Documenting Domestic Violence Services, Client Needs, and Client Outcomes

The Final Report of the Colorado Tool Development Project

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Contents

About CPR

This report was prepared by the Center for Policy Research (CPR) for the Colorado Domestic Violence Program (DVP). CPR is a nonprofit research and evaluation center in Denver, Colorado. This report was prepared by:

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Acknowledgements

This report was prepared for the Colorado Department of Human Services' Domestic Violence Program.

The Center for Policy Research would like to express gratitude to the people and programs who made this evaluation possible. Thank you to the community-based domestic violence advocacy organizations (that are unnamed to protect client confidentiality) that participated in this pilot. The Center for Policy Research is grateful for all the advocacy organizations' help in testing these new tools and making the pilot a success. This independent evaluation was supported by the Colorado Domestic Violence Program (DVP) of the Colorado Department of Human Services (CDHS). Positions expressed in this report do not necessarily reflect the official position of DVP, CDHS, or the Colorado State Government.

Recommended Citation

Rivera, E. & Prendergast, T. (2018) *Documenting Domestic Violence Services, Client Needs, and Client Outcomes: The Final Report of the Colorado Tool Development Project.* Center for Policy Research: Denver, CO.

Executive Summary

The study described in this report is Phase II of an ongoing effort to document community-based domestic violence (DV) advocacy services and measure outcomes. In October 2016, the Domestic Violence Program (DVP) convened a group of stakeholders to create and/or identify (1) an assessment tool to help DV advocates identify clients' needs at intake and (2) a client outcome measure that was appropriate for use in a DV advocacy organization and for reporting to a state funding agency.

Only one outcome measure met the criteria set by DVP and Center for Policy Research (CPR): MOVERS (Measure of Victim Empowerment Related to Safety). Additionally, the stakeholder group developed two process tools: (1) a needs assessment, and (2) a case closure tool. CPR conducted a pilot study in three DV organizations to test these tools. With client consent, pilot sites shared client-level demographics and data from these tools for 101 clients with CPR. In addition, clients completed an anonymous survey about their experience with completing MOVERS. Finally, CPR conducted post-pilot focus groups with advocates at each site. The goals of the pilot were to: (1) identify the reliability of MOVERS in Colorado organizations, (2) determine whether MOVERS was significantly related to DV services in Colorado, (3) identify areas of improvement for the needs assessment and case closure tool, and (4) provide suggestions for DVP's potential statewide implementation.

Lessons learned about MOVERS: MOVERS shows promise for evaluation use and DVP's potential effort to collect statewide outcomes data. MOVERS scores changed over time and were related to services provided. MOVERS consists of the three subscales: Internal Tools, Expectations of Support, and Trade Offs to Seeking Safety. In all, 47% of clients increased in internal tools, 37% increased in expectations of support, and 45% increased in tradeoffs. An improvement in Internal Tools was related to crisis intervention, safety planning, advocacy, counseling, mobile advocacy, and immigration assistance. An improvement in Expectations of Support was related to crisis intervention, safety planning, advocacy, and mobile advocacy. Finally, improvements in Trade Offs was related to mobile advocacy. Surprisingly, receiving assistance with navigating county human services was related to a decrease in internal tools over time. On the anonymous surveys, most (92%) clients reported that they could be honest with their advocates. Most (70%) also reported that MOVERS was not confusing, however there is room for improvement in this domain. We recommend that MOVERS be re-organized so that it is easier for clients to complete. Finally, MOVERS shows promise as an outcome measure for DV programs because most clients agreed to complete the first MOVERS and advocates were able to obtain a high percentage of follow-up surveys. Of the 101 clients at intake, only two did not complete the

survey at all. One client was in crisis and not offered the opportunity to complete the survey, and the other client declined. Of the 99 who completed MOVERS at intake, only eight clients skipped one or more question, meaning that 96% of clients completed the entire MOVERS survey at intake. A high number of follow-up MOVERS were obtained. In all, 70 clients completed a second MOVERS and, of those clients, 90% (n=63) answered every question. Two clients completed a third MOVERS, and both clients answered every question. In only one case were clients in crisis and not offered to complete their second MOVERS. The other 19 clients were no longer in services and could not be reached. Based on this pilot it appears that MOVERS scores can provide a general snapshot of the well-being of DV survivors in Colorado.

Lessons learned about the needs assessment: The needs assessment may be a useful tool to train new advocates, and as a reference tool to help advocates confirm they have discussed all domains with clients. However, many advocates were already satisfied with their comprehensive intake process and several felt that, over time, the needs assessment became duplicative. Furthermore, client-level needs assessment data at both intake and case closure may be inefficient. The case closure data can be used to calculate both client needs and whether needs were met. As such, we do not recommend that DVP extend resources to collecting and analyzing both needs assessment and case closure data.

Lessons learned about the case closure tool: Overall, the case closure tool shows promise as a useful tool for DV programs and DVP. The case closure tool provides DVP with a way to look at needs met only for those who worked on that specific domain with their advocate. This prevents the biased reporting of data and a situation where DV advocacy organizations *appear* significantly less able to meet client needs when it's actually a result of failing to adjust for what was actually worked on. Some challenges and areas for improvement were identified in the pilot. For example, Of the 20 domains, advocates worked on 0 to 12 domains with the clients in this sample, with an average of 4.5 (median = 4 domains). It is unlikely that no services were provided to clients, and indicates that some services may not be reflected in the case closure form. The main challenge advocates encountered, however, was deciding when to count a service as "meeting a need." In the pilot, advocates underreported whether or not client needs were met. For example, advocates worked on safety planning for 57 clients, yet only five were considered to have this need met. It is extremely unlikely that advocates did not provide any safety planning for 52 clients, as safety planning is a core advocacy service. Another challenge was that questions about reasons needs were not met were left mostly (or entirely) blank. These challenges can be likely be addressed through revisions to the tool, improved training and fidelity monitoring, though additional testing is needed to confirm this.

Needs Assessment Recommendations

Here are some potential uses for the Needs Assessment Tool:

Advocates
Keep handy as a checklist or reference to ensure you asked everything you wanted.

DV Organizations
Use as a training tool when showing advocates how to gain a holistic understanding of clients' situations.

DVP
Work with each individual DV program to co-create an intake process that (1) asks for the same set of questions to help advocates accurately complete the case closure tool and (2) eliminates redundancy.

Case Closure Recommendations

This tool shows promise, but needs some revisions to address challenges identified in the pilot.

To simplify the tool:
1. Remove the "was this worked on" column.

