the counterfactuals can be costly so NIJ may wish to limit the number of programs for the impact analysis.

5.1.2 Examining comparative effectiveness

This analysis strategy assumes that some version of Center programming will be useful (i.e. there is no "no programming" option in the analysis) and examines which variation in the services, operations (e.g., centralized intake), and activities of the centers are likely to produce different outcomes on the client and systems level. The first questions to address are comparisons within the samples of programs in comparison to each other. These outcome questions include:

- Does the program increase coordination of services across agencies?
- Does the program increase victim safety?
- Does the program increase access and utilization of needed services?
- Does the program increase client's satisfaction with services?
- Which combination of FJC components or services is the most effective in producing client and community level outcomes above?
- For whom does the program work most effectively?
- What program characteristics predict positive outcomes?

Exhibit 41, below, indicates the data that might be used for looking at these outcomes across participating programs. Predictive variables at the program level include: use of central intake, number/coverage of services, staffing, mental health services, child services, communication between service agencies, number of partners, context (urban/rural, etc.), resources available, co-location with CAC, etc. Predictive variables on the victim level include: demographics, immigration status, age, prior DV experiences, living situation, children, family support, financial situation, housing status, etc.

Exhibit 41: Potential Variables and Data Sources for Center Evaluation

	Measure	Data source
Dependent variables (Outcomes)		
Client level		
Access to and utilization of services	Client report of increased access	Client surveys/interviews[40]
Retention in services	Client record of service utilization	Program records
Client sense of safety	Reduced client's victimization	Focus groups
Client satisfaction with programming	Client time in service	
Reduced victimization	Client satisfaction	
Client sense of hope, satisfaction of life, etc.	Client hope or other survivor defined outcomes	
		Agency directories
Program/service level		On site stakeholder interviews
Area access to services	Increased number and types of services offered	Program records
Service coordination	Number of survivors served	Police Calls logs
Number of successful prosecutions	Evidence of increased outreach, protocols	ER aggregated data
Case processing time	Number of Calls for DV, Number of Calls for DV at same location	Court records
Utilization of DV services	Decreased ER visits for DV	UCR
Incidence of DV	Increased successful prosecutions	
Repeat incidence of DV with injury	Increased participants housing stability	
Offender accountability	Reduced case processing time	
ER visits, DV related hospitalization	Changes in DV arrests	
Housing stability		
Independent variables (Predictors of outcomes)		
Client level		
Demographics (age, ethnicity, education)	Program data on client characteristics	Program records review
Immigration status	Needs assessments	Client interviews/surveys
English as a Second Language	Dates of service	Focus groups
Prior DV victimization	Services received	
Living arrangement: with partner	Referrals	
Housing need		
Financial need		
Prior service history		
Specific services received		
Mental health and substance abuse needs		
Retention in program		
Program/Service level	Program records	
Staffing	Funding sources	Site visit observation
Funding	Outreach programming	Program records review
Community resources	Cultural competency	Stakeholder interviews
Services offered on site	Numbers and types of services in community/agencies	Staff interviews
Co-location of programming	Numbers and types of services offered	Census data
Services offered off site or by referral	Training attendance and staff coverage	UCR data
Community demographics		staffing, programming

[40] See Appendix F for Measures of Hope and other survivor defined outcomes, as well as other scales and instruments.

	Measure	Data source
Training, TA Level of services coordination Physical location Coordination/ collaboration of partners	MOUs, letters of agreement with agencies Patterns of communication Numbers of meetings, collaborative events Network of referral partners Staff caseload Data security protocols	Training attendance records Program meeting records, minutes Review of social service and law enforcement networks

Average change over time in the outcome variables can be examined across each program, across groupings of programs (criminal justice partners/no criminal justice partners, urban/rural, etc.) and for subpopulations within the groups. It is also useful to look at the data collected on all programs and individuals that are potential predictors of change at the individual, program and systems level using regression techniques. This allows the researcher to answer programmatically important questions: Are certain services or program components related to higher levels of retention of survivors? Is age a factor in utilization of services? Does the presence of law enforcement increase or decrease victim sense of safety?

This part of the analysis looks at whether the variation in components of Centers has an effect on the range of outcomes of interest. This stage of the analysis is focused on questions that help "unpack" the effect; that is, what components of the service provision predict the greatest outcomes, and for whom is the service provided most effective. These questions can be addressed through a series of predictive statistical methods using characteristics of the programs and/or characteristics of those served as predictors of the outcomes of interest. These are internal explorations rather than comparisons of the condition where the intervention does not exist and thus are directly linked to program improvement or outreach efforts.

These comparisons answer questions about the differential effects of programming on outcomes, but not the question of whether the presence of the programming itself in any form had the desired effect. Those questions are answered only by introducing a non-program comparison or a counterfactual.

5.1.3 Determining impact: Programming compared to the absence of programming

This evaluation design focuses on answering the question of whether the program effected change or if any changes observed were the result of historical trends or occurred by chance (i.e., what would have happened doing nothing at all). In its most simple form, the outcome evaluation may compare clients before and after visiting the Center to see if they made improvement to key program outcomes or compare service usage, case processing time, or domestic violence rates before, during, and after the implementation of a Center; but any measured change cannot be attributed solely to the Center. Definitively determining the impact of programming, i.e., what would have happened if the programming were not there, is more complex.

Impact questions include:

- Does the presence of a FJC significantly increase victim safety?
- What effect does a Center have on the number of DV calls for service or number of successful DV prosecutions?

- What is the effect of a Center on DV arrests?
- Does the presence of a Center increase the number of survivors served in relevant agencies?

In evidence-based research, it is widely recognized that a properly-executed experimental (i.e., random assignment) evaluation provides the strongest evidence of unbiased, internally valid impact estimates. As such, random assignment is widely considered the gold standard approach for assessing impacts and requires a clear counterfactual to use as comparison.

But the first issue for any random assignment evaluation is to consider how the lessons learned from an experimental evaluation will inform policy and practice. Knowing how the results of the evaluation will translate into policy action is essential to answering the first basic question of design: What should be randomized? If results are meant to identify whether (or which) clients should be directed to or redirected away from centers, it suggests that individuals should be randomized to participate in the program or not. If results are meant to be used to refine program structure by identifying the relative impacts of components of programs, it suggests that components within programs should be randomized. Or if results are meant to identify whether communities should implement a Center by looking at the relative impact of a center on communities, it suggests that programs themselves should be randomized. A primary goal should be to determine how the results of the evaluation will be used to inform change and develop a design that addresses those expectations.

Determining the strategy for randomization also requires practical considerations of constraints imposed by program characteristics and operations. In this case, randomization at the individual level is not feasible for multiple reasons. Whether or not a victim seeks services through a Center is not something the Center controls. Similarly, whether a victim seeks services from both the Center or directly through its partner agencies or both is also not something the Center controls.

Randomizing survivors to components of the program (e.g., social services, court advocacy) is also not feasible, first, because Centers cannot control exposure to normal standard of care and, second, because any given service need cannot be met in a variety of ways. And denying services to a randomly selected group of clients is, of course, unethical.

Researchers ideally might randomly assign multiple sites to establish a Center or not establish a Center and continue serving survivors in "business as usual." This is not feasible in this case since most of the Centers have been operating for some time. Another approach is to find a matched site to serve as a control, that is, a closely matched site where there is not Center, and collect all the same data and compare outcomes directly to each other. This is also not a strong approach for drawing conclusions. These centers operate in unique settings where a large number of confounding factors make using non-Center service areas as true controls unattractive. In addition to controlling for population characteristics, staffing etc., the evaluation has to take into account differences in a large number of other factors like history of law enforcement response to DV and availability of resources, to name only a few.

Therefore, we suggest an approach often used in observational studies in which the programs are self or government selected and withholding services to a section of the population is unethical. This approach identifies an area similar to or a "best match" to the program service area and uses data over time on that area as a comparison—but not a control. This technique called difference in differences (DiD).

