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2022 SAFE FROM THE START PROCESS EVALUATION

ICJIA

2022 Safe From the Start Process Evaluation

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Executive Summary

Introduction

Childhood exposure to violence (CEV) is a widespread public health concern associated with both immediate and long-term developmental implications. Safe From the Start (SFS) is a program designed to develop, implement, and evaluate community-based models of intervention for young children exposed to violence and their families. Research has demonstrated the program's effectiveness. However, little is known about how program sites currently operate, their strategies for overcoming obstacles, and how the program can be improved. We conducted a process evaluation with SFS sites, examining the program's operation with a focus on its three core pillars of coalition building, direct services, and public awareness. The purpose of this evaluation was to:

1. Understand how sites operate.
2. Assess sites' collaboration with other agencies.
3. Assess how clients are referred for SFS services.
4. Identify client needs and challenges.
5. Understand how clinicians deliver services and use best practices.
6. Assess sites' data collection processes.
7. Document how sites conduct community outreach and increase awareness.

Method

Procedure

From December 2021 to April 2022, we administered an online survey, facilitated focus groups, and observed virtual site visits.

Data Sources

We analyzed data collected via an online survey, four focus groups, and nine virtual site visits. Participants included SFS site clinicians and administrative staff (e.g., directors, supervisors, managers). Some participants may have been a part of two or more data collection processes.

Participant Characteristics

At least 33 providers from nine sites participated in the process evaluation. Due to the anonymous nature of the survey, we were unable to calculate an unduplicated count of participants in our study. Program sites were located in various Illinois counties, including Cook, McLean, Peoria, and Rock Island. More clinicians (39.4%) participated in the evaluation than program supervisors (33.3%) or program directors (27.3%). Most participants (64.3%) had limited experience with the SFS program, having worked from only a few months to three years for the program. About a quarter of providers (28.6%) had worked between four and six years for the SFS program and one provider had been with the program for over six years.

Data Analysis

We created a predefined coding schema that was applied across data sources. Broad thematic codes were organized based on the study's research questions and the three SFS pillars. We used NVivo, a qualitative research software, to review and identify patterns in participants' responses to focus group questions. We conducted descriptive statistics of survey and site visit data.

Limitations

We encountered some research method limitations. The study may have been skewed by self-report bias due to the presence of clinical supervisors and directors at focus groups and grant monitors at site visits. Specifically, providers may have given more socially desirable responses rather than sharing their genuine views. In addition, the methods we used to collect the data limited our ability to conduct a more comprehensive analysis. For instance, while additional administrative data that could be used to support or expand on providers' responses were available, we did not have IRB approval to analyze them for this study. Finally, we were unable to calculate an unduplicated sample size due to the anonymity of our survey; thus we cannot accurately describe whether the sample is representative of all sites.

Findings

Coalition Building

Providers reported three key objectives for building and maintaining a coalition:

1. Build a robust network to better streamline the referral process for families.
2. Collaborate with partners on public awareness endeavors to reach at-risk and/or underserved populations.
3. Provide education and training to partners to increase clinicians' knowledge of CEV and related topics.

Providers achieved these coalition objectives by exchanging referrals and sharing information and resources with their partners. Eight sites held at least one coalition meeting quarterly and six sites conduct at least one professional development training annually to ensure better collaboration among service agencies.

SFS partnerships were formed if:

1. The agency had a similar service population as the SFS program.
2. The agency was geographically close to the site.
3. SFS meets an agency's program need or the agency meets an SFS program need.
4. The agency attended an SFS training session or presentation.

Providers indicated police departments were their most common partners. They reported capacity, staff retention, and the transition to virtual meetings were barriers to successful coalition member collaboration. However, the sites were able to successfully collaborate with coalition members. To encourage agency attendance and participation at coalition meetings, they provided professional development trainings and presentations.

Direct Services

The providers' direct service activities involved making and receiving referrals, developing service plans, assessing staff capacity to provide treatment, providing therapeutic treatment, and monitoring client improvement. Providers commonly received referrals from the Department of Children and Family Services (DCFS), law enforcement, intra-agency programs, and caregivers. To develop a service plan, providers collaborated with case managers, crisis intervention managers, intake coordinators, and the courts. They also coordinated with other agencies to help meet families' immediate needs (e.g., medical services, transportation, emergency housing) and secondary needs (e.g., childcare, educational, financial, and language needs). When referrals were received, sites assessed their capacity to serve referred families with consideration for clinical staffing levels, caseloads, clinician schedules, and case characteristics.

Sites provide therapy to children ages zero to five who have been exposed to violence. They also offer services to siblings under 18 years old and caregivers. Sites used a total of 17 different therapeutic treatment modalities. However, all sites used one of two treatment types, play therapy or Theraplay.

As part of an evaluation protocol, sites gathered client information and administered assessments at specified intervals to track client progress while in service. While providers noted that the evaluation protocol had various benefits, the amount of time needed to administer the assessments and enter data into the SFS database as outlined in the protocol was a top challenge. Additionally, we identified several needs and barriers to direct service provision. These included capacity issues, training gaps, a lack of caregiver engagement, and challenges associated providing services remotely. Nonetheless, sites demonstrated various strengths in providing direct services to families, such as striving to accommodate families' busy schedules, using trauma-informed practices, offering psychoeducation to caregivers, and having internal supports in place (e.g., mentoring supervisors) to help alleviate work-related stress.

Public Awareness

Sites engaged in public awareness activities to promote and disseminate information about SFS services to community members and organizations serving similar age groups. SFS program and CEV awareness was shared through presentations to different agencies and at community events. Various professionals reached out to providers to request presentations, workshops, or training on such topics as trauma, healthy parent-child relationships and attachment, and the impact of domestic violence on young children.

Providers identified the following groups as underserved: victims of color, individuals without documents, families that only spoke Spanish, and LGBTQ+ individuals. They employed various strategies to reach underserved victims, including hiring bilingual staff and supplying outreach materials in multiple languages to mitigate language barriers and increase access to services.

However, multiple providers did not have the staff capacity or financial resources to engage in outreach activities that targeted underserved groups.

The COVID-19 pandemic impacted the types of strategies providers used to conduct community outreach activities. Presentation topics shifted from CEV to pandemic-related areas. Also, providers turned focus to rebuilding connections that were lost early in the pandemic and attending community events. We found that the main barriers to public awareness and community outreach were related to staff capacity, low engagement or buy-in, and client accessibility to online platforms. While the pandemic exacerbated existing barriers to meeting public awareness goals, the sites' use of virtual platforms created new opportunities to increase SFS program awareness and educate communities on CEV.

Discussion

While providers noted many strengths, they encountered challenges particularly related to capacity and technology. We identified areas for programmatic improvement and offer recommendations.

Recommendations

Advocate for More Program Funding to Increase Capacity. Limited funding and resulting staff shortages created capacity challenges that affected coalition building, public awareness, and direct service work. Providers reported that staff left the program due to a lack of competitive salaries, benefits, and affordable childcare, which is consistent with recent research. Results also revealed that sites received an increased number of family referrals without additional financial resources. Furthermore, high staff turnover limited direct service capacity. With additional funding, sites would be able to offer more competitive salaries and benefits, helping to recruit new hires and retain current staff.

Advance Staff Knowledge and Skills through Training. Findings point to an increased need for training to build staff knowledge and skills, including on evidence-based practices (EBPs) and treatments and SFS programmatic processes. Providers stated that training opportunities were important for their professional development. Furthermore, research suggests career development offerings can improve workplace retention among health professionals (Cosgrave, 2020). In addition, research on EBPs and treatments supports their effectiveness. According to Peña & Behrens (2019), funders are more likely to invest in programs that apply research-based EBPs with their target populations as effective interventions often reduce taxpayer expenditures. Furthermore, trainings on SFS programmatic processes would help standardize practices among staff, which is particularly important for newer staff.

Focus on Expanding and Sustaining Coalition Partnerships. Most providers faced similar coalition challenges, including weakened agency connections, low or inconsistent meeting attendance from members, and few new partnerships. Findings suggested that providers need better guidance and tools for networking with other community-based service agencies and potential partners (e.g., early learning centers) similarly invested in preventing CEV. According to the U.S. Department of Health & Human Services (n.d.), developing and strengthening partnerships helps build a more comprehensive and coordinated system for providing direct service and enables providers to better meet the needs of children and their families. Additionally, collaboration among organizations working with families exposed to violence can maximize resources, reduce siloing of services, and minimize duplicated efforts (Butterfoss, 2004; Goldman and Schmalz, 2008). Therefore, we recommend that providers focus on expanding and sustaining their coalition partnerships through various networking and team building strategies.

Explore Data Collection Methods to Further Assess Coalition Activities and Outcomes. The COVID-19 pandemic exacerbated coalition building challenges and depleted resources needed for interagency collaboration. Providers can better allocate their limited time and resources to gaps in their coalition activities with ongoing data collection. Collecting outcome data enables agencies to demonstrate to partners their progress toward programmatic goals and to obtain buy-in from new organizations (U.S. Department of Health & Human Services, n.d.). Additionally, logic models are useful for facilitating conversation about short and long-term outcomes (Butterfoss & Francisco, 2004; U.S. Department of Health & Human Services, n.d.). Another tool is the Coalition Effectiveness Inventory, useful for assessing if the coalition is informing policies and contributing to community change.

Enhance Engagement of Caregivers and Children in Services. Providers noted that some caregivers were reluctant to participate or allow their children to participate in services. Some sites successfully used strategies to keep families engaged in services longer, such as offering psychoeducation, parenting classes, and adult support groups to caregivers. Other sites should consider applying these strategies to increase caregiver engagement. Also, virtual service options made it possible for families who lived too far from site locations to receive services. However, providers reported that young children had difficulty staying engaged during these virtual sessions. Some sites provided families with therapy toolkits that allowed for interactive play and helped maintain children's attention for longer periods of time during virtual sessions.

Enhance Cross-Site Collaboration and Coordination of Public Awareness Efforts. Most sites had difficulty providing both therapeutic services and engaging in public awareness activities due to limited staff capacity. Additionally, providers reported obtaining community buy-in through virtual outreach activities had been challenging. Research findings suggested that providers should enhance cross-site collaboration and improve the coordination of public awareness efforts to alleviate staff workload and increase community members' awareness of the SFS program and the impacts of CEV. Tsao and Davis (2017) emphasized that efforts to address violence require consistent collaboration and stakeholder coordination. We recommend that SFS providers standardize their annual presentations and training offerings to better coordinate public education. Providers should use their bimonthly SFS all-sites conference calls to discuss potential opportunities for public awareness collaborations and to share their challenges or successes with community outreach.

Increase Knowledge and Accessibility of Services for Underserved Populations. While findings indicated providers had difficulty reaching underserved populations because of limited resources, they asserted that increasing underserved group awareness of the SFS program was an important programmatic goal. Underserved groups face multiple barriers to services, such as lack of transportation and services that feel welcoming, and limited service options for those living in rural areas and for people with disabilities (Smith & Hope, 2020). Additionally, when services are not sensitive to families' identities and cultures, they are less likely to participate in services (Sered & Butler, 2016). Therefore, researchers recommended that providers build supportive relationships with community organizations to increase access to social supports (McGee et al., 2021) and focus on collaborating with other local agencies to disseminate information on service options (Daro & Dodge, 2009).