2. Remove the "in progress" option under needs met.

3. Add "not applicable" as an option (so we can exclude clients who didn't work on that domain from data analysis).

To improve data accuracy:
1. Revise the "need met" language to something like "service provided."

MOVERS Recommendations

MOVERS shows promise for the evaluation of DV services. It is quick to complete, reliable, and shows a reasonable amount of change over time. MOVERS scores at least somewhat related to services, and provide some support for the idea that advocacy can have a positive impact on survivors' well-being, even if concrete needs are not met.

To simplify the tool:
1. Rearrange by subsection.
2. Create customized implementation plans with each DV advocacy organization.

To improve data accuracy:
1. Collect data on how many contacts occurred before the first MOVERS.
2. Collect data on how the answers were provided.
3. Reanalyze with a larger sample to determine whether these factors influence the scores.
4. Standardize and implement a way for programs to use their own data for evaluation and grant proposals.

Recommendations for DVP's Next Steps

1. Revise the case closure tool.
2. Identify 1-2 new advocacy organizations to test these revisions and using the CAFÉ for data entry.
3. Create implementation plans with each DV advocacy organization and assess whether this improves the percentage of clients included in the data and addresses challenges identified in this pilot.
4. Decide on whether to use the case closure tool, MOVERS, or both.

1.0 Introduction and Background

1.1 Evaluation Project Background

This report describes Phase II of an ongoing effort to document domestic violence (DV) advocacy services and measure outcomes at a statewide level. It includes a brief description of Phase I as well as a description of how Phase II was developed. The report provides: a list of recommended changes to the tools tested in the pilot, improvements to the training process, and issues to consider when implementing the tools in DV programs.

This study is Phase II of an effort to measure outcomes and document domestic violence advocacy practice at a statewide level.

Phase I Background

In Spring 2014, the Domestic Violence Program (DVP) of the Colorado Department of Human Services (CDHS) initiated a task force to (1) ask DVP-funded programs what outcomes would be important, useful, and meaningful to measure; and (2) identify tools for advocates to measure these outcomes. The task force identified five outcomes:

1. identify clients' immediate needs and provide information,
2. increase clients' positive stress management skills and coping strategies,
3. increase client access to community resources,
4. strengthen two-generation relationship skills, and
5. increase healthy relationship knowledge and attitudes for children and youth, ages 0 to 25.

There were very few measures available for DVP to review, which reflects the national landscape of domestic violence (DV) services evaluations. For more information about the national landscape of evaluating DV services, and the unique factors involved with evaluating DV services, please see Appendix A. After a review of available tools, DVP chose the self-sufficiency matrix (SSM) for advocates to measure outcomes. DVP contracted with the Center for Policy Research (CPR) to evaluate the SSM, its implementation, and the appropriateness of its use in Colorado's DVP-funded programs. CPR's evaluation found that the SSM did not achieve DVP's goals, and a new set of tools was needed to do so. The results of the self-sufficiency matrix evaluation for domestic violence programs can be found on CPR's website.

Phase II Development and Goals

The purpose of Phase II was to develop and test a series of tools that would replace the SSM. Starting in October 2016, the DVP Advisory Committee began to explore options for testing tools and held discussions during regular monthly meetings. Members of the Advisory committee included: representatives from the state DV coalition; CDHS; The Colorado Department of Public Safety, Division of Criminal Justice; rural, urban, and suburban DV advocates; and three specialized programs that serve LGBTQ survivors, youth impacted by DV, and survivors with disabilities. Facilitated by CPR, initial meetings focused on goal setting for the pilot. Figure 1.1 shows the goals that were agreed upon by the committee.

Figure 1.1. Goals for the DVP Pilot

What	How	Why / Measurable Results	Why / Impact
Set of tools	**Efficient**	**Useful, Valuable + Meaningful**	**Benefits survivors**
• Outcome measure • Assessment tool	• Practical + realistic • Easy to learn • Easy to use	• Communicate program/advocate activities • Drive more effective advocacy • Drive better access to community resources	• Increased well-being for survivors

> **"[The goal should be] That we develop an assessment tool that supports programs' needs and that intelligently communicates to DVP and CDHS the work we're doing, the challenges clients face, and the resources needed in the community."**
>
> -Committee Member

Stakeholders agreed that the pilot should **create and/or identify** both (1) an assessment tool to help advocates identify their clients' range of needs at the start of services, and (2) an outcome measure that was appropriate for domestic violence programs. This is described in more detail in the next chapter.

The new set of tools needed to be **efficient**, practical, easy to learn, and easy to use. Stakeholders specified that the set of tools must be **useful**, **valuable**, and **meaningful. They should** accurately describe advocacy activities, drive more effective advocacy through evidence-based decision making, and provide data to support increased access to community resources. As one committee member wrote, "[The goal should be] that we develop an assessment tool that supports programs' needs and that intelligently communicates to DVP and CDHS the work we're doing, the challenges clients face, and the resources needed in the community."

Finally, they determined that the set of tools should encourage advocacy practices, or drive data-based decision making to positively impact the **well-being of survivors**.

2.0 Pilot Development and Method

The pilot included the following instruments: (1) the needs assessment, (2) MOVERS, (3) a case closure tool, (4) the consent form, (5) an anonymous client survey about MOVERS, and (6) client demographics. This chapter describes the identification or development of these tools. To test whether tools 1-3 provided useful data for DVP, we included instruments 4-6. Instruments 4-6 were used for data analysis only and were never intended for DVP's statewide implementation. Due to federal confidentiality laws, a signed consent form is required before DV programs can share identifiable client-level data with outside parties, including funders. Appendix B includes all instruments that were part of the pilot.

2.1 New Tool Development and Identification

Led by CPR, the committee identified an existing scale to use for measuring outcomes (MOVERS), and decided to develop a new tool to assess clients' needs (intake) and report which needs were worked on(case closure). The new needs assessment and case closure tools are described first, followed by a description of MOVERS.

Development of a Needs Assessment and Case Closure Tool

The committee developed a new set of tools to measure clients' needs at intake and needs worked on with clients. CPR collected DVP-funded programs' existing needs assessments and reviewed them for ideas. Although some forms were unique due to the respective program's specialized services, we found many similarities. In particular, we found that most programs (74%) used some type of checklist or scores/scales as part of their needs assessment (see Figure 2.1). For example, many needs assessment forms asked "yes" or "no" for domains like housing, income, employment, food, and transportation.