Difference in differences design approach. In this approach we measure impact by looking at measures of change or improvement for the same site at a time when the program was not in operation and a time after full implementation. However, a simple pre-post comparison cannot account for historical or external trends that may have occurred that can affect the outcomes apart from programming. For this reason, evaluators often use what is termed a *difference in differences* (DiD) approach. This approach is designed to mimic an experimental design by looking at the differential effect of an intervention compared to control condition or site in a natural experiment.[1] It calculates the effect of the intervention on an outcome variable by comparing the average change over time in the outcomes of the intervention, compared to the average change over time for the comparison group. In this approach an area in geographic proximity to the program site but without a Center is selected and parallel measures of impact are compared over time, i.e., a designated time, before the program and a designated time after program implementation. Unlike a direct comparison design, the DiD approach looks at the *relative* gain or loss on the outcome measure in each site over time but then reduces the effect of the intervention gain by whatever was gained or lost in the historical comparison site. Other controls to help balance the two sites can also be introduced, using data available on the demographic makeup, income levels, police force, etc. in each area. In this design, each site in the study is paired with its comparison and the program effect is calculated on each of the outcomes of interest. In the simplest formulation the calculation is:

	Time 1	Time 2	Difference
Intervention site	X1	X2	X1-X2= Z1
Comparison sites	Y1	Y2	Y1-Y2=Z2
Difference in difference			Z1-Z2 = intervention's true effect

In essence the "true effect" of the intervention is what happened in terms of the outcome variable being examined less what happened in that outcome when there was no intervention. In a more complex form relevant site differences are balanced statistically in the analysis. This can be extended to looking at the significance of variation in the effect across sites in each grouping and between the groupings or types of programming, i.e., average effect of FJC/CACs, partial co-location models, central intake with referrals, etc., compared with each other.

Using this approach limits the variables that can be used for comparisons as it requires measuring the outcomes of DV services in ways that can be examined using the same measures over time and for multiple areas. The areas used for each program's comparison are selected to be as close to the same context (demographic makeup of population, geography, urbanity, resources) as the area where the program is operating. Again, these are not direct comparisons as would be used in a controlled experiment; they are relative comparisons of changes over time that are combined for an overall assessment of effect.

For this part of the evaluation we suggest impact measures that come from public records that can be accessed in common formats and in a time series:

- Calls for DV assistance in targeted areas
- Calls for DV assistance with serious injury
- Number of DV service agencies in targeted area
- Number of survivors served

- Arrests for DV incidents
- Number of DV survivors served in relevant agencies

The data would be collected from the pre-intervention time period to the designated study time period. Due to the added data collection costs, NIJ may consider selecting a smaller group of Centers for the full impact evaluation based on the components of the programs, fidelity to the PFJCI core elements and degree of implementation of the programming.

The two approaches suggested above both provide answers to questions policymakers and practitioners have regarding how to configure the best services and program staffing to affect the positive outcomes the Centers are intended to create. This is done either across Centers in operation to make clearer what works best in existing Centers and for whom (comparative effectiveness), and/or in a comparison of Centers to the gains or losses in outcome measures that occurred in similar places over time (DiD). Both approaches have strengths and weaknesses and the decision to utilize any given design should be driven by the relative cost of the data collection effort and the primary questions of interest.

6. Conclusions

The FJC movement began in earnest in 2004, when the PFJCI institutionalized a co-located services approach to support survivors of DV and IPV. The guiding principles established through this federal initiative–-including multi-agency collaboration and service co-location—continue to be promoted by the initiative's federal training and technical assistance provider, the Alliance.

There was no effort at the time of the PFJCI or since then to establish a national FJC model. The guiding principles were established to guide rather than prescribe to communities how best to meet the needs of the survivors in their communities. As a result, while FJCs may share the core principles of co-location to provide services to adult survivors of family violence, there is likely to be variation in how other principles have been applied by individual centers across the country. And, while there has been some movement over the past few years to institutionalize these guiding principles as best practice,[41] achieving the study goal of documenting the similarities and differences in structure and programming across operational Centers required that the scan capture both centers that call themselves FJCs and similar multi-agency co-located collaboratives. The study identified and included in the scan any Center that met the following four elements: (1) co-location; (2) multi-agency; (3) multi-disciplinary; and (4) targeting provision of services to adult survivors of family violence. In other words, any program that involves *the co-location of multiple agencies representing different disciplines that have come together to provide services to adult survivors of family violence and their families* were included in the inventory and other types of co-located models (e.g., CACs) were excluded.

Centers were identified through the Alliance, OVW grantee information, and on-line searches, which resulted in the initial identification of 117 Centers. While some of the sources for identifying FJCs were more reliable than others, the focus was on including any center that involved the co-location of multi-disciplinary agencies to serve adult survivors of family violence. The scan was, therefore, designed both to confirm that the program met the established criteria and to collect information on the structure and activities of the centers, as well as their readiness to support formal evaluation efforts.

Through the data collection and follow-up process, combined with preliminary analysis of the respondent data, the study team reduced the number of operational FJCs to 87. While we are fairly confident that this is an accurate reflection of the number of FJCs that were in operation at the time, we were not able to confirm that 35 or 40 percent of the centers met the criteria established for the study because they did not participate in the scan. These Centers are less likely to refer to themselves as a FJC and be located in the Western regions of the country than those that responded (see Appendix B for information on non-respondents).

It is also important to note that the landscape of FJCs is continually shifting. While only a small number of FJCs identified through the scan were in the process of becoming fully operational, many others are in the process of opening as of this writing. Some of the operational FJCs are expanding and contracting due to client demand and availability of funding, and still others are, or may be, in the process of closing down completely.

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[41] The Alliance's affiliation process requires that centers seeking to become affiliated as either FJCs or multi-agency models "adhere to and demonstrate the implementation of Family Justice Center Guiding Principles in service delivery." Retrieved from https://www.familyjusticecenter.org/affiliated-centers/family-justice-centers-2/.

As a result, what was learned through the scan is limited not only to Centers that were operational at the time of data collection, but also to those that responded. And, as with any study based on self-report, findings are based on information respondents were willing to provide, which may be impacted by their perception of responses preferred by the agencies supporting the scan. As a result, responses may be biased toward FJCs that are more established, more likely to adhere to principals promoted through the PFJCI, and more likely to be interested in participating in an evaluation. There may also be Centers that fit the criteria but do not identify themselves as a FJC or multi-agency center and therefore did not respond to the scan.

Nonetheless, the findings confirm that the PFJCI did, in fact, ignite a national movement with Centers operating in every region of the country. Among the responding Centers, close to half have been fully operational for over 10 years, almost all of the programs subscribe to set of guiding principles and have policies and procedures in place to support core activities like client intake and data sharing, and most of the programs met or exceeded their annual operating budget the last fiscal year. The findings also confirm that, despite the maturity of the movement, there are variations that exist across programs that should be explored to understand why the variations exist and whether they impact the effectiveness of the program generally or among certain populations. While it is anticipated that programs would vary in, for example, their governance structure, number and type of partner agencies, and client volume and demographics, their relationship to outcomes needs to be studied.

For example, while three-quarters of the responding centers reported that their FJC resides within an existing city or county agency (44%) or non-profit organization (31%), close to 20 percent of responding centers reside within a newly created city or county agency or non-profit organization. And among these Centers, the Directors may report to a non-profit board of directors, as was the case with 33 percent of the responding Centers, or a city/county department head, which was the case with 26 percent of the responding Centers. How these structures were determined and the effect on the planning and operations of the center would be important context for any evaluation, as well as provide important lessons for communities seeking to establish centers of their own.

The number and type of partner agencies is also important context when examining the services provided, where they are provided, and to whom and to how many clients. While most of the responding Centers reported involving between six and 10 partner agencies and including victim services agencies, community based organizations, criminal justice agencies, and local/state government agencies, there are some Centers that operate with either a very small number (12%) or very large number of partners (15% reported having over 20 partners), as well as a small number (12) that do not have a criminal justice or district attorney partner on-site and 14 that are part of a coordinated FJC/CAC model.

The types of partners may also be driven by or result in targeting services to specific populations or types of violence, which can also affect the demographics and service needs of the client population served. For example, while 33 percent of the responding Centers reported that the center serves all victim populations, 47 percent reported targeting services to survivors of human trafficking, and 65 percent to survivors of elder abuse. Similarly, just over half of the responding Centers indicated that they target services to special populations, that include, for example, non-English speaking populations (92%), immigrant and refugee populations (75%), elderly populations (71%), and the LGBT community (67%). Partnership arrangements can also impact where services provided, i.e., at the Center or at another location, to include satellite locations operated by six of the responding Centers.

The findings also suggest that FJCs can support evaluation efforts and are eager to assess the effectiveness of their programs. Almost all of the responding Centers use a central intake process and/or intake forms to collect a range of information, including client demographics and contact information, date and reason for the visit. And, in almost every case, responding Centers reported storing information collected at intake in an electronic database linked to the client by name or identifier. Similarly encouraging was that the majority of responding Centers also reported tracking both services requested and received by clients at the Center, and confirmed their ability to provide this data at the individual and, more commonly, at the aggregate level. However, the findings also confirm potential data challenges related to the ability of clients to opt out of electronic storage of information collected at intake, definitional issues (e.g., new versus returning clients), variation in data sources (administrative versus self-report), and data storage. Fortunately, the findings suggest a population eager to support evaluation efforts, with close to 80 percent of responding Centers reporting a willingness to participate in a formal evaluation, albeit with support (e.g., funding, staff, training and technical assistance). And about a third of the responding Centers indicated that they had some involvement in a current or prior evaluation, which in most cases, were focused on program processes.