Future Directions for Research

The current process evaluation points to avenues for future research. First, researchers should consider evaluating individual sites. While we aggregated data across sites, each site was uniquely structured and served demographically distinct families. A closer examination of select sites would help identify their unique challenges and resource needs. Second, more research is needed to better understand strategies implemented by sites to retain SFS program staff and their effectiveness. Lastly, future researchers should conduct an outcome evaluation that incorporates client perspectives. While process evaluations provide invaluable information on a program's operations, outcome evaluations are needed to better understand the program's impact (Moore et al., 2015a). Future research should assess program impacts on clients and provide opportunities for client study participation.

Conclusion

The SFS program is a community-based program established to help families exposed to violence, particularly young children under six years old. For more than two decades, SFS providers worked to expand their network of partnerships, provided direct services to families, and increased communities' awareness of CEV and related topics. To paint a clear picture of program processes and outputs, process evaluations should be conducted at regular intervals. These evaluation findings would inform recommendations that could improve program operations and client outcomes.

Introduction

Childhood exposure to violence (CEV) is a widespread public health concern. A national survey of over 4,000 children and youth revealed three in five children were exposed to at least one type of violence within the previous year (Finkelhor et al., 2015). Additionally, CEV has been associated with both immediate and long-term developmental concerns. For example, CEV places children at increased risks for mental health problems and interpersonal relationship issues (Child Welfare Information Gateway, 2019). While some evidence-based practices (EBPs) for victims of abuse have been effective at reducing the impact of CEV, process evaluations of community-based programs for young children are scarce (Moore et al., 2015b). Process evaluations inform program development by documenting how program outcomes are reached and identifying how resources can be redirected to address programmatic needs and challenges and improve client outcomes (Limbani et al., 2019).

Safe From the Start (SFS) is a state-funded program first established in 2001. It was designed to develop, implement, and evaluate community-based models of intervention for serving young children, ages zero to five and their families exposed to violence in their homes and/or communities. Community-based interventions take a holistic, public health approach to resolving community needs. After identifying the need and impacted population, community-based interventions target individual and environmental factors within the community to prevent escalation of issues and to promote well-being. Nine SFS sites operated in Illinois at the time of the study. The sites have shown promise in reducing the impact of violence exposure on children and families. For instance, 26% of children with social-emotional difficulties and 24% of caregivers with borderline- to clinical-levels of stress at intake significantly improved on the Ages & Stages Questionnaire: Social-Emotional (ASQ:SE) and Parenting Stress Index (PSI), respectively, after receiving SFS services (Gonzalez et al., 2022). However, little is known about how sites operate, including their current strategies for overcoming obstacles and how the program could be improved.

We conducted the first process evaluation of the SFS program since Illinois Criminal Justice Information Authority (ICJIA) assumed administrative program oversite[1] in 2013. We examined the program's operation, with a focus on its three core pillars of coalition building, direct services, and public awareness. The purpose of this process evaluation was to:

1. Understand how sites operate.
2. Assess sites' collaboration with other agencies.
3. Assess how clients are referred for SFS services.
4. Identify client needs and challenges.
5. Understand how clinicians deliver services and use best practices.
6. Assess sites' data collection processes.
7. Document how sites conduct community outreach and increase awareness.

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[1] Administrative program oversite refers to ICJIA's role in administering SFS grant funds, monitoring sites' programmatic activities, and conducting the evaluation.

These evaluation findings are provided to inform stakeholders about both strong and weak program components. Recommendations are made on the efficiency and effectiveness of the SFS program, including suggestions for how stakeholders can better support sites, providers, and families exposed to community and/or domestic violence.

Literature Review

Prevalence of Childhood Exposure to Violence

CEV is a widespread issue in the United States. Exposure occurs when an individual witnesses or directly experiences abuse, neglect, maltreatment, or violence. Examples of exposure to violence within the home and/or community include intimate partner violence, violence perpetrated by a family member, homicide, gun violence, gang violence, bullying, and assault. In a national survey of 4,503 children and youth between 0 and 17 years old, Finkelhor and colleagues (2015) found that three in five children (57.7%) were exposed to at least one type of violence (e.g., physical assault, sexual victimization, maltreatment, property victimization, witnessing violence) and nearly half of children (48.4%) experienced more than one type of victimization within the previous year. Additionally, an average of 6.9 per 100,000 children are hospitalized annually due to abuse or neglect (Wojciak et al., 2021). While violence affects all age groups, infants and children under four years old are particularly vulnerable to child maltreatment and death due to violence (U.S. Department of Health & Human Services, 2021; Wojciak et al., 2021). For children five years old and under, exposures to community and domestic violence have shown to be positively associated with physical and psychological abuse. The probability of experiencing psychological abuse later in life increased the earlier a child was exposed to domestic violence (Maguire-Jack et al., 2022).

In addition to its immediate harm on children, CEV can have lasting impacts on children's behaviors and family functioning. For instance, a longitudinal study of 416 children at ages four, eight, and 18 years old (i.e., adolescent) found that children exposed to physical child abuse, domestic violence, or both exhibited greater antisocial behaviors and lower attachment to parents during adolescence compared to nonexposed children (Sousa et al., 2011). Antisocial behaviors included felony assault, minor assault, status offenses, such as running away from home or being suspended from school, and delinquency. CEV also threatens the development of secure attachments. When exposed to violence at an early age, children can harbor fear and distrust toward others, hindering their ability to form positive relationships with caregivers and peers later in life (Child Welfare Information Gateway, 2019; Doyle & Cicchetti, 2017; Gustafsson et al., 2017). A systematic review of 15 studies indicated that intimate partner violence was significantly associated with less secure parent-child attachment (Noonan & Pilkington, 2020). Furthermore, research has shown that mothers exposed to violence experience mental health symptoms that negatively impact their parent-child relationships. For instance, Taylor and colleagues (2009) found that in a sample of 2,508 mothers from 20 U.S. cities that mothers exposed to IPV were at greater risk for parenting stress, major depression, and child maltreatment (i.e., physical aggression, psychological aggression, spanking, and neglect). Researchers reasoned that caregivers exposed to violence can have difficulties regulating their emotions under high-stress situations (Hungerford et al., 2012; Jocson et al., 2021; Pels et al., 2015). As a result, caregivers' ability to optimally care for their children and, consequently, the caregiver-child relationship can be disrupted when both the caregiver and child have been exposed to violence.

Early and intensive community-based intervention programs can improve outcomes for children exposed to violence (Cohen et al., 2009). Numerous evidence-based programs and interventions have been evaluated and deemed effective or promising in reducing violence and the impact of CEV (Moore et al., 2015b; Child Welfare Information Gateway, n.d.b). One such program is the Safe From the Start (SFS) program, a state-funded initiative designed to develop, implement, and evaluate community-based models for serving young children (zero to five years old) and their families who have been exposed to violence in their homes or communities.

A recent SFS study found that 26% of children with social-emotional difficulties and 24% of caregivers with borderline- to clinical-levels of stress at intake significantly improved on the Ages & Stages Questionnaire: Social-Emotional (ASQ:SE) and Parenting Stress Index (PSI), respectively, after receiving SFS services (Gonzalez et al., 2022). However, program evaluations focused on program outcomes do not identify program components that, if adjusted or improved, can contribute to positive outcomes for children and families (Moore et al., 2015b). Additionally, outcome evaluations do not assess whether programs are reaching at-risk populations and the long-term effects of these interventions on reducing the impact of CEV (Moore et al., 2015b). Process evaluations enable researchers to assess current programmatic processes, characteristics, and needs vital for informing effective public welfare programming (Limbani et al., 2019), such as SFS.

Safe From the Start Pillars

While differences exist across sites in treatment approaches, agency organization, and other aspects, all sites adhere to the SFS program model comprised of three core pillars: building coalitions, providing direct services, and raising public awareness about the issue and impact of CEV.

Coalition Building

Community-based intervention programs can help address community issues, including CEV, by building and maintaining coalitions. In a coalition, different organizations across multiple sectors collaborate and commit to a shared set of goals or targets, while each member organization maintains autonomy (Raynor, 2011). Coalitions can mobilize talents and resources to develop widespread support for a community's unmet needs (Butterfoss & Francisco, 2004). According to Thornburg and Means (2013), local organizations, such as early learning providers, schools, mental and healthcare providers, and social service agencies, are best equipped to understand the strengths and challenges of children and caregivers as they typically have the most direct contact with families in their community.

The success of coalitions depends on their conditions at the individual, organizational, and community level. At the individual level, a coalition should elect effective leaders who can create and sustain a vision, provide direction, and prioritize, innovate, and motivate its members (Raynor, 2011). Having a shared mission and cohesive goals can minimize miscommunication and conflict. Common sources of conflict typically derive from disagreements between members about goals, roles, resources, and their coalition's identity (Smathers & Lobb, 2014). Therefore, accomplishing tasks on schedule and adhering to planned strategies are key factors in successfully implementing a coalition (Minkler, 2012). At the organizational level, a coalition should create a positive working environment that supports strong relationships among its members and efficiently manages resources (Thornburg & Means, 2013). A successful coalition will know how to assess and adapt to internal and external changes (Raynor, 2011). Finally, at the community level, a coalition should involve community members in supporting their coalition activities and public awareness events (Thornburg & Means, 2013). Doing so can enhance a community's trust and buy-in and increase the likelihood of community engagement in services offered (Butterfoss and Kegler 2002, as cited in Minkler, 2012).

Additional benefits to coalitions are that they can create opportunities for all organizations involved, such as sharing a mission with others, being involved in an important cause, minimizing duplicative efforts, and enhancing visibility of one's organization and services (Butterfoss & Francisco, 2004; Raynor, 2011). Organizations use coalitions to network, share information, access resources, and build new skills (Butterfoss & Francisco, 2004). They also enable members to obtain desired outcomes with consistent collaboration, communication, and willingness to use different approaches or ideas (Raynor, 2011). However, coalitions that lack sufficient communication and guidance can cost members' significant time, autonomy in decision-making, and scarce resources (Raynor, 2011). Members of an unsuccessful coalition might feel a lack of direction from leadership or unappreciated (Butterfoss & Francisco, 2004).

Although most literature discusses a coalition's benefits, costs, and capacity conditions, this study can expand the coalition literature to include community-based programs, such as SFS, which uses coalitions to address CEV. This study will examine SFS coalition strengths, challenges, and processes.

Direct Services

CEV prevention and intervention programs that provide direct services treat or support victims exposed to violence. Examples of direct services include home visits for high-risk families, trauma and symptom screening, referrals so families can access resources (e.g., mental health counseling), and education (e.g., positive parenting) for caregivers after exposure to violence (Child Welfare Information Gateway, n.d.b). Typically, direct services aim to strengthen family relationships and increase protective factors.