Instruments Used in the Pilot

Intake
Consent Form*
Needs Assessment
MOVERS #1
Survey about MOVERS*

Case Closure
Needs Worked On
Needs Met
MOVERS #2-3
Client Demographics*

** Included only for CPR's analysis; not intended for a potential statewide implementation*

Based on this review, CPR drafted a new assessment and case closure tool using a checklist format. With input from the committee, CPR reviewed, edited, and revised these tools over the course of four months. During this time CPR also sent a draft to all DVP-funded programs and elicited their feedback. We used this feedback to revise the tool and adjust the pilot to test the concerns raised by programs (e.g., many advocates were concerned about how long administration of the tools would take, so we added a time study component to the pilot). We completed the final tools in April 2017.

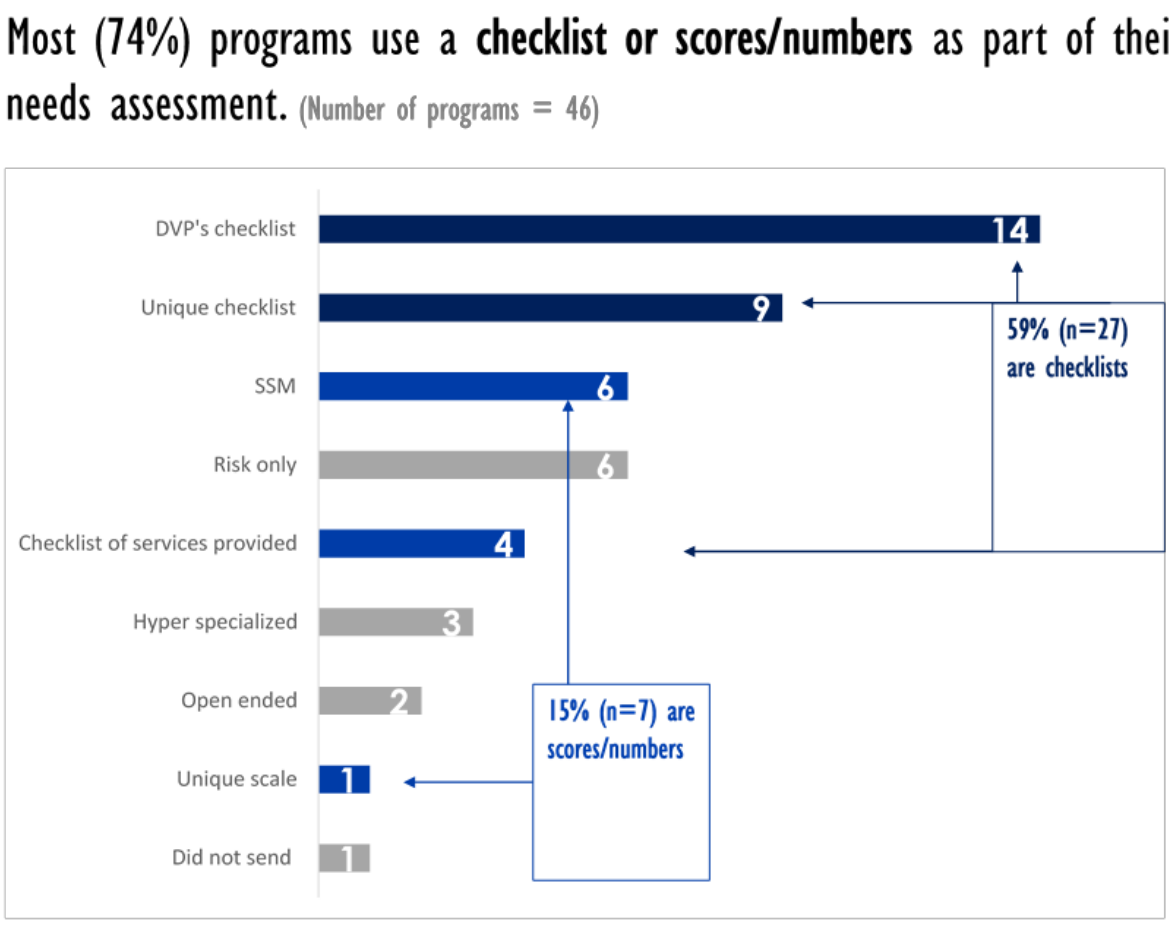

Figure 2.1. Summary of Needs Assessments collected from DV programs in Colorado

We designed the **needs assessment** to be completed at intake, and in collaboration with clients. It covers 20 domains across four categories (financial/economic, life/health, legal, and child/family-focused). The tool prompts advocates to determine their clients' needs ("needs") and then determine what clients want to work on with them ("priorities"). Our intent was to create a tool advocates could use for gathering a holistic understanding of their client's situation at intake while also setting goals and priorities for the future.

Then, once clients were no longer receiving services, advocates would complete the **case closure** instrument. The case closure includes the same domains used in the needs assessment. It includes additional columns to report on needs worked on. For each domain advocates were prompted to report: (1) whether that domain was worked on, and (2) if so, whether the need was met. The goal for the case closure to provide a way to summarize advocacy practice for each client. Clients often leave services unexpectedly, making it difficult to obtain follow-up or post data. This is a common evaluation and monitoring challenge for DV programs. Therefore, it is important to have an instrument that can be completed by advocates based on their experience and case notes, without direct client input.

The case closure form was to be completed once clients were no longer receiving services. For the pilot, this was defined as follows:

- The client explicitly or officially ended services (e.g., the client tells their advocate they won't be setting up another appointment); or
- After 14 days of no contact with the client, and there is no appointment scheduled.

Identification of an Outcome Measure

The committee reviewed several tools as potential outcome measures for the pilot study. The committee was required to find a measure that could:

- be administered by advocates to clients (i.e., no anonymous client feedback surveys);
- provide pre/post data;
- measure DVP outcome #2 (see above);
- be relevant and appropriate for DV programs; and
- have the potential to be reported monthly at the CDHS C-Stat meetings.

Only one tool met the criteria set by CDHS and CPR: MOVERS (Measure of Victim Empowerment Related to Safety). MOVERS measures "the extent to which a survivor has the internal tools to work towards safety, knows how to access available support, and believes that moving towards safety does not create equally challenging problems" (Goodman, Thomas, & Heimel, 2015, p. 7). Improvements in MOVERS scores are related to decreases in depression and post-traumatic stress disorder (Goodman, Bennett Cattaneo, Thomas, Woulfe, Chong, & Smyth, 2015; Goodman, Fauci, Sullivan, DiGiovanni, & Wilson, 2016).