The variation found in the environmental scan provides both a challenge and an opportunity for the next phase, a full evaluation. Since there is no national model of what definitively constitutes a FJC, the collection of data across centers on the different services, staffing, governance structure, partner agencies, etc. they employ to reach the common goal of victim safety is critically important to learning what works, how it works, and for whom to target resources most effectively. This means that a full evaluation needs to include data to assess implementation, processes, and outcomes across all centers included in the study. This type of evidence will be valuable to both existing centers and new communities seeking to establish FJCs of their own.

6.1 Recommendation for the National Evaluation

A critical goal for a national evaluation of FJCs is to "unpack" the role that different service models or configurations have on success for different persons accessing those services. Because of the range of client needs, one size is not likely to fit all. Given the need to understand what works for whom, it is important that the national evaluation effort include the collection of data on each program and each participant in the programming as a mandated requirement for participation and utilized as part of a comparative effectiveness approach. In addition, if the goal is to also determine impact (or what would have occurred absent a FJC) a difference in difference model can be employed.

Appendix A: List of Centers

Center Name	Responded to the Scan	If Removed, Why?	FJC/CAC Model?	Centralized Intake?	Number of partners	Criminal Justice onsite	District Attorney onsite	Willing to participate in a formal evaluation?	Center is currently being evaluated or has been evaluated in the past?
Baystate Health Family Advocacy Center	No	CAC	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Children's Advocacy Center of Green River District	No	CAC	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Children's Justice Center	No	CAC	N/A	N/A	N/A	N/A	N/A	N/A	N/A
API Chaya	No	CBO	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Catholic Charities of Jackson	No	CBO	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Domestic Violence & Child Advocacy Center	No	CBO	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Domestic Violence Resource Center	No	CBO	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Domestic Violence Service Center	No	CBO	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Honolulu Family Justice Center	No	CBO	N/A	N/A	N/A	N/A	N/A	N/A	N/A
The Advocacy Center	No	CBO	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Women's Resource Center of Scranton	No	CBO	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Family Service of the Piedmont	No	Duplicate - Part of Guilford County FJC	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Family Support Center of South Sound	No	Duplicate - Thurston Family Justice Center	N/A	N/A	N/A	N/A	N/A	N/A	N/A
West Contra Costa County Family Justice Center	No	Duplicate of Contra Costa	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Southern Maryland Center For Family Advocacy	No	MDT	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Tahirirh Justice Center	No	MDT	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Tahirirh Justice Center	No	MDT	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Tahirirh Justice Center	No	MDT	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Guam Family Justice Center	No	Not open yet	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Gateway Domestic Violence Center‡	No	Self-identified should not be included	N/A	N/A	N/A	N/A	N/A	N/A	N/A

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Note: "No Answer Provided" indicates that the Center did not respond to the question
Note: "Not Listed" indicates that the Center provided a list of on-site partners (or a list was publicly available), but a criminal justice agency/District Attorney was not among them
Note: "Yes†" indicates that the Center was classified as an FJC by the Alliance, meaning it should have centralized intake and representation from those agencies
Note: "No*" indicates that the Center was originally classified as an FJC/CAC model, but upon follow-up it was determined this was an error

This color denotes centers that did not respond to the scan, but were removed because it was determined that they did not meet the inclusion criteria.

This color denotes centers that responded to the scan but were later removed because they did not meet the inclusion criteria.

Center Name	Responded to the Scan	If Removed, Why?	FJC/CAC Model?	Centralized Intake?	Number of partners	Criminal Justice onsite	District Attorney onsite	Willing to participate in a formal evaluation?	Center is currently being evaluated or has been evaluated in the past?
This color denotes centers that did not respond to the scan, but were removed because it was determined that they did not meet the inclusion criteria.	No		Unknown	Yes†	11 to 15	Yes	No†	Unknown	Unknown
This color denotes centers that responded to the scan but were later removed because they did not meet the inclusion criteria.	No		Unknown	No†	Unknown	Yes†	No†	Unknown	Unknown
Contra Costa Family Justice Center-Concord‡	No		Unknown	Yes†	11 to 15	Yes†	Yes†	Unknown	Unknown
FACES of Hope Victim Center‡	No		Unknown	Yes†	16 to 20	Yes	Yes	Unknown	Unknown
Family Advocacy Center of Northern Minnesota‡	No		Yes	Unknown	0 to 5	Unknown	Unknown	Unknown	Unknown
Family Justice Center - North County	No		Unknown	Yes†	Unknown	Yes†	Yes†	Unknown	Unknown
Family Justice Center - San Jose	No		Unknown	Yes†	Unknown	Yes†	Yes†	Unknown	Unknown
Family Justice Center - South County	No		Unknown	Yes†	Unknown	Yes†	Yes†	Unknown	Unknown
Family Justice Center of Central Louisiana (Rapides Parish)‡	No		Unknown	Yes†	6 to 10	Yes	Yes	Unknown	Unknown
Family Justice Center of Erie County‡	No		Unknown	Yes†	6 to 10	Yes	Yes	Unknown	Unknown
Family Justice Center of Georgetown and Horry Counties‡	No		Unknown	Yes†	21+	No†	No†	Unknown	Unknown
Family Justice Center of Northwest Ohio‡	No		Unknown	Yes†	Unknown	Yes†	Yes†	Unknown	Unknown
Family Justice Center of St. Joseph County‡	No		Unknown	Yes†	21+	Yes	Yes	Unknown	Unknown
Fresno Family Justice Bureau	No		Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown
Glendale Family Advocacy Center‡	No		Unknown	Yes†	0 to 5	Yes	Yes	Unknown	Unknown
Harford Family Justice Center‡	No		Yes	Yes†	Unknown	Yes†	Yes†	Unknown	Unknown
Hennepin County Domestic Abuse Service Center‡	No		Unknown	Unknown	11 to 15	Yes	Yes	Unknown	Unknown
Imperial County Family Justice Center‡	No		Unknown	Yes†	Unknown	Unknown	Unknown	Unknown	Unknown
Indio Family Justice Center	No		Unknown	Yes†	Unknown	Yes†	Yes†	Unknown	Unknown
Montgomery County Family Justice Center‡	No		Unknown	Yes†	11 to 15	Yes	Yes	Unknown	Unknown
Mujer One-Stop Domestic Violence and Certified Sexual Assault Center‡	No		Unknown	Yes†	0 to 5	No†	No†	Unknown	Unknown

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Note: "Not Listed" indicates that the Center provided a list of on-site partners (or a list was publicly available), but a criminal justice agency/District Attorney was not among them
Note: "Yes†" indicates that the Center was classified as an FJC by the Alliance, meaning it should have centralized intake and representation from those agencies
Note: "No*" indicates that the Center was originally classified as an FJC/CAC model, but upon follow-up it was determined this was an error

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Center Name	Responded to the Scan	If Removed, Why?	FJC/CAC Model?	Centralized Intake?	Number of partners	Criminal Justice onsite	District Attorney onsite	Willing to participate in a formal evaluation?	Center is currently being evaluated or has been evaluated in the past?
One Safe Place (Shasta County, CA)‡	No		Unknown	Yes†	6 to 10	No†	No†	Unknown	Unknown
Peoria Family Justice Center‡	No		Unknown	No	0 to 5	Yes	Yes	Unknown	Unknown
Riverside Family Justice Center	No		Unknown	Yes†	Unknown	Yes†	Yes†	Unknown	Unknown
Sacramento Regional Family Justice Center‡	No		Unknown	Yes†	11 to 15	No†	No†	Unknown	Unknown
Safe on Seven‡	No		Unknown	Yes†	6 to 10	Yes	Yes	Unknown	Unknown
San Diego Family Justice Center‡	No		Unknown	Yes†	6 to 10	Yes	Yes†	Unknown	Unknown
Scottsdale Family Advocacy Center‡	No		Unknown	Yes†	0 to 5	Yes	Unknown	Unknown	Unknown
Southwest Family Advocacy Center‡	No		Unknown	Yes†	6 to 10	Yes	Yes†	Unknown	Unknown
Southwest Family Justice Center	No		Unknown	Yes†	Unknown	Yes†	Yes†	Unknown	Unknown
ST. PAUL FAMILY JUSTICE CENTER (Bridges to Safety‡)	No		Unknown	Yes†	11 to 15	Yes	Yes	Unknown	Unknown
The Center for Family Safety and Healing‡	No		Unknown	Yes†	0 to 5	Yes	Yes	Unknown	Unknown
The City of Phoenix Family Advocacy Center‡	No		Unknown	Yes†	Unknown	Yes	No†	Unknown	Unknown
Ventura Family Justice Center	No		Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown
YWCA of Spokane Family Justice Center‡	No		Unknown	Yes†	0 to 5	Yes	Yes	Unknown	Unknown
Family Crisis Center, INC (Dell Hayden Memorial)	Yes	CAC	N/A	N/A	N/A	N/A	N/A	N/A	N/A
SAGE: Safety Advocacy Growth Empowerment	Yes	CAC	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Abused Adult Resource Center	Yes	CBO	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Barren River Area Safe Space Inc.	Yes	CBO	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Family and Child Abuse Prevention Center	Yes	CBO	N/A	N/A	N/A	N/A	N/A	N/A	N/A
H.A.V.E.N. Family Resource Center	Yes	CBO	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Mahoney House	Yes	CBO	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Northern Arizona Center Against Sexual Assault	Yes	CBO	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Start Off Smart, Inc - The Justice Center	Yes	MDT	N/A	N/A	N/A	N/A	N/A	N/A	N/A
One Door - One Stop Center (North Platte)	Yes	Only open with all onsite partners one day per week	N/A	N/A	N/A	N/A	N/A	N/A	N/A