Evaluations of evidence-based youth welfare programs indicated that interventions utilizing a socio-ecological approach can disrupt one's likelihood of experiencing negative long-term outcomes due to CEV (Child Welfare Information Gateway, 2021; U.S. Department of Justice, 2020). The socio-ecological approach acknowledges that individual, relationship, community, and societal factors influence each other and can provide a lens for how violence is understood. By focusing on each level, researchers can identify and learn about factors that contribute to violence or are likely to be impacted by violence exposure at a particular level. Then, researchers can focus on treatment and prevention efforts at each level. According to this approach, prevention and treatment efforts should be multi-modal and targeted at improving each level simultaneously to sustain lasting, population-level impact within a community (Child Welfare Information Gateway, 2021). For example, treatment approaches that supplement a child's individual therapy with education for caregivers on child development would satisfy the individual- and relationship-levels of the socio-ecological approach.

The use of trauma-informed practices in interventions for families exposed to abuse, violence, and other adversities is also promising (Cohen et al., 2009). Organizations that use trauma-informed care strive to understand a person's life history; recognize trauma's impact, signs, and symptoms on a person's health and behaviors; and employ best practices when trying to elevate the health of individuals exposed to trauma (Substance Abuse and Mental Health Services Administration, 2014). Trauma-informed practices can be employed at the organizational and clinical levels. At the organizational level, practices include hiring a trauma-informed workforce, creating a safe environment for staff and clients, and taking measures to reduce secondary trauma and stress in staff members. At the clinical level, practices involve training providers in trauma-specific treatment approaches, screening clients for trauma, and encouraging clients to be active participants in their own treatment planning (Menschner & Maul, 2016). In a systematic review of 75 studies on child welfare initiatives, Bunting et al. (2019) found that families who received services at agencies that practiced trauma-informed care had improved outcomes. This included increased child emotional and behavioral well-being, caregiver ability to meet personal and children's needs, and family safety, and decreased child mental health symptoms and caregiver stress.

While the SFS program has demonstrated past successes in reducing concerning behaviors and symptoms in young children exposed to violence (e.g., Gonzalez et al., 2022; Schewe & Chang, 2018), it is unclear which site practices may be contributing to (or detracting from) the program's mission of reducing negative impacts of CEV. Thus, we will identify site treatment modalities and their promising practices and gauge the needs and challenges providers encountered when delivering services.

Public Awareness

Public awareness can be an effective approach for increasing community members' knowledge of CEV and services available to young victims of violence. Public awareness efforts provide communities with the resources and social support needed to create an environment for fostering positive youth functioning (Daro & Dodge, 2009). For example, organizations can offer resources to families on healthy parent-child relationships, child safety skills, and protocols for reporting suspected maltreatment (Child Welfare Information Gateway, n.d.a). According to Daro and Dodge (2009), other awareness efforts focus on building a community's social networks and supports by inviting residents and key stakeholders to participate in child abuse prevention initiatives and allowing them to share their concerns or service barriers. Research suggests families who are strongly connected to community networks are better equipped to cope with the stress and daily demands of being a parent (Negash & Maguire-Jack, 2016).

Additionally, prospective clients, especially those who are underserved, benefit from public awareness activities that better streamline resources and information on service availability and eligibility. According to the Violent Crime Control and Law Enforcement Act of 1994, underserved populations face barriers in accessing and using victim services (34 U.S.C. § 12291, 2022). These populations include people of color, LGBTQ individuals, persons with disabilities, older adults, and formerly incarcerated individuals (OVC Report to the Nation, 2017). Language barriers, cultural biases, and social isolation also prevent victims from seeking help or staying engaged in services (OVC Report to the Nation, 2017). Therefore, spreading awareness of victim services can build a more supportive community and increase a family's willingness to seek help

(Negash & Maguire-Jack, 2016). A Child Welfare Information Gateway (2020) study explored how child welfare professionals access and share information on resources and services for children and families. The study found child welfare personnel share information with colleagues or other professional contacts several times a week, most commonly through face-to-face conversations, emails, and organizational meetings. However, gaps were identified in the types of information accessible to child welfare professionals, especially frontline workers. Participants in the study indicated a need for more access to information about community or local services for children and families, child welfare laws and policies, and learning opportunities (e.g., conferences, workshops, training) (Child Welfare Information Gateway, 2020).

This process evaluation will explore the strengths and gaps in the strategies used by SFS sites and partner organizations to share information. Public awareness efforts used to reach underserved children and families will also be discussed.

Method

Procedure

We conducted a process evaluation of nine SFS sites from December 2021 to April 2022. As part of the evaluation, we administered an online survey, facilitated focus groups, and observed virtual site visits conducted by ICJIA Federal and State Grants Unit staff. We recruited SFS service providers to participate in the survey and focus group through email. ICJIA grants staff invited us to attend the virtual site visits.

Data Sources

Table 1 summarizes the types of data analyzed and the number of participants in each data source. Participants included SFS site clinicians and administrative staff (e.g., directors, supervisors, managers). Some participants may have been a part of two or more of the data collection processes.

Table 1
Data Sources

Data Source	Quantity	No. of Participants
Survey	1	22
Focus Groups	4	14
Site Visits	9	28

Note. Site visit participants included SFS site program staff (e.g., clinicians, program directors, supervisors, and managers).

Survey

We released a 20-minute Qualtrics survey to providers in December 2021. Service providers answered questions about their levels of involvement and concerns with their site's data collection process. Additionally, the survey included questions about database training and assessment tool usage and requested suggestions for improving the overall data collection process.

Focus Groups

Four semi-structured focus group sessions were conducted with service providers in February 2022 to gain a better understanding of the program's main pillars of work: coalition building, direct services, and public awareness. Sessions ranged from 68 to 116 minutes with a mean length of 93 minutes (*SD*=22.3). Focus group questions covered topics about the program's referral process, outreach to underserved populations, community awareness, service planning, agency capacity, collaboration efforts and barriers, and the impact of COVID-19 on the program.

Site Visits

Providers are required to participate in site visits with an ICJIA grant monitor or program director every grant cycle to discuss their programs' financial status, operations, and progress on programmatic goals. This year, site visits were held virtually from March 2022 through April 2022. We observed nine site visits, one for each site, and compiled notes on providers' responses to standardized questions created by the grant program director. Specific topics covered during the site visit included service options, referral processes, client termination procedures, assessment protocol and database entry challenges, coalition efforts, and public awareness activities.

Participant Characteristics

Providers at all nine sites participated in the process evaluation. Program sites were located in Cook, McLean, Peoria, and Rock Island counties. However, due to the anonymous nature of the survey, we were unable to calculate an unduplicated count of study participants. A total of 33 individual providers participated in focus group and site visits. In addition, we received 22 survey responses from at least one provider at each site. *Table 2* summarizes the roles of providers who participated in the focus group and site visits. More clinicians participated in the evaluation than program supervisors or directors.

Table 2

Provider Roles in Focus Group and Site Visit Sample

	N	%
Clinician	13	39.4
Program Supervisor/Manager	11	33.3
Program Director	9	27.3

Note. The sample totaled 33 participants.

Providers participating in focus groups were asked how long they had been involved with the program. Most participants (64.3%) had limited experience with the SFS program, having worked from only a few months to three years for the program. About a quarter of providers (28.6%) had worked between four and six years for the SFS program and one provider had been with the program for over six years.

Data Analysis

We created a predefined coding schema that was applied across data sources. Broad thematic codes were organized based on the study's research questions and the three SFS pillars. For example, codes for each pillar included general procedures, strengths, challenges, pandemic impact, capacity challenges, and provider recommendations. Transcription services were used to transcribe the audio from the focus group sessions. We used NVivo, a qualitative research software, to review and identify patterns in participants' responses to focus group questions. We conducted descriptive statistics of survey and site visit data.

Limitations

We encountered some research method limitations. The study may have been skewed by self-report bias due to the presence of clinical supervisors and directors at focus groups and grant monitors at site visits. Specifically, providers may have given more socially desirable responses rather than sharing their genuine views. The biases could have included providers attributing positive outcomes to their work and negative outcomes to external factors to project positive program and work performance. Then, the methods we used to collect the data limited our ability to conduct a more comprehensive analysis. For instance, administrative data from the Completion of Services Forms (CSF), a questionnaire completed by providers on every child and caregiver who received services, could be used to support or expand on providers' responses. The forms record similar information discussed in our focus groups and site visits, such as types of services provided, treatment modalities used, and family barriers to service engagement. Providers have been collecting CSF data for over a decade, thus longitudinal trends and patterns in these administrative data could be analyzed. However, we did not have IRB approval to analyze them for this study. Finally, we were unable to calculate an unduplicated sample size due to the anonymity of our survey; thus we cannot accurately describe whether the sample is representative of all sites.

Findings

The following summarizes how sites operationalized each pillar, needs and barriers associated with each pillar, and site strengths as they relate to each pillar. Providers' suggestions for program improvements are discussed.

Coalition Building

Coalition building refers to providers' partnerships with community-based agencies and with other local and state organizations serving families exposed to violence. Providers reported three key objectives as being associated with building and maintaining a coalition:

1. Build a robust network to better streamline the referral process for families.
2. Collaborate with partners on public awareness endeavors to reach at-risk and/or underserved populations.
3. Provide education and training to partners to increase clinicians' knowledge of CEV and related topics.

Providers achieved these coalition objectives by exchanging referrals and sharing information or resources with their partners. Coalition members met regularly to discuss agency goals, service options, and referral processes. Additionally, they updated each other on community needs and active projects or events requiring collaboration. For example, a provider shared their coalition members informed the program of places and people in need of immediate assistance due to a flood in the community. Regarding public awareness, providers encouraged members to discuss strategies for preventing re-victimization of children and families, especially those who are underserved or negatively impacted by the COVID-19 pandemic. Providers also coordinated with internal and external speakers to offer training on CEV, domestic violence, human trafficking, and complex trauma to support staff professional development.

While all sites strived to achieve these three coalition objectives, coalition structures and types of partnerships differed.

Coalition Structure

Research findings suggest the COVID-19 pandemic and partnership types impacted site coalition structures. Prior to the pandemic, providers offered breakfast or lunch at meetings and encouraged members to host in-person meetings to increase attendance and engagement. However, since 2020, most meetings were conducted virtually through Zoom conference calls. As a condition of their SFS grants, all sites were required to meet with their coalition members at least quarterly and conduct at least one annual training. Eight sites reported holding at least one coalition meeting quarterly and six sites conducted at least one annual professional development training to ensure better collaboration among service agencies. Sites were also required to collect information on the number and content of coalition meetings and the educational opportunities provided to coalition members. Other additional data collection processes documenting coalition activities or sites' progress towards coalition goals were not discussed in this study.

Most sites employed an independent coalition model where SFS program coordinators and clinicians shared coalition building responsibilities, such as preparing meeting agendas, training, and presentation materials. In contrast, one site had integrated its SFS coalition with an intra-agency program's coalition which focused on the same age group. Intra-agency programs are housed within the same agency as the SFS program. Therefore, staff from SFS and the intra-agency program work together in leading coalition building activities. A provider from this site highlighted the benefits of integrating the two coalitions, which included an expanded partnership network, shared community partners, and a more efficient use of time and resources. Specifically, this structure reduced the number of coalition meetings members needed to attend, providing them with more time to engage in other coalition building activities. Another provider in an integrated coalition agreed this strategy was beneficial. However, staff retirements and the pandemic caused the integrated coalition to lose its partners and revert to an independent SFS program coalition. This occurrence prompted many providers to rebuild and create new partnerships. providers to rebuild and create new partnerships. providers to rebuild and create new partnerships. providers to rebuild and create new partnerships. providers to rebuild and create new partnerships. providers to rebuild and create new partnerships. providers to rebuild and create new partnerships. providers to rebuild and create new partnerships.