MOVERS is a promising tool to use for outcome evaluation of DV services because:

- It measures an outcome that is appropriate for DV services (and maps onto the leading evidence-supported DV services theory of change (Sullivan, 2016));
- It was developed with DV stakeholder input (e.g., DV advocates, DV researchers, DV survivors), specifically to measure the impact of DV services;
- The development process was rigorous and has been subject to a scientific validation and reliability study with a sample of 301 DV services clients (Goodman, Bennett Cattaneo, Thomas, Woulfe, Chong, & Smyth, 2015);
- It can be used as a pre- and post-outcome measure;
- A post-outcome measure can be completed with short-term DV clients (minimum at least three contacts, recommended to be about one month between assessments if possible); and
- It is a brief survey (13 items) that is already available in English and Spanish.

2.2 Pilot Study Goal and Questions

The purpose of this pilot was to determine whether the data provided by these tools could achieve the goals stated above in Figure 1.1. In other words, the pilot aimed to determine which tools (or components of tools) would provide DVP with reliable and accurate data if collected on a statewide basis. CPR also sought to identify how DVP could analyze, report on, and take action in light of this data

The key pilot study questions were:

- Are the tools efficient (i.e., practical, easy to learn, easy to use)?
- What resources are needed to collect, analyze, and report this data?
- Are the tools reliable and complete (e.g., will missing data be a problem)?
- Are the tools accurate?
- Can the data be used to drive more effective advocacy?
- Can the data be used to drive better access to community resources?
- What changes to the training, tool, and/or implementation would improve this process?

2.3 Pilot Selection and Training

The committee identified potential sites that would be appropriate for testing the new tools across a range of services. DVP selected the final programs that would participate in the pilot.

DVP invited the directors of these programs to participate in the pilot via a letter explaining the details and requirements. DVP and CPR then held a follow-up call with the directors. Pilot sites were provided with a small monetary stipend, the opportunity to attend a statewide domestic violence advocacy conference, and an exemption from reporting their SSM data during the pilot period.

Three sites from three separate counties participated in the pilot: a large, urban site that primarily serves the Latinx community; a large suburban site that is relatively close to a large city; and a small rural site. These sites remain unnamed to protect their clients' confidentiality. Each site provided a different range of services. However, clients who received core services are represented in most of this pilot (See Appendix C for list of core services). As noted in section 2.5, there are some exceptions for clients who received residential services.

2.4 Pilot Implementation

CPR obtained IRB approval for the pilot in April 2017. CPR and DVP developed training materials for the pilot sites and facilitated one four-hour, in-person training session for all sites. Each advocate was given a binder with instructions, resources, and copies of the tools. Not all advocates who were going to use the tools attended the training. Each site identified one or two point people. CPR hosted weekly technical assistance calls with these point people for the duration of the pilot. Point people were responsible for training advocates who did not attend the initial training, entering pilot data into Survey Monkey, collecting consent forms and pilot data from their co-workers, and reporting back to their organization on the decisions/information discussed during the weekly calls.

Recruitment for the pilot ended when we obtained 101 clients, which took about 2.5 months (May 15, 2017 to August 4, 2017). From there, sites continued to collect follow-up MOVERS data. CPR instructed them to submit all MOVERS scores and case closure data up through August 31, 2017. Only 27 to 51% of clients were invited to participate in the pilot. Of clients who were invited, 82 to 97% agreed to participate.

Table 2.1. Recruitment Numbers by Site

	Number of clients served	Percentage of clients invited to participate in the pilot	Opt-in rates, of those offered to participate
Specialized program	136	51% (70)	97% (68)
Small rural program	33	33% (11)	91% (10)
Large urban program with residential services	103	27% (28)	82% (23)

Asking clients to participate in the pilot did not occur at the rate we had hoped for. When asked about what barriers they encountered when asking clients to participate, advocates or their supervisors stated:

- The point person did not work with clients and, as such, was unaware during the weekly calls that so many clients were not being invited to participate.
- The amount of work required to complete all of the pilot materials was significantly more than expected.
- Programs were understaffed during the summer, when they lose many of their interns.
- Advocates were already working overtime and on weekends to meet the demands of their clients and the recruitment of any additional pilot clients would have required even more staff time.

Many of the materials advocates found burdensome were related to the research component of the pilot (e.g., consent form) and will not be included in DVP's potential statewide implementation. For example, the pilot was expected to take two to three months, as we expected a much higher proportion of clients to be recruited into the pilot. However, it took nearly three months of data collection to reach the goal of 100 clients, plus an additional month to allow for case closure data to be collected. Furthermore, one program experienced significant problems with Survey Monkey due to internet connection problems, so data entry took nearly three to four times longer than anticipated to complete. Additional testing is needed to determine how to increase the percentage of clients included in the data. We discuss such areas for exploration more thoroughly in a later section.

2.5 Pilot Study Data

This was a mixed method pilot. The quantitative data was based on two sources: clients and advocates. CPR obtained client-level data through:

- MOVERS surveys;
- A brief anonymous survey about clients' experiences completing MOVERS;
- The needs and priorities clients reported to their advocate at intake; and
- Some demographic information clients reported to their advocate.

Advocates provided additional quantitative data about clients in the case closure tool:

- Whether they (or someone at their advocacy organization) worked on those needs with clients;
- Whether they felt their clients' needs were met;
- What barriers were encountered when needs were not met; and
- What type of services were provided to clients (e.g., counseling, support groups).

Advocates also completed optional forms during the pilot. These forms were attached to each client information packet. Advocates could add ongoing notes about what it was like to use the tool, and whether they encountered any issues. CPR collected these forms to inform the questions posed during post-pilot focus groups. About one month after the pilot data was completed, CPR hosted focus groups with pilot program staff. This qualitative data provided insight on how the tools were administered as well as recommendations for improving the tools.

2.6 Pilot Study Sample Characteristics

Important Note about the Varying Sample Sizes Throughout This Report

CPR received 101 completed intake and case closure surveys. The intake data (needs assessment and first MOVERS) had very little missing data and the full sample was used to analyze MOVERS at intake. However, clients who received in-house residential services from one pilot site had significant missing data from the case closure and client demographics. In addition, none of the follow-up MOVERS were submitted to CPR. CPR removed these 11 clients from the case closure and follow-up MOVERS data analysis. Advocates from this group stated that they were severely understaffed and overwhelmed during the pilot, and were unsure exactly what happened. Thus, the degree to which these tools work for residential services is unknown and requires additional testing.