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Note: "No Answer Provided" indicates that the Center did not respond to the question
Note: "Not Listed" indicates that the Center provided a list of on-site partners (or a list was publicly available), but a criminal justice agency/District Attorney was not among them
Note: "Yes†" indicates that the Center was classified as an FJC by the Alliance, meaning it should have centralized intake and representation from those agencies
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This color denotes centers that responded to the scan but were later removed because they did not meet the inclusion criteria.

Center Name	Responded to the Scan	If Removed, Why?	FJC/CAC Model?	Centralized Intake?	Number of partners	Criminal Justice onsite	District Attorney onsite	Willing to participate in a formal evaluation?	Center is currently being evaluated or has been evaluated in the past?
A Safe Place Family Justice Center for Clackamas County	Yes		Yes	Yes	6 to 10	Yes	Yes	Yes	No
Alameda County Family Justice Center	Yes		No	Yes	16 to 20	Yes	Yes	Yes	Yes
Bexar County Family Justice Center	Yes		No*	Yes	6 to 10	Yes†	Yes	No Answer Provided	No Answer Provided
Buncombe County Family Justice Center	Yes		No*	Yes	6 to 10	Yes	Yes	Yes	No
Contra Costa Family Justice Center-Richmond	Yes		Don't Know	Yes	21+	Yes†	Yes†	No	Yes
Crystal Judson Family Justice Center	Yes		No	Yes	16 to 20	Yes†	Yes†	No	No
Cuyahoga County Family Justice Center	Yes		No	Yes	6 to 10	Not Listed	Not Listed	Yes	Yes
Essex County Family Justice Center	Yes		No*	Yes	6 to 10	Yes†	Yes†	No Answer Provided	No
Family Justice Center of Acadiana	Yes		No	Yes	11 to 15	Yes†	Yes†	Yes	No
Family Justice Center of Alamance Co.	Yes		No	No	6 to 10	Yes	Yes	Yes	No
Family Justice Center of Boston	Yes		No Answer Provided	No	11 to 15	Yes†	Yes†	Yes	No
Family Justice Center Sonoma County	Yes		Yes	Yes	6 to 10*	Yes†	Yes†	Yes	Don't know
Family Safety Center	Yes		No	Yes	11 to 15	Yes	Yes	Yes	No
Family Safety Center of Memphis and Shelby County	Yes		No	Yes	21+	Yes	Yes	No Answer Provided	No Answer Provided
Family Support Center - Thurston County Family Justice Center Program	Yes		Don't Know	Yes	0 to 5	Yes	Yes	No	No
Gateway Center for Domestic Violence Services	Yes		No	Yes	11 to 15	Yes	Yes	Yes	Yes
Guilford County Family Justice Center	Yes		Yes	No Answer Provided	16 to 20	Yes	Yes	No Answer Provided	No Answer Provided
Irving Family Advocacy Center	Yes		No*	No Answer Provided	0 to 5	Not Listed	Not Listed	No Answer Provided	No Answer Provided
Knoxville Family Justice Center	Yes		No	Yes	21+	Yes†	Yes†	No Answer Provided	Yes

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Note: "Not Listed" indicates that the Center provided a list of on-site partners (or a list was publicly available), but a criminal justice agency/District Attorney was not among them
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Center Name	Responded to the Scan	If Removed, Why?	FJC/CAC Model?	Centralized Intake?	Number of partners	Criminal Justice onsite	District Attorney onsite	Willing to participate in a formal evaluation?	Center is currently being evaluated or has been evaluated in the past?
Mary's House	Yes		No Answer Provided	No	No Answer Provided	No Answer Provided	No Answer Provided	No	No
Mesa Family Advocacy Center	Yes		Yes	No Answer Provided	6 to 10	Not Listed	Not Listed	No Answer Provided	No Answer Provided
Morris Family Justice Center	Yes		No*	Yes	6 to 10	Yes†	Yes†	Yes	No
Nampa Family Justice Center	Yes		Yes	Yes	No Answer Provided	Yes	Yes	Yes	Yes
Nashville Family Justice Center/Jean Crowe Advocacy Center	Yes		No	Yes	16 to 20	Yes	Yes	Yes	No
New Orleans Family Justice Center	Yes		Yes	Yes	6 to 10	Yes†	Yes†	Yes	Yes
New Star Family Justice Center	Yes		Yes	Yes	6 to 10	Not Listed	Yes	No	No
New York City Family Justice Center, Bronx	Yes		No	Yes	16 to 20	Yes†	Yes†	Yes	Yes
New York City Family Justice Center, Brooklyn	Yes		No	Yes	21+	Yes†	Yes†	Yes	Yes
New York City Family Justice Center, Manhattan	Yes		No	Yes	21+	Yes†	Yes†	Yes	Yes
New York City Family Justice Center, Queens	Yes		No	Yes	16 to 20	Yes†	Yes†	Yes	Yes
New York City Family Justice Center, Staten Island	Yes		No	Yes	16 to 20	Yes†	Yes†	Yes	Yes
Northwest Louisiana Family Justice Center	Yes		No*	Yes	0 to 5	Yes†	Yes†	Yes	Don't know
Oklahoma City Family Justice Center	Yes		No	Yes	6 to 10	Yes†	Yes†	No Answer Provided	No Answer Provided
One Place Family Justice Center	Yes		No	No	6 to 10	Yes	Yes	Yes	No
One Place of the Shoals	Yes		No*	Yes	6 to 10	Yes	Yes	Yes	No
One Safe Place Tarrant Regional Family Justice Center	Yes		No	Yes	16 to 20	Yes†	Yes†	Yes	Yes
Pinal County Attorney's Office Family Advocacy Centers	Yes		Yes	No Answer Provided	0 to 5	Not Listed	Not Listed	No Answer Provided	No Answer Provided

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Note: "No Answer Provided" indicates that the Center did not respond to the question
Note: "Not Listed" indicates that the Center provided a list of on-site partners (or a list was publicly available), but a criminal justice agency/District Attorney was not among them
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Center Name	Responded to the Scan	If Removed, Why?	FJC/CAC Model?	Centralized Intake?	Number of partners	Criminal Justice onsite	District Attorney onsite	Willing to participate in a formal evaluation?	Center is currently being evaluated or has been evaluated in the past?
Rose Andom Center (Denver Family Justice Center)	Yes		No*	Yes	11 to 15	Yes†	Yes	Yes	No
Safe Haven Resource Center (Lake Superior Regional Family Justice Center)	Yes		No	Yes	6 to 10	Not Listed	Not Listed	No	No
Salt Lake Area Family Justice Center at the YWCA Utah	Yes		No	Yes	11 to 15	Yes	Yes	Yes	Don't know
San Joaquin County Family Justice Center	Yes		No	Yes	6 to 10	Yes†	Yes†	Yes	No
Sojourner Family Peace Center	Yes		Yes	No	21+	Yes	Yes	Yes	No
Solano Family Justice Cener	Yes		Yes	No Answer Provided	No Answer Provided	No Answer Provided	No Answer Provided	No Answer Provided	No Answer Provided
Stanislaus Family Justice Center	Yes		Yes	Yes	6 to 10	Not Listed	Not Listed	No	No
Strafford County Family Justice Center	Yes		Don't Know	Yes	11 to 15	Yes	Yes	Yes	No
Strength United	Yes		No*	No	6 to 10	Yes†	Yes†	Yes	Yes
Sweetwater County Family Justice Center	Yes		Yes	Yes	6 to 10	Yes	Yes	Yes	No
The Center for Family Justice (Bridgeport Center for Family Justice)	Yes		Yes	Yes	6 to 10	Not Listed	Not Listed	Yes	No
The Family Justice Center of Ouachita	Yes		No*	Yes	21+	Yes	Yes	Yes	Yes
The Orange County Family Justice Center and Foundation	Yes		Don't Know	No Answer Provided	16 to 20	No Answer Provided	No Answer Provided	No Answer Provided	No Answer Provided
Tri-County Family Justice Center	Yes		Yes	Yes	No Answer Provided	Yes†	Yes†	No	Don't know
Westchester County Family Justice Center	Yes		No Answer Provided	Yes	21+	Yes	Yes	Yes	Don't know