Partnerships. Coalition membership varies by site. Findings indicated partnerships are formed if:

1. The agency has a similar service population as the SFS program.
2. The agency is geographically close to the site.
3. SFS meets an agency's program need or the agency meets an SFS program need.
4. The agency attends an SFS training session or presentation.

When establishing partnerships, providers reported considering agency missions, values, reputations, service populations, proximities, and alignment with SFS program goals. They described seeking coalition members offering services in communities served by the SFS program and that would be easily accessible for prospective families.

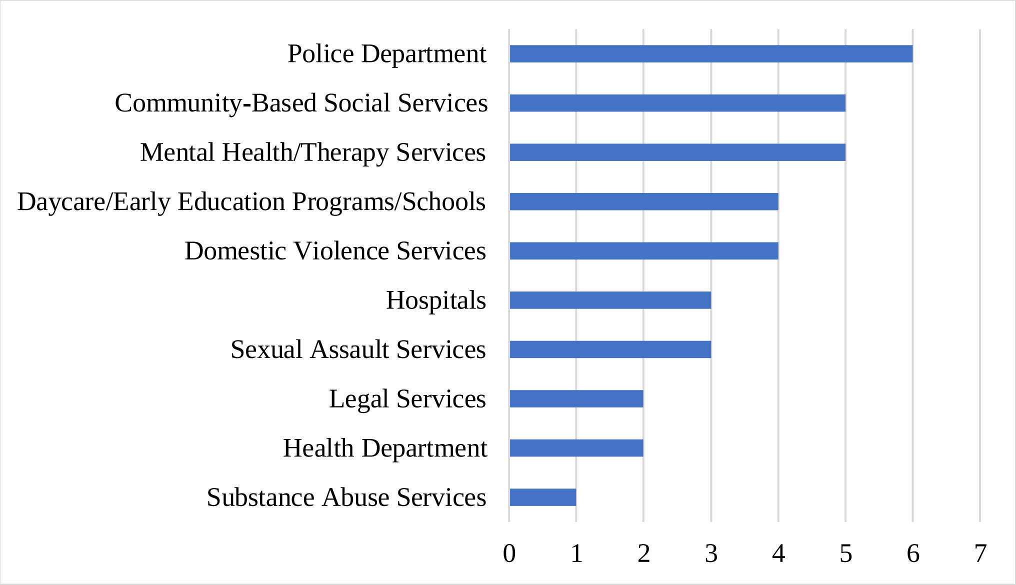
Additionally, providers evaluated agency capacities and referral processes to ensure the resources and services offered by the agency would benefit their SFS program. For example, providers partnered with community-based organizations that were better equipped to meet the needs of certain underserved populations. Some SFS providers said language barriers prevented them from assisting immigrants. Also, the lack of specialized training on best practices for serving LGBTQ+ communities, necessitated partnerships with community-based organizations that serve that population.

Lastly, partnerships were formed with agencies that requested an SFS training session or attended an SFS presentation. A SFS provider invited a local youth service provider to join their coalition and attend quarterly meetings after receiving CEV training from SFS clinicians. We also found that some coalition partnerships were temporary, established to meet a short-term need, such as training or gain support for community events, whereas other partnerships were more active and included consistent referral and resource sharing.

Providers discussed their coalition's composition and identified critical coalition partnerships. *Figure 1* shows the types of agencies with which SFS coalitions had formed partnerships. The most common coalition partnership was with local police departments. Other common partners included community-based social services agencies, mental health care providers, domestic violence agencies, and early education programs (e.g., Head Start).

Figure 1

Most Common Coalition Partnerships, by Agency Type



Note. The sample included nine SFS sites. Data were drawn from site visit reports. One site did not report its coalition partnerships.

Sites most commonly formed a coalition with agencies most critical to the SFS program's work. One provider remarked how their police department was very active in their community, bringing awareness to the SFS program and educating children on violence and safety planning. Other providers reported that community-based social service agencies and mental health care providers were important because they had conducted intakes with clients before they arrived at SFS sites. One provider said, "By the time [clients are] assigned to us, we're ready to start therapy services because [external providers have] already done a lot of the case management work." Lastly, providers indicated providing more professional development training and resources to law enforcement and social service agencies than other agency partners.

Needs and Barriers

We found that the main barriers to successful coalition member collaborations were capacity, staff retention, and the transition to virtual meetings. Providers described how staff capacity impacted their coalition-building activities. The majority of coalition activities were led by clinicians. Increased referrals and direct service needs sometimes resulted in the need to prioritize service provision over coalition building activities. Furthermore, when the SFS program waiting lists were too long, sites denied referrals from partners, which weakened connections with those agencies.

Providers expressed needing greater support from funders and stakeholders to increase staff capacity for coalition building activities. One provider said a lack of partnerships with agencies in rural counties created a barrier to reaching families in those communities. Additionally, frequent staffing changes negatively impacted coalition member connections. Providers reported that new staff work to rebuild rapport and relationships with coalition partners while becoming familiarized with the program.

Lastly, it was difficult for sites to maintain consistent member engagement at virtual coalition meetings. Multiple providers said coalition partners experienced virtual meeting fatigue because their interactions with partners only occurred online. While some coalition members attended scheduled meetings, providers noted difficulties in eliciting active participation, including agency updates. One provider described low meeting attendance and difficulty bringing on more new partners.

Strengths

Despite provider capacity, staff retention, and technology challenges, SFS sites were able to successfully collaborate with coalition members. Specifically, sites used various strategies to encourage agency attendance and participation at coalition meetings. One provider described how their coalition had speakers talk about grief related services for children with incarcerated, deported, or deceased caregivers. Other speakers shared information by conducting presentations on trauma, playful parenting, and positive discipline. Coalitions that provided professional development trainings and presentations on service options available through other agencies observed increased participation from members at meetings. In addition, some coalitions created invitation lists comprised of new organizations and those who had attended previous meetings. This helped address low meeting attendance while contributing new perspectives and resources.

Strong meeting attendance and participation also helped reduce provider workload and increased collaboration. Lastly, other strengths of sites' coalition work were that it enabled them to provide centralized waiting lists and offer increased case management services to prospective SFS families via coalition partners, streamlining the referral making process. For example, a provider highlighted how one of their coalition partners screened children for potential sexual violence exposure and placed them on a centralized waiting list for connection with any of over 30 specialized service providers. When spots open, clients were matched with the provider that best meets their needs. Providers reported that coalition partners also provided case management services to families before referring them to an SFS site.

Direct Services

Direct services are those activities that SFS providers engage in that are expected to have a direct benefit to clients. They typically involve provider-client interaction. Providers described engaging in making and receiving referrals, developing service plans, assessing staff capacity to provide treatment, providing therapeutic treatment, and monitoring client improvement. They also reported using various assessment tools at established intervals to assess client well-being, as outlined in the SFS program's evaluation protocol.

Referrals

Providers described receiving referrals from multiple sources, including the Department of Children and Family Services (DCFS), law enforcement, intra-agency programs, and caregivers. They reported the number of referrals they received from DCFS and law enforcement had grown in recent years. One provider shared that judges demonstrated a preference in their court decisions for programs utilizing child-parent psychoeducation (CPP) for court-involved families with children who had been exposed to violence. CPP is an evidence-based treatment shown to reduce symptoms and increase resilience among young children exposed to violence (U.S. Department of Justice & U.S. Department of Health & Human Services, 2011).

Sites also received many referrals from intra-agency programs, housed under the same agencies as the SFS program. Intra-agency programs provide a variety of services, including emergency housing, domestic violence counseling, medical advocacy, forensic services and advocacy, home visitations, and early education. In addition, some referrals are initiated by a caregiver seeking services for their child. These caregivers contact an SFS provider after learning about the program online, at SFS-hosted community awareness events, or from family members or friends who received SFS services.

Providers also reported that some referrals are made using an SFS referral form that SFS providers supply to their partner agencies. When a caregiver seeks services from an SFS partner agency and providers suspect a young child may have been exposed to violence, the partner agency can complete an SFS referral form and send it to sites. The partner agency can use the form to document some preliminary information about the prospective client, such as the family dynamic and presenting issue. The partner agency asks caregivers if an SFS provider can contact them to schedule an intake appointment or provides caregivers with an SFS site’s number to schedule an appointment.

To promote program referrals, SFS providers presented program-related materials at monthly events to coalition members, informing members about the types of services offered by the program. Providers also reported distributing information about the program via presentations, flyers, and referral forms to community agencies and schools for information sharing with families.

Providers noted that families were placed on a waiting list when the number of incoming referrals exceeded their capacity to provide services. However, providers engaged local partners to meet their clients’ immediate needs, such as food or housing. Sites with intra-agency programs made it easier for providers to offer families with needed services as they were able to share resources and provide services at one location.

Service Planning

A service plan outlines the supports, activities, and resources required for clients to achieve personal goals while receiving treatment. To develop a service plan for children and caregivers, providers collaborate with case managers, crisis intervention managers, intake coordinators, and the courts. They also coordinate with other agencies to help meet families’ immediate needs (e.g., medical services, transportation, emergency housing). Referred families often have multiple needs, such as childcare, housing, educational, financial, and language needs. Providers asserted that it was important to address those needs so that families could remain in treatment. They reported contacting partner agencies that had reliably provided needed services to SFS families in the past. Sites heavily relied on community partners to meet clients' needs because they did not provide or did not have the capacity to provide all needed services.

Providers stated that they typically use a minimum of three sessions to gather information, build rapport, and gauge family needs. Some sites required treatment plans to be reviewed and approved by a supervisor within 30 days of a provider's initial contact with the child client. To guide treatment planning, providers completed mental health and evaluative assessments with families and discussed assessment results with caregivers. Providers shared that while they offer their professional observations and recommendations, they make it a priority to involve caregivers when setting treatment goals and steps for achieving them. Supervisors also reviewed treatment plans and case notes and met with providers weekly one-on-one or monthly as a team.

Funding for the SFS program is limited. Without additional grant funds, most sites did not have sufficient financial resources for case managers, crisis intervention managers, and intake coordinators. As a result, most providers performed job duties associated with positions other than their own. Some SFS sites leveraged intra-agency staff to meet gaps in services for families.

Assessing Capacity

When referrals were received, providers reported assessing their capacity to serve those referred families. In their assessment, supervisors considered the site's clinical staffing level, current caseloads, clinician schedules, and case characteristics.