Client Demographics

Client demographics were reported with the case closure data, some of which was missing. Many of the categories presented below were not mutually exclusive, so not all percentages

add up to 100% and some add up to more than 100%. Client age ranged from 19 to 70 years old, with an average age of 40.97 (median = 40 years old).

Four clients' ages were not reported. About 51% (n=54) of clients had children, 12% (n=12) were from rural areas, and 13% (n=13) reported a disability.

Table 2.2. Client Location and Background

N=101	% (n)
Rural	12.1% (12)
Parent	53.5% (54)
Disability	12.9% (13)

Clients' race/ethnicity and language were also reported. These options were "check all that apply." Most (59%) participants spoke Spanish and were Latinx (65%).

Table 2.3. Client Race/Ethnicity and Language

N=101	% (n)
Race and/or Ethnicity	
Unknown	2% (2)
Black	2% (2)
White	30.7% (31)
AIAN	2% (2)
Asian	1% (1)
Hispanic	65.3% (66)
NHPI	0%
Middle Eastern	1% (1)
Biracial or multi-racial	1% (1)
Language	
English	41.4% (41)
Spanish	58.6% (58)

We also asked for clients' gender and sex. There were no differences between the two in this sample, so only gender is reported. Most clients were women (81%); 17% were men. Most clients reported their sexual orientation as straight (93%, n=94); 2% of clients reported being bisexual. Finally, the goal of the pilot was to focus on domestic violence victims. However, clients often come to advocacy organizations having endured multiple victimizations, and other victimization types were reported. Most clients were DV (93%) and/or stalking (9%) survivors. Notably, up to nine clients were not DV victims. CPR retained these clients in analysis because exploratory analyses demonstrated that their

inclusion had no statistically significant effect on the results. Given the small sample size, we included them to increase statistical power.

Table 2.4. Client Gender, Sexual Orientation, and Type of Victimization

N=101	% (n)
Gender	
Cis Woman	81.2% (82)
Cis Man	16.8% (17)
Non-binary	0%
Transgender	0%
Missing	2% (2)
Sexual Orientation	
Straight	93.1% (94)
Bisexual	2% (2)
Lesbian	0%
Gay	0%
Queer	0%
Missing	5% (5)
Victimization	
DV	92.9% (92)
SV	5.9% (6)
Stalking	8.9% (9)
Elderly abuse	5.0% (5)
Child Abuse	1.0% (1)
Human Trafficking	0%
Missing	2% (2)

3.0 Client Needs at Intake

This chapter summarizes the data provided by, and advocates' experiences with using, the needs assessment tool. This needs assessment was intended to replace advocacy organizations' current needs assessment tool. As noted earlier, we designed the needs assessment tool to work with the case closure tool in providing a snapshot of the needs and needs worked on with DV clients.

Across these two tools, DV programs were able to report on:

- What are DV clients' needs when they seek services?
- Which needs are a priority for clients when they seek services?
- What do advocates work on with clients?
- Which needs are met, to the best of the DV advocacy organization's ability?
- When needs are unmet, why?

Needs Assessment Basics

When it was completed?
Intake, usually before MOVERS (though sometimes MOVERS came first).

How was it completed?
Advocates completed the form, but clients chose their own answers.

At first, most advocates completed during intake while talking with clients. But, then most advocates completed it after intake.

How long did it take?
The median time was only 13 minutes.

3.1 Time to Complete the Needs Assessment

The needs assessment was a relatively short instrument to complete. The median completion time was only 13 minutes, with a range of 1 minute to 75 minutes. This wide range reflects the differences in how the needs assessment was administered, which is described next.

3.2 Client Needs and Priorities at Intake

Table 3.1 shows the needs and priorities reported by survivors at intake. The top five needs among parents and non-parents were: mental health (64%), safety planning (63%), civil legal services (55%), immigration services (46%), and victim compensation (39%). Just over half (52%) of clients were parents whose top need was child mental health (35%). The lowest-ranked needs were: substance abuse (4%), education/GED services (13%), child protective services support (17%), transportation (21%), and employment (26%). This information is helpful in further demonstrating that DV clients' needs and priorities vary significantly.

Clients identified most needs as a priority (i.e., they wanted to work on it now, with their advocate). However, there were some domains where clients did not want to work on the area even though they reported it as a need. For example, 30% of clients who said social support was a *need* did not report it as a *priority*. This was also the case for: substance abuse (25%), direct financial assistance (24%), employment (19%), and education/GED (15%).

Needs Assessment Data

Top Five Needs
1. Mental health
2. Safety planning
3. Civil legal services
4. Immigration services
5. Housing

Lowest Five Needs
1. Substance abuse support
2. Education/GED
3. Child protective services
4. Transportation
5. Employment

3.3 How the Needs Assessment Was Administered

During training, we stated that the needs assessment should be used *during* advocates' initial conversations with clients. Based on the focus groups with advocates, we learned advocates used the needs assessments in various ways. Many advocates reported that they initially used the tool while speaking with clients, but over time began completing the tool *after* that initial conversation. Although the intention was for pilot sites to replace their current needs assessment with this tool, several advocates preferred to use their existing process, and ultimately used both tools (new and existing) in the pilot. Advocates also stated that as they become more experienced they tend to strive towards having an honest, authentic, survivor-driven conversation with clients without having to use paperwork.

In some cases, advocates would review the tool before finishing intake and ask clients about any domains that were not addressed during the conversation. In other cases, advocates completed the needs assessment after the client left (based on the intake conversation with clients). Advocates would then add a reminder to themselves to ask clients about that domain during the next meeting. Regardless of when it was completed, advocates reported that the needs assessment was straightforward and easy to complete.