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Note: "No Answer Provided" indicates that the Center did not respond to the question
Note: "Not Listed" indicates that the Center provided a list of on-site partners (or a list was publicly available), but a criminal justice agency/District Attorney was not among them
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Developing Center Name
Family Justice Center-Little Rock
Kern County FJC
Fresno Family Justice Bureau
Los Angeles FJC
NAPA County FJC
Ventura County FJC
Jefferson County FJC
New Haven FJC
FJC-New London
Southern Nevada FJC
Monmouth FJC
FJC-Nassau County
Rockingham County FJC
Washington County FJC
Sullivan County FJC
Hays County FJC
Guam FJC

Appendix B: FJC Scan—Non-Respondents

Thirty-five FJCs were identified as meeting the criteria for the scan but did not respond to requests for information. For simplicity, these Centers for which information was not collected will be referred to as "non-respondents" (n=35). A search of publicly available information was conducted for these Centers (almost exclusively on their websites) in order to determine the representativeness of the responding sample. This section provides the results of that search.

Given the limited nature of publicly available information the non-respondent scan focused on collecting information on basic information about the Centers, including their geographical location, their partner organizations, the services they provide on-site, the number of clients served, whether they had a co-located Child Advocacy Center, and whether they had any satellite locations. The availability of the information varied from center to center.

Geographic Location. As with the responders, the non-respondent group was diverse geographically: Although a plurality of Centers are located the South (n=13), almost as many are in Western states (n=12). Eight are in states in the Midwest, and two are in the Northeast.

Table 1: Non-respondents by Region

Region	N	%
South	13	37%
West	12	34%
Midwest	8	23%
Northeast	2	6%
Total	**35**	**100%**

Partner Organizations. Likewise, the non-respondents varied in the number of agencies and organizations with which they partnered. Of the 27 Centers for which data were available, most had between five and 10 partner organizations (n=15), whereas only two had three or four partners. Six Centers had between 11 and 20 partner organizations, and four had 21 or more. It should be noted that when on-site and off-site partner organizations were delineated, the on-site number was the one used (this was the case for five Centers). For most of the Centers, it was not made clear which organizations were on- vs. off-site, so it is possible some of the larger numbers are artificially inflated.

Table 2: Non-Respondents by Number of Partner Organizations

Partner Organizations	N	%
3 to 4	2	7%
5 to 10	15	56%
11 to 20	6	22%
21+	4	15%
Total	**27**	**100%**

Non-respondents' profiles of partner organizations tended to be similar to those of the Centers that responded to the survey—most have on-site representation from law enforcement, prosecutors and legal aid/advocacy groups, health care providers (including, commonly, providers of sexual assault forensic exams), counseling, and other community-based organizations. Presence of law enforcement and prosecutors will likely be most crucial for evaluation purposes, and they are well-represented. Of the 27 Centers for which we were able to obtain partner organization information, 25[1] Centers have representation from at least one law enforcement agency, and 18 have city or county prosecutors on-site. Of the Centers that differentiated between on- and off-site partners, the most common on-site partners were Child Protective Services, legal aid/advocacy, prosecutors, and health care providers (n=3 for all).

Services On-Site. Centers provided a range of services on-site, including crisis intervention, legal advocacy, counseling, and medical examinations. Of the 27 Centers with information regarding on-site services, most (n=23) offered legal services, and a majority offered counseling (n=17), advocacy (n=16), and housing/employment/transportation assistance (n=16). Table 3 below shows the number and percentage of Centers providing various types of services on-site.

Table 3: Non-respondents by Services Provided On-site

FJC NAME	N	%
Case Management	13	48%
Crisis Intervention	11	41%
Counseling	17	63%
Advocacy	16	59%
Child Services	14	52%
Referrals	11	41%
Education/ Prevention	12	44%
Legal Services/Advocacy	23	85%
Immigration Assistance	6	22%
Medical	9	33%
Law Enforcement	14	52%
Housing/Employment/etc.	16	59%

As noted previously, FJCs are similar in structure to CACs, and they are occasionally co-located. Of the non-responders, only one had a CAC on-site. The majority of other Centers (n=17) had some sort of child services or care available but did not mention a CAC specifically.

Satellite Locations. Finally, some (n=6) non-responding Centers provide services at satellite locations in addition to their central offices. However, at least two of the six may actually have multiple independently operated sites, but it is difficult to discern based on publicly available information. For instance, the Family Justice Center of Central Louisiana opened two FJCs in 2016—one in Central Louisiana (Rapides Parish) and one in Acadia. The two FJCs seem to operate independently; it is unclear if the Acadia FJC was newly "opened" in 2016 (it appears that it was already operating as a shelter) or just given the FJC designation.

[1] Two of the 25 Centers were not explicit about having law enforcement on-site.

Appendix C: Consent Language

Environmental Scan of Family Justice Centers and Multi-Agency Collocated Collaboratives in the United States

CONSENT LANGUAGE

You are invited to participate in a scan of Family Justice Centers (FJCs) throughout the United States. Abt Associates Inc. and the Alliance for HOPE International are conducting this scan on behalf of the National Institute of Justice and Office on Violence Against Women, U.S. Department of Justice in an effort to gain a national understanding of FJCs and similar multi-agency collocated collaboratives and their ability to support future evaluation efforts.

On behalf of your center (and any satellite facilities that your FJC supports), you will be asked questions related to program governance, operational status, funding status, service provision, policy and procedures, data collection and analysis capabilities, and history tracking outputs and outcomes. While we anticipate that this instrument will take approximately 30-45 minutes to complete, it may be helpful to have the following materials available: client counts and demographic information, partner agency information and staffing levels, and service provision information. There is no cost to you for participating in this survey.

Risks and Privacy:
There is a small risk of loss of confidentiality associated with participation; however precautions will be taken to protect your responses. Upon completion of the data collection, paper documents will be destroyed and the electronic file will be downloaded onto a password-protected computer for analysis. Your responses, including your name and contact information, will be linked to the FJC and provided to NIJ to support future evaluation activities. A de-identified version will also be made available to other researchers through the National Archive of Criminal Justice Data. All data will be deleted from Abt's secure network a year after the study concludes

Voluntariness:
Participation in this study is voluntary. You may withdraw from the survey at any time, and you may refuse to answer any questions that you are not comfortable with.

Incentive:
To compensate you for your time, we will offer an incentive ($50 check) for completing the scan.

Research Questions:
If you have any questions regarding this project or the participating in the pre-test, please contact the Project Manager, Mica Astion, via email (Mica_astion@abtassoc.com) or phone (617) 520-2568 (not a toll free number).

Appendix D: FJC Data Collection Instrument

National Survey of Family Justice Centers/Multi-Agency Collocated Collaboratives

Your name: _____

Your role at the Center: _____

Contact information:

Address: _____

Email: _____

Phone number: _____

Name of the Center: _____

Primary location address: _____

1. Center Director's name: _____
2. Please provide your Center's mission statement: _____

_____

3. Does the Center have (or subscribe to) a guiding principle? ☐ Yes ☐ No
4. Please indicate on the following scale where the Center is in the implementation process (ranging from 1, early planning, to 5, fully operational) and then provide a description of its status below.

Planning		Partially Operational		Fully Operational
Center is in the early planning phases, (e.g. strategic planning, fundraising, identifying location, etc.)	Center is farther along in the planning process, but not yet open.	Center is open, but only partially operational (e.g. space is not completed, partners are not all collocated, etc.)	Center is almost fully operational, but is not yet serving clients as intended.	Center is open, operating, and serving clients as intended.
1	2	3	4	5
☐	☐	☐	☐	☐

Please describe your implementation status: _____

_____

National Survey of Family Justice Centers and Multi-Agency Collocated Collaboratives

5. What date did you become/plan to become fully operational: _____

6. Please indicate the name of the agency or agencies who lead(s) the Center:

   _____

7. Please indicate what type of agency/agencies this is:

   ☐ (a) An existing city or county department (government)
   ☐ (b) A newly formed city or county department (government)
   ☐ (c) An existing private non-profit 501(c)3 organization (Non-profit)
   ☐ (d) A new private non-profit 501(c)3 organization (Non-profit)
   ☐ (e) Other, *please specify* _____

8. Who provides oversight or governs the operations of the Center (i.e. to whom does your Director report)? *Please check all that apply*?