Clinical Staffing Levels. A range of one to five clinicians provided treatment to SFS clients at each site. Many clinicians were partially funded by the SFS program. One clinician shared that 25% of their time was supported by another grant. As a result, their SFS client caseload was limited to 10-12 clients. To increase capacity, some sites hired interns using non-SFS funds to assist clinicians with data entry. Also, capacity was limited by clinicians' language skills and specialization. A best practice utilized by sites is to try to match clients with clinicians that are culturally and age appropriate. For example, one site stated that their bilingual clinician served only Spanish-speaking clients. Another site had their clinicians work with either children or adult clients exclusively. Proper fit between clients and clinicians' skillsets increased the likelihood of clinicians being able to provide quality service and for clients to complete treatment.

Caseload. A case represents a client receiving services with a treatment plan. A clinician's caseload, or the number of cases they handled at one time, varied by site. Many clinicians cited that 10 cases was an ideal maximum caseload, but that their caseload commonly exceeded that amount. Depending on the complexity of families' needs, a clinician might have up to 15 clients on their caseload. Providers reported that less time intensive cases required three months of services, whereas more complex cases required more sessions and took longer to close. Some clinicians shared that they struggled with determining when to stop accepting new cases, especially when the number of incoming referrals was great.

Clinician Schedules. Some sites examined clinicians’ schedules rather than their caseloads when gauging their capacity to accept more families. For example, one site did not add more cases to their clinicians’ caseload once their schedule was filled. Another site set capacity for their clinicians at 17 weekly direct service hours.

Case Characteristics. Some cases required substantially more staff time and resources because of their complexity. Cases with children in foster care often required more staff time because clinicians typically needed to provide services to multiple caregivers. Thus, more session time had to be allocated toward family therapy or to address caregivers’ individual needs, impacting their capacity to serve additional families. Furthermore, capacity was also limited when clinicians needed to travel to clients’ homes for sessions because it was determined to be the best space for service provision. In addition, sites had limited capacity to serve families with limited English proficiency. Despite efforts to recruit and retain qualified bilingual clinicians or interpreters, few sites were successful due to less than competitive salaries and benefits. As a result, families with limited English proficiency are placed on a waiting list until a bilingual clinician is available or they are referred to another agency.

Treatment

Clinicians provide therapy to children under six years old who have been exposed to violence. They may also refer families to another program if families do not meet program eligibility criteria or their site has reached capacity. Different therapeutic treatment modalities, which include treatment models and approaches, are used by sites. At site visits, providers reported using 17 different treatment modalities. *Table 3* summarizes treatment modalities used by multiple sites or those rated using the California Evidence-Based Clearinghouse’s Scientific Rating Scale (CEBC, n.d.). The Scientific Rating Scale rates the strength of the research evidence supporting a practice or program using a scale of 1 to 5, with the following values:

- 1 = “Well-Supported by Research Evidence.”
- 2 = “Supported by Research Evidence.”
- 3 = “Promising Research Evidence.”
- 4 = “Evidence Fails to Demonstrate Effect.”
- 5 = “Concerning Practice.”
- NR = “Not Able to Be Rated” due to lack of available research evidence.

A value of 1 represents a practice with the strongest research evidence and 5 represents a concerning practice that appears to pose substantial risk to children and families. All sites used play therapy[2] or Theraplay treatments.[3] While most sites used various treatment modalities, one exclusively used CPP. Providers stated that they "…don't adhere to one modality because we [want to] make sure that we're flexible in meeting the needs of every specific child and family that come through [the program]."

Table 3

Therapeutic Treatment Modalities Used by Sites

Modality	No. of Sites	Scientific Rating
Play Therapy	5	-
Theraplay	4	3
ARC Attachment, Regulation and Competency (ARC) Framework	4	NR
Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)	3	1
Child-Parent Psychotherapy (CPP)	2	2
Eye Movement Desensitization and Reprocessing (EMDR)	2	1
Psychoeducational Therapy	2	-
Motivational Interviewing (MI)	1	1
Systematic Training for Effective Parenting (STEP)	1	3

Note. Only modalities used by multiple sites or rated by the CEBC are listed here. Eight modalities, which were each used by a single site and not evaluated by the CEBC, were omitted.

"-" indicates the modality was not included on the CEBC list.

Younger, less verbal children typically under four years old were more likely to participate in dyadic sessions with caregivers. While some sessions were conducted separately with the child and caregiver, providers emphasized that dyadic work was important for strengthening the child-caregiver relationship, restoring the children's sense of emotional safety, and building long-term family resiliency. Play therapy and creative activities (e.g., sand tray therapy) were frequently utilized with younger children to help them feel safe when exploring, express themselves naturally, and build emotional intelligence. Providers advocated for less verbal clients who were still developing the ability to express themselves, such as conferring with homeroom teachers or school social workers on their clients' behalf. Providers also focused on building children's confidence so they could advocate for themselves.

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[2] Play therapy is when a therapist uses toys and other play materials to encourage the child to explore and express their feelings, thoughts, experiences, and behaviors. Play is considered children's natural medium of communication (Landreth, 2012).

[3] Theraplay is when the therapist guides play between the caregiver and child using games and activities in a way that helps the caregiver regulate the child's behavior. Caregivers communicate love, joy, and safety to the child while fostering a sense of security, connectedness, and worthiness of being cared for (The Theraplay Institute, n.d.).

As part of treatment, caregivers received education. Two sites reported offering parenting classes and group workshops to caregivers (e.g., Circle of Security Parenting Program;[4] Systematic Training for Effective Parenting[5]). Additionally, providers taught caregivers about child development and developmentally appropriate behaviors. If trained in these areas, providers also taught caregivers about trauma's impact on child development and helped caregivers understand and process their own trauma experiences. They reported that as a result of these efforts caregivers were able to respond more appropriately to their children's needs and learned how to talk to their children when issues arose.

Site visit data revealed that all nine sites offered services to siblings under 18 years old who had also been exposed to violence. However, sites varied in their capacity to serve children older than five years. If a family member's needs could not be met by the SFS program, the program referred them to an intra-agency or an external agency program. Providers shared that they blended different treatment modalities, such as play therapy, talk therapy, and motivational interviewing, when working with older children because these children were more verbal and more focused on identity development relative to younger children. Providers were also more likely to conduct sessions individually with older children before bringing children and caregivers together for a dyadic session. Furthermore, older children were more willing to allow providers to direct sessions. Providers were more likely to use play therapy as a means to introduce topics for focused conversations, compared to with younger children where providers used play therapy to allow younger children to freely express their emotions. Providers disclosed that in sessions with older children, providers encouraged them to share their thoughts and emotions while teaching them emotional regulation strategies.

Providers assessed the caregiver's relationship with each child to determine the best therapy structure. They offered family therapy to non-offending caregivers and eligible siblings as a group if it was assessed that family members would benefit from this type of treatment approach. The provider might also decide to hold multiple dyadic sessions instead because of a family members' increased service needs or the age difference between siblings. Providers observed that families with more children in services had greater non-therapeutic needs. Additionally, as the age gap between siblings increased providers found it more difficult to address all siblings' developmental needs in one family session.

Four sites service disengagement upon a client's successful completion of treatment occurred over multiple sessions. During these final sessions, providers shared that they reviewed service goals and accomplishments with families, ensured families had appropriate referrals for continued support, and encouraged families to return for services, if needed. These sessions led up to a celebratory ceremony similar to a graduation. Providers also described efforts to reach

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[4] Circle of Security Parenting Program is a video-based program during which facilitators educate caregivers about how to promote secure attachment. Caregivers learn to read and understand their child's emotional needs, help their child manage emotions, promote their child's self-esteem, and acknowledge their child's need for security (Circle of Security International, 2022).

[5] Systematic Training for Effective Parenting consists of three separate programs that help caregivers relate to their child from birth to adolescence. Caregivers learn to understand their child's behaviors, encourage cooperative behaviors in their children, and change dysfunctional relationships by understanding alternatives to inappropriate disciplining methods (STEP, 2021).

families who disengaged from services before treatment was complete. All sites made multiple attempts by phone or in person to reach families who had missed sessions. Before closing their cases, providers allowed families several weeks to return providers' calls or permitted them to miss up to three consecutive sessions. These families were sent a letter of termination detailing when their cases would be formally closed, that they could return for services when needed, and information about additional resources. After cases were closed, eight sites stated that they did not re-contact families due to safety concerns unless requested by the caregiver to do so or if the family had court involvement.

Pandemic Impact on Direct Services. Prior to the pandemic, services were offered to families in person at site offices. Providers reported that in-person sessions were beneficial because they made it easier to maintain young children's attention and the offices felt comfortable and safe for families and providers. Additionally, one provider described opportunities for occasional therapeutic outings with families. This enabled families to create positive memories together and for providers to address children's behavioral or emotional concerns in a public setting. Providers also reported conducting therapy in families' homes, particularly when families encountered transportation or childcare barriers. However, offices were temporarily closed in March 2020 due to the pandemic's stay-at-home mandates. As a result, sites began offering services virtually through online video sessions.

Providers asserted that the length of time families are in services has increased compared to before the pandemic. Providers cited several reasons for this increase. Two providers shared that their sites had experienced delays in training new clinicians. Sessions were also frequently disrupted when families or providers had to quarantine for 14 days after exposure to COVID-19 or if experiencing COVID-19 symptoms. Providers believed families were more likely to cancel virtual sessions than in-person sessions. Additionally, one provider pointed out that sessions with younger children were challenging because social distancing and masks were required. As a result, facial expressions could not be observed. This is important for teaching children emotional identification and regulation.

A majority of sites have resumed in-person services or have adopted a hybrid model, serving families both in person and remotely. At least two sites continue to provide all services remotely. While sites reported an increase in the number of new families receiving SFS services, providers saw a decline in returning families. Providers shared that caregivers who had previously received services in person did not want to shift to virtual services. When sites re-opened for in-person services, providers stated that some families were uncomfortable with returning to the office as they did not want to risk potential COVID-19 exposure.

Evaluation Protocol. As a condition of their state funding, sites are required to utilize an evaluation protocol outlining steps for collecting assessment data from families who consent to research participation. The protocol specifies the forms and assessments to be used and when to administer them. The protocol includes the following forms and assessments:

1. Background Information Form (BIF): A form developed by the SFS Advisory Committee for gathering demographic and background information on participating children and their families.

2. Child Behavior Checklist (CBCL): A valid and reliable measure of children's behavioral and emotional problems for children a year and a half to 18 years old (Achenbach & Rescorla, 2000).
3. Parenting Stress Index (PSI): A valid and reliable measure of caregiver stress (Abidin, 1995).
4. Ages & Stages Questionnaire (ASQ): A questionnaire used to identify infants and young children at risk for developmental delays or disorders and for whom early intervention services may be needed (Squires et al., 1999).
5. Ages & Stages Questionnaire: Social-Emotional (ASQ:SE): A questionnaire used to identify infants and young children at risk for emotional and social disorders (Squires et al., 2003)
6. Caregiver Completion of Services Form (Caregiver CSF) and Child Completion of Services Forms (Child CSF): Forms developed by SFS sites and completed by providers after a child or caregiver completes treatment or leaves services before treatment is complete. The forms are used to describe the services provided to families and service-related outcomes.