Table 3.1 Client Needs and Priorities at Intake (N=101)

Domain	Need			Priority	
All clients	**Yes**	**No**	*Missing*	**Yes**	**No**
Housing	41% (41)	58% (59)	*1% (1)*	95% (39)	5% (2)
Food	30% (30)	66% (67)	*4% (4)*	90% (27)	10% (3)
Direct Fin Assist.	29% (29)	68% (69)	*3% (3)*	76% (22)	24% (7)
Employment	26% (26)	73% (74)	*1% (1)*	81% (21)	19% (5)
Transportation	21% (21)	78% (79)	*1% (1)*	95% (20)	5% (1)
Mental Health	64% (65)	32% (32)	*4% (4)*	95% (62)	5% (3)
Physical Health	30% (30)	69% (70)	*1% (1)*	93% (27)	7% (2)
Substance Abuse	4% (4)	96% (97)	-	75% (3)	25% (1)
Social Support	29% (29)	71% (72)	-	70% (19)	30% (8)
Education/GED	13% (13)	83% (84)	*4% (4)*	85% (11)	15% (2)
Safety Planning	63% (64)	34% (34)	*3% (3)*	95% (61)	5% (3)
Victim Comp/VRA	39% (39)	58% (59)	*3% (3)*	97% (38)	3% (1)
Immigration	46% (46)	54% (54)	*1% (1)*	100% (46)	0% (0)
CJ Services	38% (38)	60% (61)	*2% (2)*	92% (34)	8% (3)
Civil Legal Services	55% (56)	43% (43)	*2% (2)*	95% (53)	5% (3)
CPS	17% (17)	79% (80)	*4% (4)*	88% (14)	13% (2)
Among Parents: 52% (53) of the sample					
Child Care	17% (9)	80% (43)	*2% (1)*	63% (5)	38% (3)
Child Mental Health	35% (19)	56% (30)	*9% (5)*	95% (18)	5% (1)
Child Phys Health	20% (11)	70% (38)	*9% (5)*	91% (10)	9% (1)
Parenting Support	17% (9)	74% (40)	*9% (5)*	100% (9)	0% (0)

3.4 A Note About Asking Both "Needs" and "Priorities"?

The needs assessment asks whether each domain is a need and whether that need is a priority (i.e., something that the client wants to work on with their advocate now). We added this distinction based on feedback from advocates in Phase I. Advocates stated that just because a domain is a need, it is not necessarily an area that the client wants to work on with their advocate. The SSM did not provide a way to report that, so this option was added to this pilot.

In practice, however, advocates across sites varied on whether they found the difference between "needs" and "priorities" to be helpful. Some found the difference to be unnecessary or confusing because if a client has a need, it is inherently urgent and thus a priority. Other

advocates found it was a valuable reminder to both clients and advocates to think about short-term versus longer-term goals. Others thought the distinction was helpful for some clients to plan their next steps.

3.5 A Note About Capturing Client Needs at Intake vs. Case Closure

A key question is whether DVP should gather client-level data about client needs at intake or case closure. Several advocates spoke about how client needs change over time. Several advocacy sessions may be required to get a comprehensive picture of a client's situation. Some clients may not be emotionally ready to discuss all of their needs at intake, which means that many needs could be underreported at that time. Conversely, by the time advocates complete the case closure data, they will have had more time to build rapport with clients, which gives them that more complete picture. Therefore, the case closure data may be more useful than the needs assessment data in providing information about client needs.

3.6 Potential Uses for This Needs Assessment Tool

We do not recommend that individual (client-level) needs assessment data be reported to DVP because it will be more accurate and efficient to collect data about client needs from the case closure. However, the needs assessment tool shows promise in other ways. Some advocates stated that the tool had—or could potentially have—helped with advocacy practice in the following ways:

Key Lessons Learned

This needs assessment tool may be helpful for:

Training for new advocates

Keeping track of client needs when they have multiple advocates

As a quick check before ending intake, to see what was missed

As a reminder to follow-up during the next conversation

- To train new advocates or new advocacy organizations on how to gather holistic information about clients and to use as a guide while they learn effective advocacy practice;
- To help keep track of client needs when multiple advocates work with a single client; and
- As a reference tool, to make sure all relevant domains were discussed.

Overall, advocates reported having mixed experiences with the needs assessment tested in this pilot. This needs assessment tool may be a useful starting point for advocacy organizations and DVP to work together and create an intake process that works for each individual advocacy organization.

Needs Assessment Recommendations

Here are some potential uses for the Needs Assessment Tool:

Advocates
Keep handy as a checklist or reference to ensure you asked everything you wanted.

DV Organizations
Use as a training tool when showing advocates how to gain a holistic understanding of clients' situations.

DVP
Work with each individual DV program to co-create an intake process that (1) asks for the same set of questions to help advocates accurately complete the case closure tool and (2) eliminates redundancy.

4.0 Case Closure

This chapter summarizes the data provided by, and advocates' experiences with using, the case closure tool. This tool records services used by clients. The committee designed it to work with the needs assessment (described in the previous chapter) to provide a snapshot of the needs worked on with DV clients.

How Phase I impacted the case closure tool

The case closure was designed to address some key challenges raised by advocates in Phase I.

Phase I concerns
Change in client scores were reported even when clients did not work on that domain.

To address these issues, advocates reported:
1. Was it a need?
2. Did the client want to work on it?
3. Did the client work on it?
4. Was the need met?

4.1 How This Tool Addressed Phase I Challenges

One goal of the current project was to improve on the Phase I pilot, which involved the SSM. Previously, changes in SSM score were reported without giving advocates an opportunity to report on whether their clients wanted to work on each specific domain, or whether clients were able to work on that domain. In other words, DV programs were reporting on whether change happened in a domain, even when clients did not want to work on that domain.

To generate information on the domains clients wanted to work on, we built in four questions across intake and case closure. Responses to these questions enable us to calculate the percentage (or number of) needs met *based on what clients wanted to work on*:

- (intake) Is this a need?
- (intake) Does the client want to work on this right now?
- (case closure) Was this domain worked on with the client?
- (case closure) If so, was their need in this domain met?

Advocates could now also report up to four reasons why client needs were not met on the case closure form. This was another improvement over the SSM, designed to address advocates' fear that they will be held accountable for failing to address needs that are beyond their control. The possible reasons for failing to meet needs are:

- Safety barriers (e.g., concerns that their abusive partner/ex-partner will harm them for trying to address that domain);
- Community barriers (e.g., lack of community resources or policies in place that prevent clients from meeting their needs);
- The client had other priorities that emerged; or
- The client left services before the need could be met.

4.2 Needs Worked On, Needs Met, and Barriers Encountered

One of DVP's main interests is in being able to report on the services that were provided and how many survivors' needs were met. Given that this report is *pilot* data, we caution readers from making conclusions about needs worked on or met based on *this* data.

Advocates worked on 0 to 12 domains (out of 20) with the clients in this sample, with an average of 4.5 (median = 4 domains). For parents, the range was 0 to 13, with an average of 4.82 (median = 5 domains). The 0 may represent clients who only needed crisis intervention at the time of services, or who were in services for such a short period of time it was difficult to actually begin to work toward meeting a need. Crisis intervention was not a domain tracked in this pilot.