   (***Examples:*** If your Center is led by the police department, than you would respond (a) to Q7 and (c) to Q8. If the center sits within local government, but is overseen by a community board, than the answer to Q7 would be (a), but the answer to Q8 would be (d)).

   ☐ (a) Board of Supervisors
   ☐ (b) Nonprofit Board of Directors
   ☐ (c) City/County Department Head (District Attorney, Police Chief, Mayor, etc.)
   ☐ (d) Joint Leadership Committee (Steering Committee, Community Advisory Board)
   ☐ (e) Other (*please specify*): _____

9. Is the Center centralized at a single location or do you also have satellite locations?

   ☐ Center is centralized at a single location, **no** satellite locations.
   ☐ Center is centralized at a single location **and has** satellite locations.

      a. If you have satellite locations, please indicate the number of locations: _____

      b. Please provide the names of the satellite locations (*if applicable*):

         _____

   ☐ Center is not centralized at a single location.

10. Is the Center part of a coordinated Family Justice Center/Child Advocacy Center Model?

    ☐ Yes
    ☐ No
    ☐ Don't know

11. Please identify the partners of the Center in the table below.

a. Please indicate which partners have formal MOUs with the Center to co-locate staff on-site.

b. Please indicate what type of organization the partner agency represents.

c. Please indicate if staff from these agencies are collocated at the primary site, a satellite, or located offsite.

d. Please indicate the total number of full-time equivalent (FTE) and part-time equivalent (PTE) staff allocated to the Center by each of the partner agencies.

PARTNER NAME	MOU?	Type of Agency (*select all that apply*)							PRIMARY SITE/ OFFSITE/ SATELLITE	# Staff Assigned to Primary Site and/or Satellite(s)	
		Community Based Organization	**Local/State Government**	**Legal Advocacy/ Court**	**Criminal Justice Agency**	**Victim Service Agency**	**Civil Legal Services**	**Other, *please specify (below)***		**Number of FTE**	**Number of PTE**
	Y /N	☐	☐	☐	☐	☐	☐	☐			
	Y /N	☐	☐	☐	☐	☐	☐	☐			
	Y /N	☐	☐	☐	☐	☐	☐	☐			
	Y /N	☐	☐	☐	☐	☐	☐	☐			
	Y /N	☐	☐	☐	☐	☐	☐	☐			
	Y /N	☐	☐	☐	☐	☐	☐	☐			
	Y /N	☐	☐	☐	☐	☐	☐	☐			

Other, *please specify:* ____

____

____

____

12. If you were not able to provide staffing information broken out by partner agency (above), please provide the total number of FTEs and PTEs assigned to the primary site and satellites (if applicable) below.

    a. Primary site:

        i. Number of FTE: _____

        ii. Number of PTE: _____

    b. Satellite(s):

        i. Number of FTE: _____

        ii. Number of PTE: _____

13. Excluding Center staff identified in question 11 or 12, please specify the number of full and part-time equivalent staff employed (i.e., salary is paid) through the Center (including satellite locations). This could include positions like Center Director, Assistant Director, Volunteer Coordinator, Navigator, etc.

    a. Number of FTE: _____

    b. Number of PTE: _____

14. How many volunteers does the Center have on staff at the primary and satellite locations?

    a. Number of volunteers at primary location: _____

    b. Number of volunteers at satellite locations: _____

15. Which of the following documents have been developed by the Center and/or its partners? (*Check all that apply)*

    ☐ Mission Statement
    ☐ Strategic Plan
    ☐ Partnership Agreements
    ☐ Confidentiality Agreements
    ☐ Intake Procedures
    ☐ Information Sharing Agreements
    ☐ Operations Manual/Policy and Procedures
    ☐ Safety and Security Protocol

16. In the last completed fiscal year, what was your Center's annual operating budget (i.e. expenses/costs for ONLY Center staff, programs/services, and facilities. Do not include any budgets or contributions from partner agencies):

    $ _____

a. The Center's fiscal year: from (date) _____ to (date) _____

17. In the last completed fiscal year, did the Center meet, not meet, or exceed the operating budget?

☐ Center **exceeded** the operating budget
☐ Center **met** the operating budget
☐ Center **did not meet** the operating budget

18. Please select the Center's three primary sources of funding? (*check only three)*

☐ Public funding
☐ Federal grants (*check all that apply*)
  ☐ Grants to Encourage Arrest and Enforce Protection Orders Improvement
  ☐ Rural Sexual Assault, Domestic Violence, Dating Violence, and Stalking Assistance Program
  ☐ STOP Grant Program
  ☐ Byrne/JAG
  ☐ Other (please specify) _____
☐ State grants
☐ Donations/Fundraising
☐ Private funding
☐ Victim compensation fund
☐ Victims of Crime Act (VOCA) funds
☐ Insurance reimbursement

19. Please select which of the following characteristics best describes the location where the Center is primarily located:

☐ Urban (continuously built up area of 50,000 residents or more)
☐ Large town (population between 10,000 and 50,000)
☐ Suburban (area with a committing relationship with an urban center)
☐ Rural (population under 2,500, not within a greater metropolitan area)

20. Please indicate the state(s)/county/city/towns served by the Center:

a. State(s): _____

b. County: _____

c. City: _____

d. Towns: _____

21. Please indicate the total number of clients served each of the years listed below (please complete as fully as possible)?

2011:	_____	☐ Don't know	☐ Center was not operational
2012:	_____	☐ Don't know	☐ Center was not operational
2013:	_____	☐ Don't know	☐ Center was not operational
2014:	_____	☐ Don't know	☐ Center was not operational
2015:	_____	☐ Don't know	☐ Center was not operational

22. Please indicate how you define the following:

a. Clients: _____

_____

b. "New" Clients (e.g. first visit to the FJC; those returning after more than 1 year):

_____

_____

c. "Returning" Clients (e.g. clients receiving ongoing services): _____

_____

23. In the last 30 days, how many clients (new, returning, and total) did the Center serve?

a. Number of new clients: _____ ☐ Don't know

b. Number of returning clients: _____ ☐ Don't know

c. Total number of clients: _____ ☐ Don't know

24. What is the average number of clients served per month at your Center: _____

a. Please indicate what proportion of the clients are:

i. New: _____ ☐ Don't know

ii. Returning: _____ ☐ Don't know

b. If you are not able to indicate which clients are new versus returning, please explain:

_____

25. Please select what types of violence are currently being targeted for services by your Center (*please select all that apply)*:

☐ Domestic violence
☐ Adult sexual assault
☐ Child sexual assault
☐ Child sexual abuse
☐ Child physical abuse
☐ Human trafficking
☐ Teen dating violence
☐ Elder abuse
☐ Other (please specify) _____
☐ Center serves all victim populations

26. Does your Center currently target its services to any special populations?

☐ Yes
☐ No

a. If yes, please specify the types of clients below (*please select all that apply).*

☐ Non-English speaking populations
☐ Lesbian, gay, bisexual, and transgender
☐ Perpetrators (e.g. assault, abuse, etc.)
☐ Immigrant and refugee populations
☐ American Indian/Alaskan Native populations
☐ Elderly populations
☐ People with disabilities
☐ Deaf/hard of hearing
☐ Blind/sight impaired
☐ Rural or remote populations
☐ Populations living on a military base
☐ Veterans
☐ Children
☐ Other (please specify) _____

27. Please describe characteristics of your Center's client population in the past year:

a. Gender:
   i. % male: _____
   ii. % female: _____
   iii. % transgender: _____
   iv. % other: _____
   v. % unknown: _____

b. Age range:
   i. % 0 – 17: _____
   ii. % 18 – 30: _____
   iii. % 30 - 50: _____
   iv. % 50 and older: _____
   v. % unknown: _____

c. Race:
   i. % White: _____
   ii. % Black/African American: _____
   iii. % Asian: _____
   iv. % American Indian/Alaskan Native: _____
   v. % Hawaiian/Pacific Islander: _____
   vi. % unknown: _____

d. Ethnicity:
   i. % Hispanic: _____

e. Primary Language: _____

28. Please indicate which services are provided by the Center onsite, at a satellite, offsite, or through referral (i.e., not through partner agencies) (*please select all that apply)*.