Survey findings indicated that program supervisors or staff provided formal training on each assessment at eight sites. The remaining site did not provide assessment training. In addition to the assessments outlined in the evaluation protocol, seven sites used other assessments, such as the Adverse Childhood Experiences Questionnaire, the Life Stressor Checklist, the Traumatic Events Screening Inventory, and the Relationship Assessment Tool. Providers shared that these additional assessments allowed them to gain a more comprehensive understanding of family members' experiences with adversity, plan treatment approaches and goals, and gauge families' additional service needs during and after treatment.

The evaluation protocol recommends that providers administer assessments at three timepoints: at intake (Time 1), after five to eight sessions (Time 2), and upon treatment completion or when clients leave services prior to treatment completion (Time 3). Providers indicated that during intake session they gathered background information from families and caregivers completed required paperwork. Providers also informed caregivers about the opportunity to participate in the SFS evaluation study and obtained consent. Participation was voluntary and declining participation did not impact treatment service provision. We reviewed site visit data and found that sites administered Time 1 forms and assessments with caregivers in the first three sessions. At Time 1, the protocol directs providers to administer the BIF, CBCL, PSI, ASQ, and ASQ:SE.

The protocol also directs providers to re-administer the CBCL and PSI at Time 2. Findings revealed that most sites were unable to re-administer these assessments after the recommended five to eight sessions, such as due to clinicians' need to spend more sessions with clients to build rapport. Six sites administered Time 2 assessments after five to 12 sessions and the three other sites administered them after six months, or 18-24 sessions. Additionally, the protocol recommends that providers re-administer the CBCL and PSI at regular intervals if families remain in services for more than 12 sessions. Only two sites reported re-administering the recommended assessments for these families. They re-administered the CBCL and PSI every three or six months or after families received nine or 18 additional treatment sessions.

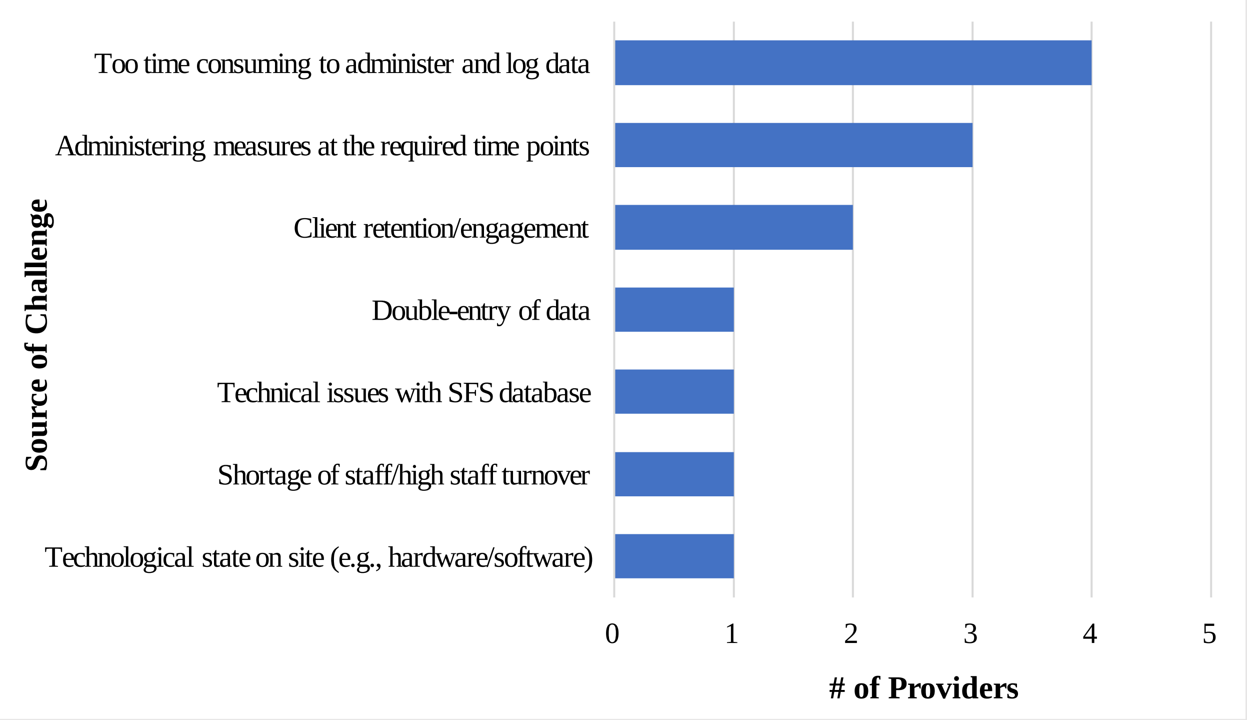
At Time 3, the protocol recommends that providers re-administer the CBCL and PSI and complete both the Caregiver CSF and Child CSF for each client receiving services. When families left services unexpectedly, providers were unable to re-administer the CBCL and PSI, but they completed the clients' CSFs to the best of their abilities.

Data Collection Process. Providers enter assessment data into the web-based SFS database. Survey findings indicated that 15 of 22 respondents (68%) gathered SFS assessment data or entered it into the database. When asked what percentage of their funded SFS time they used for entering client data, 15 providers reported spending a range of 10% to 66% of their time on data entry, with an average of 23%. Four sites reported not having access to training on the SFS database. Two of these sites relied on a program assistant or administrative staff trained in database entry to enter assessment data, rather than clinical providers. Five sites reported staff received informal training on the SFS database from other agency providers or leadership. Despite a lack of access to database training, eight sites reported experiencing little to no issues with the database during site visits. One site had recently lost a staff member responsible for data entry impacting their ability to enter data.

Protocol Disadvantages and Advantages. Survey findings point to ways in which the current evaluation protocol can be improved. We asked participants to rank a list of eight programmatic challenges. Participants indicated that their top challenge was the amount of time spent administering and entering data (*Figure 2*).

Figure 2

Highest Ranked Program and Protocol Challenges



Note. Sample was 13 providers. Nine providers did not respond to this survey question.

Double entry occurs when providers transfer assessment data from paper forms to a database or when they enter data into more than one database (e.g., SFS database and agency's internal database).

Providers were concerned that caregivers underreported needs when assessments were re-administered at Time 2 because more time was needed for them to establish enough rapport with families to the point where families felt safe to disclose problems and needs without fear of third-party involvement (e.g., child protective services). As a result, they suggested increasing the number of sessions between Time 1 and Time 2. Another cited challenge was that it was time consuming to administer assessments and enter data. The time required to administer assessments extended the length of time in services for some families. Providers stated that the numerous assessments could deter families from services, particularly if they had not received mental health services previously or did not understand how assessments related to treatment.

Findings revealed the evaluation protocol had several benefits. Providers reported using the assessments as opportunities to build rapport with families, such as by teaching psychoeducation to caregivers and discussing family goals based on assessment findings. Also, providers stated that assessment findings helped them identify families' strengths and areas of improvement, which can inform treatment goals and the action steps needed for achieving those goals.

Needs and Barriers

We identified a number of needs and barriers to direct service provision, including capacity issues, training gaps, a lack of caregiver engagement, and challenges associated remotely providing services.

Capacity. Site capacity limitations made it increasingly challenging to provide direct services to eligible families. According to providers, the number of referrals sites received increased in recent years. However, resources, such as funding and personnel, have not increased comparably, resulting in more families being placed on waiting lists. Providers reported that families waited one to three months for their first appointment. They offered to refer families on waiting lists to other agencies for services until they had an opening, but those programs frequently had their own waiting lists.

Turnover has also negatively impacted site capacity; five sites identified it as a challenge. Providers expressed that staff members only remained in their positions for two to three years. They also stated that new hires needed to be oriented to the program and complete training before they could begin providing treatment. To retain staff, supervisors employed various strategies, including offering sign-on bonuses and using other funding sources to increase staff salaries. However, providers said sites' attempts to retain staff with increased pay had been unsuccessful because the salary and benefits offered were still not competitive compared to other agencies. Supervisors also noted that providers often left after obtaining clinical licensures or because childcare was unaffordable.

Training. Also, providers reported needing training materials or updated guides and protocols that instructed them on how to implement the evaluation protocol, enter data into the

SFS database, and interpret assessment results. In addition, it could take several months for new staff to complete training on assessments and until these trainings were completed providers could not start treatment plans with families. Providers from sites that utilized CPP, and other evidence-based treatment modalities, reported seeing an increased number of referrals from the courts. Across sites providers wanted access to evidence-based trainings. However, training on evidence-based treatments can be costly and certification can take a year or more. Therefore, sites used different strategies to continue to provide evidence-based treatment options. They invested time in training new staff, hired clinical providers trained in evidence-based modalities, or secured additional, non-SFS funds to pay for training costs.

Caregiver Engagement. Providers noted that one barrier to service engagement was caregivers' reluctance to participate in services or to have their children continue with services. Some caregivers had unreasonable expectations for how services could benefit their families, such as assuming services would eliminate their children's symptoms. One provider commented, "Sometimes, if the relief doesn't feel fast enough, sometimes [caregivers] can disconnect because they're looking for the potential for something that might come a little faster, and the work is a little more in-depth and reflective [than they expected]." Also, providers noted that it was challenging to keep families with complex trauma or stress engaged in services. Sometimes caregivers were hesitant to talk about the traumatic events that necessitated services or were not ready to do the clinical work required to heal from trauma. As a result, providers reported that caregivers would abruptly discontinue services when sensitive topics were discussed.

Remote Services. Providing services virtually created additional challenges. For instance, when staff provided services remotely, clients commonly logged on to sessions from their homes. However, it was difficult for children and caregivers to talk privately during individual sessions. Other household members could overhear these conversations, making such spaces feel less safe than site offices. It is particularly concerning for providers when caregivers and children in services are still living with their perpetrators who could overhear sessions or when domestic violence cases are still active. Additionally, providers noticed that children under four years old needed more stimulation and in-person interaction than older children to maintain attention. To help address this challenge, one site delivered therapeutic toys to families that children could then use during therapy. Other sites have been trying to leverage partnerships to create "co-locations," or collaborative spaces where providers from different agencies can meet with clients outside the office for in-person sessions. When engagement, accessibility, or safety was a concern, places like the Department of Human Services offices, outdoor parks, libraries, and schools were used for in person sessions. Providers stated that technology has been "both a blessing and a curse." For instance, virtual sessions allowed providers to reach families they would otherwise be unable to serve because of the distance between the family and sites' offices. On the other hand, virtual sessions made it difficult for clinicians to keep young children engaged for very long behind a screen.

Strengths

Sites demonstrated various strengths in providing direct services to families. First, providers strived to accommodate families' busy schedules. Providers shared that parents' work obligations have impeded their ability to participate in services or take their children to services.

To address this challenge, one site reserved two to three days per week to meet with families outside regular work hours. Another site adopted a hybrid approach. Staff were on site twice a week for in-person services, or as needed, and offered services remotely the rest of the week.

Secondly, providers used trauma-informed practices. For instance, providers took measures to ensure that families felt safe. One strategy used by clinicians was to ask a child for permission to sit next to them or if the child was more comfortable with the office door open. During sessions providers took care to acknowledge the caregiver's own past trauma history and ongoing trauma while considering the families' needs and safety concerns. Providers stated that supporting caregivers in making sense of their trauma experiences has helped them heal.