Case Closure Data

Top Met Needs for Non-parents
1. Direct financial assistance
2. Substance abuse support
3. Physical health
4. Transportation
5. Social support system & Education/GED (tied)

Top Met Needs (Including parents)
1. Child's mental health
2. Direct financial assistance
3. Child's physical health & parenting support (tied)
4. Substance abuse support
5. Physical health

Top 5 Unmet Needs (Including parents)
1. Victim compensation
2. Employment
3. Safety planning*
4. Immigration services
5. Child protection services

It is extremely unlikely that advocates did not provide safety planning. This is likely due to misinterpretation and underreporting.

For non-parents, the number of needs met ranged from 0 to 8, with an average of 1.00 (median = 0). For parents, the number of needs met ranged from 0 to 10, with an average of 1.33 (median = 1). Table 4.1 shows the priorities, domains worked on, and needs met for each domain.

Table 4.1 Client Priorities, Domains Worked On, and Percentage of Needs Met

N = 90	Priority[1]	Worked on[2]	Need met[3]	*Need met[4]*
Housing	31% (28)	96% (27)	37% (10)	*11% (10)*
Food	21% (19)	89% (17)	24% (4)	*4% (4)*
Direct Fin. Assistance	19% (17)	94% (16)	81% (13)	*14% (13)*
Employment	17% (15)	93% (14)	7% (1)	*1% (1)*
Transportation	13% (12)	67% (8)	50% (4)	*4% (4)*
Mental Health	61% (55)	100% (55)	22% (12)	*13% (12)*
Physical Health	20% (18)	83% (15)	53% (8)	*9% (8)*
Substance Abuse	3% (3)	100% (3)	67% (2)	*2% (2)*
Social Support System	12% (11)	127% (14)	43% (6)	*7% (6)*
Education/GED	9% (8)	88% (7)	43% (3)	*3% (3)*
Safety Planning	60% (54)	106% (57)	9% (5)	*6% (5)*
Victim Comp / VRA	41% (37)	95% (35)	6% (2)	*2% (2)*
Immigration	51% (46)	100% (46)	17% (8)	*9% (8)*
Criminal Justice Services	37% (33)	103% (34)	26% (9)	*10% (9)*
Civil Legal Services	56% (50)	94% (47)	21% (10)	*11% (10)*
Child Protection Services	16% (14)	79% (11)	18% (2)	*2% (2)*
Parents Only				
Child Care	4% (4)	75% (3)	33% (1)	*1% (1)*
Child's Mental Health	20% (18)	72% (13)	85% (11)	*12% (11)*
Child's Physical Health	9% (8)	50% (4)	75% (3)	*3% (3)*
Parenting Support	9% (8)	100% (8)	75% (6)	*7% (6)*

Residential clients (n=11) were excluded from this analysis due to data quality concerns.
1 – Reported at intake
2 – Number/Percent of clients who worked on this domain, of those who wanted to work on it
3 – Percentage of clients whose need was met in this domain, of those who worked on it
4 – Percentage of clients who need was met in this domain, of the full sample (all clients)

The Importance of Adjusting Percentages of Needs Met Based on What Was Worked On

When calculating the percentage of client needs that were met, it is important to account for whether or not the client identified that domain as a need. To demonstrate this, Table

4.1 shows various ways to calculate the percentages of client needs, priorities, needs worked on, and whether their needs were met.

The last column demonstrates the importance of adjusting for important factors such as parental status, needs, priorities, or what was worked on. Take physical health for example: 53% **of clients who worked on that domain** with their advocates had their need met. Yet, only 9% of **all clients** had this need met. Using the 9% calculation (i.e., all clients) makes DV advocacy organizations ***appear*** significantly less able to meet client needs when it's actually a result of failing to adjust for what was actually worked on. As another example, when including all clients it appears as though DV advocates only met clients' needs regarding their children's physical health for 3% of clients. That is only because this fails to account for what was worked on and whether the client was a parent. When both are accounted for, 75% of clients had this need met.

4.3 Core Services and Targeted Services Provided to Clients

In addition to domain-specific services, advocates reported on the number of service contacts they made and whether specific core services and targeted services were provided to each client (See Appendix C for more information). This information will not be part of DVP's future implementation, as CPR only collected it to have additional context when analyzing data. Please note that the residential clients (*n*=11) were removed from this analysis due to data quality concerns, so the sample size is 90 for this section.

Services Provided Basics

This information was for CPR's data analysis only, and was not intended to be part of a potential statewide implementation.

When it was completed?
When the case closure was completed.

How was it completed?
Advocates completed the form based on their case files.

Advocates reported 1 to 50 service contacts for non-residential services, for an average of 9.72 (median=7 contacts). Pilot clients were in services for 48.52 days on average (median=45 days). The range was 1 to 105 days, but most clients were in services for at least 2 weeks. According to DVP's records, the average length of non-residential services was 114.73 days (During October 1, 2016-September 30, 2017). We do not know how well these tools, including MOVERS, would work for residential clients and/or clients in services longer than 1.5 months.

Advocates also reported on the core services and targeted services provided. They could choose "yes" or "no" for each service. Clients received 1 to 13 services in total (core + targeted), for an average of 5.21 services (median=5 services). The range of core services provided was 1 to 8, with a mean of 3.37 (median=3). Information and referral (82%), safety planning (63%), and crisis intervention (49%) were the top three core services provided.

Table 4.2. Core Services Provided

N = 90	% (n)
Information and referral	82.2% (74)
Crisis intervention	48.9% (44)
Safety planning	63.3% (57)
Counseling	32.2% (29)
Support groups	7.8% (7)
Advocacy	43.3% (39)
Shelter*	2.2% (2)
Court advocacy	45.6% (41)
Transportation	5.6% (5)
Medical accompaniment	1.1% (1)
Language assistance	4.4% (4)

** Residential clients (n=11) were removed from analysis due to data quality concerns.*

Targeted services are unique to each DV organization and vary based on each organization's mission, capacity, resources, and community. The range of targeted services provided was 0 to 5, for a mean of 1.84 (median=2). The top three targeted services provided were immigration assistance (49%), help with navigating human services (43%), and civil legal advocacy (39%).