SERVICES PROVIDED	ONSITE	SATELLITE	OFFSITE	REFERRAL
Advocacy	☐	☐	☐	☐
Blind/Sight Impaired Victims Assistance	☐	☐	☐	☐
Career Counseling/Job Training	☐	☐	☐	☐
Childcare	☐	☐	☐	☐
Child Protective Services/Child Welfare Services	☐	☐	☐	☐
Community Outreach and Education	☐	☐	☐	☐
Counseling for Adults	☐	☐	☐	☐
Counseling for Children	☐	☐	☐	☐
Deaf/Hard-of-Hearing Assistance	☐	☐	☐	☐
Dental Assistance	☐	☐	☐	☐
Elder Abuse Specialized Services	☐	☐	☐	☐
Employment Assistance	☐	☐	☐	☐
Forensic Documentation of Injuries	☐	☐	☐	☐
Forensic Exam – Sexual Assault	☐	☐	☐	☐

SERVICES PROVIDED	ONSITE	SATELLITE	OFFSITE	REFERRAL
Forensic Exam – Domestic Violence	☐	☐	☐	☐
Food Assistance	☐	☐	☐	☐
Financial Planning	☐	☐	☐	☐
Human Trafficking Specialized Services	☐	☐	☐	☐
Housing – Emergency	☐	☐	☐	☐
Housing – Transitional	☐	☐	☐	☐
Housing – Long-term Affordable	☐	☐	☐	☐
LGBT Community Specialized Services	☐	☐	☐	☐
Interpretation/Translation Services	☐	☐	☐	☐
Law Enforcement Investigation	☐	☐	☐	☐
Legal assistance – immigration	☐	☐	☐	☐
Legal assistance – custody / visitation	☐	☐	☐	☐
Legal assistance – divorce / dissolution	☐	☐	☐	☐
Legal assistance – other civil legal	☐	☐	☐	☐
Legal assistance – restraining orders	☐	☐	☐	☐
Legal assistance – criminal justice legal assistance (e.g. victim's rights)	☐	☐	☐	☐
Legal advocacy/court accompaniment				
Self-Sufficiency Programs (Life Skills Counseling and Development)	☐	☐	☐	☐
Medical Services	☐	☐	☐	☐
Mental Health Treatment Services	☐	☐	☐	☐
Mentoring	☐	☐	☐	☐
Military Assistance	☐	☐	☐	☐
Parenting Classes	☐	☐	☐	☐
Primary Prevention Work	☐	☐	☐	☐
Probation/Parole Services	☐	☐	☐	☐
Prosecution Assistance	☐	☐	☐	☐
Safety Planning	☐	☐	☐	☐
Sexual Assault Services	☐	☐	☐	☐
Substance Abuse Services	☐	☐	☐	☐
Supervised visitation and/or safe exchange services	☐	☐	☐	☐
Support Groups for Adults	☐	☐	☐	☐
Support Groups for Children	☐	☐	☐	☐
Teen & Youth Services	☐	☐	☐	☐
Transportation	☐	☐	☐	☐
Victim Compensation	☐	☐	☐	☐

SERVICES PROVIDED	ONSITE	SATELLITE	OFFSITE	REFERRAL
VOICES Committee (Survivor-Led Advocacy for the Center)	☐	☐	☐	☐
Other (*please specify):* _____	☐	☐	☐	☐
Other (*please specify):* _____	☐	☐	☐	☐
Other (*please specify):* _____	☐	☐	☐	☐
Other (*please specify):* _____	☐	☐	☐	☐

29. Does your Center provide services for perpetrators onsite?

☐ Yes
☐ No

a. *If yes:* Below please indicate the types of services provided to perpetrators onsite (e.g. batterer's intervention, treatment/counseling, parenting classes):

_____

_____

_____

30. Does the Center use a centralized intake process?

☐ Yes
☐ No

a. If not, please describe intake procedures (e.g., greeter meets client at door and walks them to desired agency) below.

_____

_____

_____

31. Does the Center use an intake form?

☐ Yes
☐ No

a. If yes, please attach copy of the intake form.

32. In the table below, please specify which information is collected as part of the intake process and how that information is stored (*please select all that apply).*

Types of Information	Collected?	How is information stored? (i.e. paper files, electronic database, or not stored)	If electronic database, type of database? (i.e. ETO, ARJIS, Excel, Access, or other - *please specify*)
Date of visit	☐		
Contact information	☐		
Demographic information	☐		
Race/ethnicity	☐		
Primary language(s) spoken	☐		
Limited English proficiency	☐		
Immigration status	☐		
Housing status	☐		
Employment	☐		
Education	☐		
Number/age of children	☐		
Military status	☐		
Household income	☐		
Reason for visit	☐		
Medical needs	☐		
Mental health needs	☐		
Substance abuse history/status	☐		
Risk/danger assessments	☐		
Client's criminal history	☐		
Information on the abuser	☐		
Law enforcement involvement in the current situation (for which services are being sought)	☐		
If law enforcement is involved, police report number for most recent incident	☐		

Types of Information	Collected?	How is information stored? (i.e. paper files, electronic database, or not stored)	If electronic database, type of database? (i.e. ETO, ARJIS, Excel, Access, or other - *please specify*)
Referring organization	☐		
Received services from FJC previously	☐		
Other (*please specify):* _____ _____	☐		

33. If you indicated that any of the information above is stored in an electronic database, how long has have you maintained these electronic records? _____

34. Is the data purged at specific intervals?

☐ Yes
☐ No
☐ Don't know

a. If yes, how frequently? _____

35. Can clients opt-out of providing information at intake? In other words, can clients receive services anonymously?

☐ Yes
☐ No
☐ Sometimes (*Please explain):* _____

36. If clients opt-out of providing information at intake, are services limited or refused as a result?

☐ Yes
☐ No
☐ Sometimes (*Please explain):* _____

37. Please indicate any other reasons services would be limited or refused:

_____

38. Can clients who are providing information opt-out of information being inputted into a statistical database?

☐ Yes
☐ No
☐ Sometimes (*Please explain):* _____

39. Is information in the Center's electronic database linked to the client by name or identifier?

☐ Electronic database linked to client by **NAME**
☐ Electronic database linked to client by **IDENTIFIER**

a. If clients are tracked using names or identifiers, does the electronic (statistical) database also track **service requested** by clients at the Center?

☐ Yes ☐ No ☐ Don't know

i. If yes, can the data be provided at the:

a. De-identified individual level? ☐ Yes ☐ No ☐ Don't know

b. Aggregate level? ☐ Yes ☐ No ☐ Don't know

ii. If yes, years available: _____

b. If clients are tracked using names or identifiers, does the electronic (statistical) database also track **services received** by clients?

i. At the Center? ☐ Yes ☐ No ☐ Don't know

ii. Outside of the Center? ☐ Yes ☐ No ☐ Don't know

c. If yes, can the data be provided at the:

i. De-identified individual level? ☐ Yes ☐ No ☐ Don't know

ii. At the aggregate level? ☐ Yes ☐ No ☐ Don't know

a. If yes, years available: _____

40. If information on clients and/or services are not tracked by the Center, *please specify why* (e.g. lack of resources, no access to electronic database, confidentiality concerns/limitations):
_____

41. If clients are not tracked using an identifier, can you provide aggregate information on services provided?

☐ Yes
☐ No

a. If yes, years available: _____

42. Does the Center follow-up with clients (e.g., asking clients to fill out an exit survey, participate in a focus group, calling to follow-up, etc.)?

☐ Yes
☐ No

a. If yes, at what intervals (*please check all that apply)?*

☐ Upon exiting the center
☐ As part of follow-up
☐ At/on a certain time period after visiting the center
☐ Other (please specify): _____

b. If yes, does the follow-up include all clients or a sample of clients?

☐ All clients
☐ Sample of clients
☐ Don't know

43. Please specify the type of information collected from clients and the method used to collect the information (*please check all that apply).*

Types of Information	**Collected?**	**How Collected? (i.e. exit survey, focus groups, follow-up calls, or other – *please specify*)**
Services received	☐	
Services partially received (services started, but were not continued)	☐	
Services not received	☐	
Reasons services partially/not received	☐	
Satisfaction with services	☐	
Perception of access to services	☐	
Other (please specify): _____ _____	☐	

a. If you indicated that you collect any of the above information through surveys, is this information tracked in an electronic (statistical) database?

☐ Yes, in all cases
☐ Yes, but only if the client agrees
☐ No, information is not tracked.

i. Are responses linked to the client?