Additionally, providers noted a persistent need for psychoeducation among caregivers. Caregivers often did not understand how trauma impacted their child's brain and development. Caregivers described problematic behaviors as the "child being bad," resulting in caregivers reacting negatively (e.g., greater discipline). Providers addressed this challenge by incorporating more psychoeducation in their sessions with caregivers. Specifically, providers reinforced the importance of early childhood mental health with caregivers and helped caregivers understand that children's behaviors stemmed from underlying needs. By helping caregivers better understand what their children were experiencing, providers stated that it helped restore trust and safety between the child and caregiver.

Furthermore, providers reported having internal supports to help alleviate work-related stress. In addition to weekly supervision, sites made efforts to support staff self-care. One provider shared that their site had procured external therapists for staff to talk to, organized a vicarious trauma group, and hosted monthly relaxation events (e.g., yoga, massages). This provider believed that making staff "connections on a pretty regular basis to support one another…can help mitigate some of those burnout feelings." Another provider noted that work flexibility had helped create a more hospitable work environment. In particular, while one site offered in-person services Monday through Thursday, staff were permitted to work remotely on Fridays. Staff used Fridays to complete case notes and to connect with families virtually.

Public Awareness

The final pillar is public awareness, including education about CEV in providers' communities and outreach to underserved populations. Providers engaged in public awareness activities to promote and disseminate information about SFS services with community members and organizations serving similar age groups. SFS program and CEV awareness was shared through presentations to local agencies and while attending community events. Professionals from community organizations, law enforcement, schools, colleges, domestic violence shelters, and state conferences reached out to providers to request presentations, workshops, or training. Oftentimes, these agencies were SFS coalition partners. Topics frequently requested were about trauma, child abuse and recognition, Adverse Childhood Experiences, healthy parent-child relationships and attachment, child development, infant mental health, and the impact of DV on young children. Providers also shared information on these topics at community events multiple times throughout the year. The most common types of community events attended were resource and school fairs. One provider stated that their staff typically attended four to six resource fairs annually. Other popular community events included food drives, intra-agency events, and specific activities held during DV, teen dating violence, and/or child abuse awareness months. Providers distributed flyers about SFS services and informational pamphlets on CEV to community partners and prospective families, especially those who were underserved.

Underserved Populations

Most providers defined underserved populations as those who historically have been marginalized due to their ethnic or racial background, citizenship status, and sexual orientation. Providers listed the following groups as underserved: victims of color, individuals without documents, Spanish-speaking only families, and LGBTQ+ individuals. Also underserved were individuals who faced additional service barriers due to resource limitations. These underserved populations included families living at or below the poverty line or residing in neighborhoods with limited access to grocery stores and community resources. Providers reported exchanging referrals with community partners that work with underserved groups to reach underserved victims. Some providers hired bilingual staff and supplied outreach materials in multiple languages to mitigate language barriers and increase access to services. Additionally, to increase accessibility and address underserved victims' broad needs, some providers offered one-time mental health services and longer-term therapeutic support using a co-located service delivery model in which services were provided at a partner agency's office.

However, multiple providers did not have the capacity or resources to use these public awareness approaches to reach underserved populations. They described how limited staff capacity and long waiting lists were barriers to engaging in outreach activities that targeted underserved groups. While some providers had hired bilingual clinicians, others reported not having the financial resources to do so and could not pay for interpretation services. Oftentimes, sites who cannot meet clients' specialized needs refer clients to other agencies.

Pandemic Impact on Community Outreach

The pandemic impacted the types of strategies sites used to conduct community outreach activities. Before March 2020, providers regularly offered in-person presentations to community partners and participated in various coalitions and resource fairs. These activities provided opportunities to connect face-to-face with community members and share information about the SFS program. However, after the pandemic began, community organizations requested fewer presentations and outreach activities became virtual. Additionally, presentation topics shifted from CEV to pandemic-related collective trauma, grief in communities of color, accessible housing, safety planning, and changes to COVID-19 mandates. Efforts to reach underserved victims were exacerbated by significant staff turnover and a shift toward conducting outreach activities virtually.

Providers described being focused on rebuilding connections that were lost early during the pandemic and attending community events more consistently to spread awareness about the program. Some providers reconnected with previous partners and shared information about the SFS program using online flyers, brochures, and training materials. Community organizations and other partners posted SFS online flyers on their agency websites and included SFS program information in their public awareness presentations. Providers also hosted virtual information-sharing sessions. For example, one site hosted weekly, online 90-minute listening sessions on the SFS program and other available agency resources for community members. Other sites hosted monthly or quarterly virtual information sharing events to inform community members about the SFS program and provide CEV education.

Needs and Barriers

We found that the main barriers to public awareness and community outreach were related to staff capacity, low engagement or buy-in, and client accessibility to online platforms. At most sites, clinicians were responsible for both public awareness efforts and direct service delivery. Therefore, time spent preparing for and participating in community events reduced the amount of time clinicians were available to provide direct services. Some providers described how difficult it was to extend accommodating presentation requests to providing services to more families. One provider stated that the "presentations are wonderful. We're getting the community educated. What they also do is bring in referrals for our program. [However], without adequate staff…we're promoting our program but then [are] not following up with being able to provide the service." Providers from another site canceled evening appointments with families to complete presentation-related tasks, such as updating materials with newer information, creating materials in languages other than English, and making them virtually available. Also, prior to the pandemic, providers arranged childcare for community members attending presentations or workshops. This further decreased their abilities to provide clinical service hours. COVID-19-related restrictions on in-person gatherings limited provider access to schools and community organizations, negatively impacting relationships and referral connections. Some providers expressed challenges in obtaining buy-in from community members. Providers had difficulty communicating the importance of providing services to young children exposed to violence, especially those under five years old. Many clients did not have access to virtual platforms and could not attend online SFS workshops or events, resulting in low attendance.

Strengths

While the pandemic exacerbated existing barriers to meeting public awareness goals, sites' use of virtual platforms created new opportunities to increase SFS program awareness and educate communities on CEV. For example, online awareness efforts alleviated childcare barriers for families and helped SFS staff better manage their time, as they no longer needed to commute to presentations, resource fairs, or other events. Other providers highlighted that a benefit of hosting or attending virtual or in-person public awareness events consistently was that it enabled sites to build strong relationships with other organizations serving similar populations. Providers invited community leaders to present at information sharing events to increase community member and prospective family attendance. Finally, all providers agreed that engaging with people in a workshop or event, either online or in-person, was more beneficial than sending pamphlets or materials on the SFS program or the impact of violence.

Providers' Goals for Program Development

Providers recommended various SFS program goals for each pillar of work (*Table 4*).

Table 4
Providers' Goals for the Program

Pillar of Work	Providers' Goals
Coalition Building	Expand service partnerships by learning new networking strategies
	Establish better connections with community-based organizations, especially where families frequent
	Reconnect with referral agencies, particularly schools and early learning centers, to ensure they know sites are accepting referrals
	Collaborate with partners sharing a similar mission to streamline service offerings and share resources
	Build partnerships with other service providers and related agencies to help reach families in rural communities
	Create or attend an event for all SFS providers to discuss complex trauma
	Conduct outreach with past and prospective partners to inform them sites are active. This could include visiting agencies or sending materials to promote awareness
Direct Services	Increase capacity to serve more families through increased SFS state grant funds
	Attend trainings on evidence-based treatment modalities and on SFS program procedures and policies
	Learn alternative strategies for managing waiting lists (e.g., by need rather than by order of arrival)
	Alleviate assessment and data entry burden by reducing entry of families' data into multiple databases, making assessments available online, and shortening the intake form to include information essential for treatment planning only
	Educate caregivers using psychoeducation, child development, or similar curriculum
Public Awareness	Increase referral agencies' knowledge of SFS services to minimize the potential that referral agencies will provide prospective families with inaccurate information about the services sites offer
	Ensure underserved populations are aware of SFS services and know how to access services
	Spend time in the community so faces can be matched to the organizations they represent
	Proactively engage with communities rather than relying on the public to contact sites with requests for presentations

Discussion

This process evaluation documented SFS sites' program structure, treatment approaches, and successes and challenges in program implementation across the SFS program model's three pillars of work. Sites developed their coalitions by networking and sharing resources (e.g., referrals, information) with community-based agencies and other local and state organizations serving families exposed to violence. Coalition partners were essential referral sources for families in need of SFS services. Providers utilized evidence-based treatment modalities, trauma-informed practices, and an evaluation protocol to collect client assessment data for research and treatment purposes. Additionally, sites promoted community awareness by attending community events (e.g., resource and school fairs), disseminating flyers and pamphlets at these events, and fulfilling community group and member requests for presentations. While providers noted many strengths, they encountered challenges particularly related to capacity and technology. We identified areas for programmatic improvement and offer recommendations.

Recommendations

In developing recommendations, we considered the following: providers' goals for the program, barriers to each pillar of work, and the resources needed to overcome challenges. Recommendations highlight ways in which sites and stakeholders can refine their approaches to help increase program effectiveness and efficiency.

Advocate for More Program Funding to Increase Capacity

Limited funding and resulting staff shortages created capacity challenges that affected providers' work across both the coalition building and direct service pillars. Providers reported staff left the program due to a lack of competitive salaries, benefits, and affordable childcare. This finding is consistent with recent research. A 2021 survey involving over 1,000 nonprofit organization from across the United States found that 79% of nonprofits cited salary competition and 23% reported the inability to find childcare as major factors that affected recruitment and retention (National Council of Nonprofits, 2021). Additionally, a survey of home- and community-based service employees found that workers who reported a lack of health insurance were more likely to report intent to leave that workforce (Stone et al., 2016).

Results also revealed that sites received an increased number of family referrals, but no additional financial resources. To better meet client need despite limited capacity and funding, providers prioritized direct services and data entry over coalition building activities. Furthermore, high staff turnover, resulted in more time and resources being used to recruit and train new staff, further limiting direct service capacity. With additional funding sites would be able to offer more competitive salaries and benefits, helping to recruit new hires and retain current staff. Increased funding could also be used to hire a case manager or resource coordinator dedicated to helping families acquire needed resources. This would enable clinicians to focus on providing treatment to families. Such efforts are needed to alleviate staff shortages and meet the growing demand for SFS services. Thus, program stakeholders should advocate for additional funding for the SFS program.

Advance Staff Knowledge and Skills through Training

Findings point to an increased need for training to build staff knowledge and skills, including on EBPs and treatments. Providers stated training opportunities were important for their professional development. Furthermore, research suggests that career development offerings can improve workplace retention among health professionals (Cosgrave, 2020). For managers and administrators in the child welfare field, trainings should be centered on leadership and management, policy making, workforce development, and program implementation (Child Welfare Capacity Building Collaborative, n.d.). Trainings for direct service providers should focus on evidence-informed practices, program implementation, and cultural competence and humility. Training helps providers learn to effectively perform their job duties, develop competencies to grow into new positions, and adapt to changing conditions (Child Welfare Capacity Building Collaborative, n.d.).