☐ Yes
☐ No
☐ Don't Know

44. Based on the responses above, please confirm the extent to which you can provide the following outcome data:

Outcomes	**Ability to provide data (i.e. not available, available, or challenge to provide – *please specify*)**	**Years of data available**
Number of clients seeking services		
Number of new clients seeking services		
Number of returning clients seeking services		
Sources referring clients		
Services sought by client		
Reasons for seeking services		
Number of clients receiving services		
Services received onsite		
Services received at a satellite		
Services received offsite		

Outcomes	Ability to provide data (i.e. not available, available, or challenge to provide – *please specify*)	Years of data available
Services received based on referral (i.e., not through partner agencies)		
Services not received		
Reason services not received		

45. Does the Center use the data collected for any purpose?

☐ Yes
☐ No
☐ Don't know

a. If yes, please indicate the purpose(s) for collecting data (*please check all that apply)*?

Purpose for Collecting Data	Check all that apply
Internal analysis (e.g., feedback to staff)	☐
Improve service delivery	☐
Center annual reports	☐
Justification for funding	☐
Grantee funding requirement	☐
Evaluations	☐
Other (*please specify*) _____ _____ _____	☐

46. Would you be willing to participate in a formal evaluation (e.g., a study looking at the impact and outcomes of family justice centers)?

☐ Yes
☐ No

a. If not, please briefly explain your concerns about participating.

_____

_____

_____

47. If you were to participate in a formal evaluation, what types of support do you think you would need to participate (*please select all that apply)*?

☐ Funding *(please specify approximately how much funding would be needed to participate in an evaluative program):* $_____

☐ Staff *(please specify how many staff hours per month):* _____/month

☐ Training and Technical Assistance (please identify types of TTA below)

☐ Extracting data
☐ Interpreting confidentiality guidelines
☐ Other (please specify):_____

☐ Other (please describe) _____

48. Is the Center currently being evaluated or has it been evaluated in the past (*if yes, please attach a copy of final report from evaluation or any interim or preliminary findings)*?

☐ Yes
☐ No
☐ Don't know

a. If yes, please indicate the type of evaluation?

☐ Needs assessment *(collecting and analyzing feedback from stakeholders to support program improvement)*
☐ Process evaluation *(evaluation to determine how services are being delivered)*
☐ Outcome evaluation *(evaluation to determine whether outcomes are being achieved)*
☐ Impact evaluation *(evaluation to determine the effectiveness of programming)*
☐ Not sure

b. Who is conducting/conducted the evaluation (please select all that apply)?

☐ Internal staff
☐ Independent evaluator (e.g., an organization separate from the Center or a university-affiliated scholar)
☐ Others (*please specify)*: _____

c. If an independent evaluator is conducting /conducted the evaluation, did you provide electronic data to the evaluator?

☐ Yes
☐ No
☐ Don't know

i. If yes, any challenges in providing electronic data (*please specify)?*

_____

_____

Appendix E: FJC Study Letter from OVW

U.S. Department of Justice

Office on Violence Against Women

Washington, DC 20530

May 15, 2016

Dear Family Justice Center and Multi-Agency Collaborative Directors:

I am writing to encourage your participation in the Environmental Scan of Family Justice Centers in the United States being conducted by Abt Associates, Inc. This survey is the first of a multi-phase effort by the Office on Violence Against Women and the National Institute of Justice to better understand the benefits of Family Justice Centers and the conditions under which these benefits may be maximized. Your participation will provide the information needed to identify similarities and differences across Family Justice Centers and other similar collocated collaboratives in such areas as participating partner agencies, target populations, operational policies and procedures, and service provision.

While you may have a sense of the impact your center has had on victims and their families, partner agencies, and your community, formal measurement and documentation is important to the continuation of this movement, which officially began in 2004 with the President's Family Justice Center Initiative. The information you provide will help to improve our understanding of the many centers that exist across the country and help to ensure appropriate design for future evaluations of Family Justice Centers.

If you have any questions, please contact Meg Chapman, Senior Associate, Abt Associates, Inc. at 301-634-1740. Thank you in advance for taking the time to participate in this critical survey.

Sincerely,

Bea Hanson
Principal Deputy Director

Appendix F: Instruments and Scales

The following is an overview of survivor defined, organization, and other outcome scales that have been used in other research studies.

1.1 Survivor Defined Outcomes

- **Chan Hellerman's Adult Dispositional Hope Scale (AHS).** A 12-item, self-report questionnaire developed and validated in the 1990s by Snyder et al that conceptualizes hope as a "positive motivational state that is based on an interactively derived sense of successful agency (i.e., goal-directed energy) and pathways (i.e., planning to meet goals)." All items are scored using an 8-point Likert scale with response options ranging from "definitely false" to "definitely true."[1]
- **Family Environment Scale (FES).** An assessment tool developed and validated in the late 1970s – early 1980s by Moos and Moos to measure the social and environmental characteristics of families. Contains 10 subscales and three distinct forms. The Real Form (Form R) measures people's perceptions of their actual family environments, the Ideal Form (Form I) rewords items to assess individuals' perceptions of their ideal family environment, and the Expectations Form (Form E) instructs respondents to indicate what they expect a family environment will be like under, for example, anticipated family changes.[2]
- **Survivor Defined Practice Scale Instrument.** Assess participants' perception of the degree to which their advocates: 1) help them achieve their goals, 2) facilitate partnership, and 3) are sympathetic to their individual needs.[3]
- **Satisfaction with Life scale.** Developed to assess participant's satisfaction with their lives as a whole. The scale does not assess satisfaction with specific aspects of their lives, but allows subjects to weigh these aspects in whatever way they choose.[4]
- **Meaning in Life Questionnaire.** Assesses meaning in life using 10 items rated on a seven-point scale from "Absolutely True" to "Absolutely Untrue." Meaning in life is divided into two subsections: the Presence of Meaning subscale measures how full respondents feel their lives are of meaning. The Search for Meaning subscale measures how engaged and motivated respondents are in efforts to find meaning or deepen their understanding of meaning in their lives.[5]
- **PERMA Profiler.** The PERMA-Profiler measures the five pillars of well-being: positive emotion, engagement, relationships, meaning, and accomplishment, along with negative emotion and health.[6]
- **Psychological Well-Being Scales.** Classifying psychological well-being as consisting of 6 dimensions: autonomy, environmental mastery, personal growth, positive relations with others, purpose in life, self-acceptance, this self-report scale is designed to assess individual's well-being at a particular moment in time within each of these 6 dimensions. Individuals respond to various

[1] http://positivepsychology.org.uk/hope-theory-snyder-adult-scale/
[2] http://www.cps.nova.edu/~cpphelp/FES.html
[3] http://journals.sagepub.com/doi/pdf/10.1177/0886260514555131
[4] https://ppc.sas.upenn.edu/resources/questionnaires-researchers/satisfaction-life-scale
[5] https://ppc.sas.upenn.edu/resources/questionnaires-researchers/meaning-life-questionnaire
[6] https://ppc.sas.upenn.edu/resources/questionnaires-researchers/perma-profiler

statements and indicate on a 6-point Likert scale how true each statement is of them. Higher scores on each on scale indicate greater well-being on that dimension.[7]

- **Quality of Life Inventory.** Assesses an individual's quality of life through self-report of the importance they attach to each of 16 life domains (on a 3-point rating scale) as well as their current satisfaction with each domain (on a 6-point rating scale). The inventory is scored to determine an overall current quality of life for the participant.[8]

1.2 Organization Outcomes

- **Integrated Practice Assessment Tool.** Measures the level of integration, communication, and collaboration within an organization.[9]

1.3 Other Outcomes

- **Self-sufficiency Matrix (Colorado Family Support Assessment 2.0, 2015).** Assesses family self-sufficiency for families with children, and is administered in waves. The baseline should be completed before service receipt, with on-going follow ups every 3 to 6 months. This assessment is only useful for clients who have used services for at least 90 days.[10]
- **Outcome Evaluation Strategies for Domestic Violence Programs.** Developed by the Pennsylvania Coalition Against Domestic Violence, this guide contains three logic models for evaluation domestic violence programs, and includes several outcome measures. It provides a detailed strategy for creating an evaluation plan tailored for the evaluation on an intended program.[11]

[7] https://ppc.sas.upenn.edu/resources/questionnaires-researchers/psychological-well-being-scales

[8] https://ppc.sas.upenn.edu/resources/questionnaires-researchers/quality-life-inventory

[9] https://www.integration.samhsa.gov/operations-administration/IPAT_v_2.0_FINAL.pdf

[10] http://centerforpolicyresearch.org/wp-content/uploads/SSM-Evaluation-FinalReport-CenterForPolicyResearch-2016.pdf

[11] https://www.dvevidenceproject.org/wp-content/uploads/PCADV-Sullivan_Outcome_Manual.pdf

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