In addition, providers would benefit from additional training on EBPs and treatments (e.g., CPP, ARC, Theraplay) and SFS programmatic processes (e.g., evaluation protocol, assessments). According to Peña & Behrens (2019) funders are more likely to invest in grantees using EBPs shown to be effective with the program’s target population because effective interventions often reduce taxpayer expenditures. Furthermore, trainings on SFS programmatic processes would help standardize practices among staff, which is particularly important for newer staff. Program protocol fidelity reduces the likelihood of providers, researchers, and stakeholders from drawing inaccurate conclusions about the program’s effectiveness (Breitenstein et al., 2010).

Focus on Expanding and Sustaining Coalition Partnerships

Most providers faced similar coalition challenges, including weakened agency connections, low or inconsistent meeting attendance from members, and few new partnerships. Furthermore, the loss of longstanding staff inhibited sites’ ability to expand and maintain partnerships because other staff lacked the necessary information and relationships. Findings suggest that providers need better guidance and tools for networking with other community-based service agencies and potential partners (e.g., early learning centers) similarly invested in preventing CEV. According to the U.S. Department of Health & Human Services (n.d.), developing and strengthening partnerships helps build a more comprehensive and coordinated system for providing direct service and enables providers to better meet the needs of children and their families. Additionally, collaboration among organizations working with families exposed to violence can maximize resources, reduce siloing of services, and minimize duplicated efforts (Goldman & Schmalz, 2008; Butterfoss & Francisco, 2004). Therefore, researchers recommend that providers focus on expanding and sustaining their coalition partnerships through various networking and team building strategies.

Providers should review the partners they have in their coalition and assess if they represent diverse agency types (e.g., local, state, community-based, etc.), communities served, and services offered. Such a review could help providers determine gaps and strengths in their partnership composition. Some providers reported consistently maintaining lists of former, current, and new partnerships to address low meeting attendance and ensure diversity of perspectives in coalition activities. Other providers should follow a similar networking strategy to document changes in partnerships over time and explore potential trends in their coalition membership.

The U.S. Department of Health & Human Services (n.d.) suggested leaders should plan annual retreats, interagency forums, and evaluation discussions to encourage ongoing participation and team building. Coalitions in the study that provided more professional development training and annual events observed an increase in member engagement and collaboration. Team building activities also provide opportunities to recognize and celebrate coalition achievements, which can boost the stakeholder morale (Goldman & Schmalz, 2008). Providers can end coalition meetings with a client success story or a public awareness achievement to highlight positive outcomes and reinforce the importance of the coalition (U.S. Department of Health & Human Services, n.d.).

Explore Data Collection Methods to Further Assess Coalition Activities and Outcomes

The COVID-19 pandemic exacerbated coalition building gaps and depleted resources needed for interagency collaboration. Many SFS coalitions had to re-evaluate how to engage in coalition building activities virtually after school partners and other community organizations closed. One provider's coalition structure changed completely from being an interagency coalition to an SFS program coalition, losing multiple members in the process. Additionally, significant staff turnover limited providers' capacity to gain buy-in from new partnerships. Due to both the pandemic's negative impact on coalition member engagement and providers' limited resources, we recommend they assess how to reallocate resources and time to more effectively employ coalition building strategies.

Ongoing data collection activities can help providers identify gaps so that their limited time and resources can be used more efficiently and effectively. For example, collecting outcome data enables agencies to demonstrate to partners that they are making progress towards programmatic goals and to obtain buy-in from new organizations (U.S. Department of Health and Human Services, n.d.). Tracking and sharing progress toward short and long-term coalition objectives can help build trust among partners by enabling them to celebrate quick wins and to be transparent with partners about areas that need additional attention or resources (Goldman & Schmalz, 2008). Butterfoss and Francisco (2004) agreed that evaluating a coalition plays a key role in sustaining community partnerships and recommended three levels of data collection. The first data collection level involves recording the types of activities engaged in, member attendance, and whether the coalition itself is operating as intended (Butterfoss & Francisco, 2004). Sites' grant agreements required them to collect these data. Level two includes assessing whether coalition objectives are being partially or fully met and level three is focused on data collection efforts that inform policies and programmatic decision making (Butterfoss & Francisco, 2004). We recommend that sites explore strategies for collecting level two or three data to better understand their progress towards achieving coalition outcomes.

One tool that can be useful for facilitating conversation about short and long-term outcomes is a logic model (Butterfoss & Francisco, 2004; U.S. Department of Health & Human Services, n.d.). A logic model outlines the resources needed to carry out activities believed to result in desired outcomes. Sites can reserve time during coalition meetings to identify and clarify different benchmarks for the fiscal year and illustrate how the activities connect to anticipated outcomes. Another useful tool for assessing if the coalition is informing policies and contributing to community change is the Coalition Effectiveness Inventory. The assessment is a free, validated, and readily available checklist that evaluates the strengths and needs of one's coalition. SFS coalition leadership can complete this assessment to aid discussion with key partners about their coalition's overall effectiveness.

Enhance Engagement of Caregivers and Children in Services

Providers noted some caregivers were reluctant to participate or allow their children to participate in services. Some sites successfully used strategies to keep families engaged in services longer. Strategies for engagement include offering psychoeducation, parenting classes, and adult support groups to caregivers. Other sites should consider utilizing these strategies to increase caregiver engagement. Findings suggested that unrealistic expectations of service outcomes may have contributed to caregivers' disengagement from services. Thus, referral partners should educate families about available SFS services and expected outcomes. This information also should be communicated at intake to help manage families' expectations.

Virtual service options made it possible for more families living long distances from site locations to receive services. However, providers reported that young children had difficulty staying engaged during these virtual sessions. Some sites provided families with therapy toolkits that allowed for interactive play and helped maintain children's attention for longer periods of time during virtual sessions. This is a strategy that can be used by other sites to increase child engagement when services are provided remotely. While providers reported benefits to offering in-person services, some sites remained closed after stay-at-home COVID-19 mandates were lifted. Therefore, to provide in-person services, providers may need to collaborate with families to find or create confidential, safe spaces for children outside of traditional service areas. This could include sitting in cars or outside spaces for in-person sessions (National Institute for Children's Health Quality, n.d.).

Enhance Cross-Site Collaboration and Coordination of Public Awareness Efforts

Most sites had difficulty providing both therapeutic services and engaging in public awareness activities. Preparing materials for outreach activities and participating in community events reduced time for direct service provision. Additionally, providers emphasized that obtaining community buy-in through virtual outreach activities had been challenging. Research findings suggest that providers need to enhance cross-site collaboration and improve coordination of public awareness efforts. This can alleviate staff workload and increase community members' awareness of the SFS program and the impacts of CEV. Tsao and Davis (2017) emphasized that efforts to address violence require consistent collaboration and coordination across stakeholders. Cross-sector or cross-site coordination can foster more unified public awareness (Tsao & Davis, 2017). Each SFS site offers unique service delivery perspectives with staff who are familiar with different communities, systems, and organizations. Also, encouraging sites to collaboratively address community outreach needs and challenges can decrease duplicate efforts and allow for resource reallocation (Tsao & Davis, 2017).

We recommend that SFS providers standardize their annual presentation and training offerings to better coordinate public education. Sites prepare presentations and trainings on similar topics, such as the impact of CEV, trauma, healthy child and parent relationships, and child development, for community events and partners, resulting in duplicate efforts. Therefore, sites should share commonly requested presentation materials. Limiting the number of new or live training sessions conducted annually can further minimize the burden associated with creating new presentation and training materials. Providers should also consider sharing site materials with collaborative online tools, such as Microsoft's OneDrive and Basecamp. Providers should use their bimonthly SFS all-sites conference calls to discuss potential opportunities for public awareness collaborations and to share their challenges or successes with community outreach. In addition, these meetings can be used to coordinate presentation and training material development. By increasing cross-site collaboration and better coordinating public awareness efforts, providers can effectively communicate the impacts of CEV and reduce the stigmatization of using social services (Fortson, et al., 2016).

Increase Knowledge and Accessibility of Services for Underserved Populations

Findings indicated that providers had difficulty reaching underserved populations because of limited resources. Specifically, most providers did not have the financial resources to hire bilingual staff or to offer outreach materials in multiple languages. However, providers identified increasing awareness of the SFS program to underserved groups as an important programmatic goal. Sites partnered with agencies to ensure underserved clients' needs were met. Therefore, we recommend that providers promote the SFS program to underserved populations to better facilitate their access to services.

According to O'Connor et al. (2020), Black, Indigenous, and people of color were more likely to be exposed to several neighborhood risk factors that can negatively impact a child's development, including exposure to high rates of violence, unsafe housing, limited access to grocery stores, and lack of economic opportunities for caregivers. Underserved groups also face barriers, such as lack of transportation and services that feel welcoming, and limited service options for those living in rural areas and for people with disabilities (Smith & Hope, 2020). Additionally, when services are not sensitive to families' identities and cultures, they are less likely to participate (Sered & Butler, 2016).

Providers should build supportive relationships with community organizations that can increase access to social supports and mitigate risk factors and barriers to services (McGee et al., 2021). Providers should focus on collaborating with other local agencies to disseminate information on service options and to provide co-located services in the community to better meet underserved populations' needs (Daro & Dodge, 2009). If providers cannot hire bilingual staff, they should build strong connections with partners that offer interpretation and translation services (McGee et al., 2021). Outreach materials should use language that promotes resiliency and helps families understand service benefits (Sweetland, 2021). Providers should assess public awareness and outreach materials to ensure that they focus on the benefits of healing and describe the interventions, rather than the impacts of violence and trauma (McGee et al., 2021; Sweetland, 2021).

Future Directions for Research

The current process evaluation points to avenues for future research. First, researchers should consider evaluating individual sites. In the present, we aggregated data across sites. However, each site is uniquely structured and serves demographically distinct families. A closer examination of select sites would help identify their unique challenges and resource needs. Furthermore, researchers could explore the relationship between sites' characteristics, such as organizational size, treatment modalities used, quality of supervision, availability of trainings, and capacity, and positive child and family outcomes.

More research is also needed on the strategies implemented to retain SFS program staff and their effectiveness. The National Council of Nonprofits (2021) suggested that efforts to make the workplace more equitable may improve employee retention. Additionally, personal care aids who completed a competency-based training[6] were more likely to stay in their roles (Luz & Hanson, 2015). Thus, researchers should examine the sites' strategies for retention and outcome.

One additional suggestion for future research is to conduct an outcome evaluation that incorporates clients' perspectives. While process evaluations provide invaluable information on a program's operations, outcome evaluations are needed to better understand program impact (Moore et al., 2015a). For the SFS program, this includes the impact that service receipt has on children and their families. The current study limited participation to providers and focused on program operation, needs, and barriers. Future research should assess program impacts on clients and provide opportunities for client study participation.

Conclusion

The SFS program is a community-based program established to help families, particularly young children under six years old, who have been exposed to violence. For more than two decades, SFS providers have worked to expand their network of partnerships, provided direct services to families, and increased community awareness of CEV and related topics. To paint a clear picture of program processes and outputs, process evaluations should be conducted at regular intervals. Evaluation findings could inform recommendations to improve program operations and, thus, the clients being served.

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[6] Competency-based trainings are designed to teach the baseline skills required to perform specialized tasks.

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