Table 4.3. Targeted Services Provided

N = 90	% (n)
Mobile advocacy	24.4% (22)
Parenting support	11.1% (10)
Immigration assistance	48.9% (44)
Civil legal advocacy	38.9% (35)
Supportive housing	13.3% (12)
Navigating human services	43.3% (39)
Adult education	4.4% (4)
Substance use support	0%

** Residential clients (n=11) were removed from analysis due to data quality concerns.*

4.4 How the Case Closure Tool Was Completed

Like the needs assessment, advocates reported that the case closure form was relatively easy to complete. However, domains worked on and whether needs were addressed (or "met") may have been underreported. From the focus groups and a review of pilot data CPR identified two main reasons for this underreporting: (1) training content was not retained long term, and (2) programs did not have a system in place to track this information in a way that helped them complete the case closure tool.

Case Closure Basics

When it was completed?
After clients completed services, or after two weeks of no contact with clients.

How was it completed?
Advocates completed the form based on their case files.

How long did it take?
Not long. However, much of it was left blank or skipped over quickly.

Options for **whether a domain was worked on** included "yes," "no," or "not applicable." CPR included the "not applicable" category so we could temporarily exclude those clients from analysis as needed. If a client did not identify an individual domain as a need or priority—*and they never worked on that domain with their advocate*—we would not assess whether that need was met. During training we stated that if a client reported "no" for a domain at intake but it emerged as a need later on, then advocates should choose "yes" or "no" for this question. However, during the pilot some advocates only completed the "worked on" section if clients reported the corresponding issue as a need at intake. Advocates did not always report when new needs emerged, or when additional services were provided, on the case closure instrument.

During training we also stated that providing services to the best of advocates' abilities counted as "**meeting a need**." For example, if a client needed something beyond the scope of available services by the advocacy organization (e.g., counseling), then advocates may only be able to provide a referral. This *would* still count as meeting a need for DVP's purposes. A review of the data, however, indicated that advocates set a higher bar for whether a need was "met." For example, advocates worked on safety planning for 57 clients, yet only reported that the need was met for five clients. It is extremely unlikely that advocates did not provide any safety planning for 52 clients as safety planning is one of the core advocacy services. They likely provided safety planning, but given that safety was still a concern for clients, reported that the need was not met. Indeed, the focus groups confirmed that advocates underreported whether needs were met (to the best of the organization's ability). Some advocates did not count providing services as meeting a need during the pilot and thought that they would have needed to follow up with clients to find out whether their needs were fully met (e.g., completed counseling sessions).

Finally, across sites some parts of the case closure tool were left entirely, or almost entirely, blank. Advocates did not use the "in progress" option on the case closure tool. Additionally, reasons needs were not met was left almost entirely blank. Advocates did not provide specific reasons. Additional testing is needed to identify ways to improve reporting on these categories.

4.5 Advocates' Experiences with the Case Closure Tool

Overall, advocates were mostly neutral or somewhat positive about the case closure tool. Some found it burdensome to complete and report both the needs assessment and case closure tools together, along with the other research components (e.g., consent form, demographics). As stated earlier, the research components will be eliminated from additional testing in the future to gain a more accurate sense of how long these tools will take to complete in practice.

While most advocates preferred the yes/no dichotomous nature of the questions, some were opposed to this. Some advocates stated that it is inappropriate to assume how clients feel regarding whether a given need had been met. They suggested replacing this category with "services provided."

Another challenge was completing the "reasons needs weren't met" section. Advocates did not have a place to record this information while working with clients. As such, the case closure form was typically completed quickly and from memory. While it was relatively easy to remember what services were provided, trying to recall the barriers for each need was near impossible. Future implementation should include a way to help advocates keep track of these barriers while they work with clients.

Still another challenge was that advocates did not remember what counted as a community barrier. For example, during training we discussed that a long waitlist for subsidized housing would count as a barrier for meeting a housing need. During the pilot focus groups, few advocates remembered that this counted as a community barrier. Once we talked about this during the focus groups, however, advocates restated the value of having this type of data and we were encouraged to keep this information. We recommend that the tool be revised so that definitions and examples of various barriers are provided on the tool, rather than buried in a manual.

4.6 Potential Uses for the Case Closure Data

Overall, advocates reported that the case closure data provide (or could provide) a generally accurate way to report on clients' needs and what services were provided. The dichotomous nature of the tool worked well for most advocates and will also be relatively straightforward for DVP to analyze and report. The data from this pilot may represent an underreporting of needs met. We caution against using this pilot data for allocating resources or performing evaluation. Future training, fidelity monitoring, and supports from DVP will increase the accuracy of case closure data.

As demonstrated above, any report of "needs met" should always be adjusted based on parental status, client needs, priorities, or what clients actually worked on. Furthermore, reporting the percentage of needs met by domain may provide more useful data than averaging or counting the number of needs met for clients.

Potential Uses for the Case Closure

What value did or could it provide?

Accurate reflection of what advocates work on with their clients.

Demonstrates, with data, the degree of unmet needs among survivors (justification that more resources are needed).

Could demonstrate, with data, how some external barriers make it difficult for survivors to meet their needs.

Case Closure Recommendations

The "reasons needs weren't meant" section showed promise, but needs some rethinking. We recommend working with the committee, and the next pilot site, to revise this section.

To simplify the tool:

1. Remove the "was this worked on" column.

2. Remove the "in progress" option under needs met.

3. Add "not applicable" as an option (so we can exclude clients who didn't work on that domain from data analysis).

To improve data accuracy:

1. Revise the "need met" language to something like "service provided."

5.0 MOVERS

5.1 Overview of MOVERS

MOVERS is a 13-question survey given to clients to measure empowerment related to safety. These 13 questions are made up of three subscales: Internal Tools, Expectations of Support, and Tradeoffs for Seeking Safety.

The questions we hoped to answer during the pilot were:

- How and when was MOVERS implemented?
- What were clients' experiences with completing MOVERS?
- Does MOVERS have adequate reliability?
- Is MOVERS an accurate and useful outcome measure for DV services?
- Was MOVERS useful for advocacy planning and practice?

MOVERS

What is MOVERS?
The Measure of Victim Empowerment Related to Safety (MOVERS) is a short, 13-question outcome evaluation survey.

It has three subsections:
1. Internal Tools
2. Expectations of Support
3. Tradeoffs for Seeking Safety

As stated earlier, we received 101 client intakes, but several follow-up MOVERS (and other data) were missing for 11 of these clients. Therefore, the sample analyzed differs between pre- and post-MOVERS. This is noted when relevant.

5.2 How and When MOVERS Was Administered

A trauma-informed approach to evaluation means that clients are not asked to complete an evaluation survey while in crisis. Given that clients are often in crisis during the first contact, many advocates are justifiably concerned about asking clients to complete an outcome measure. Advocates reported on how many service contacts occurred before administering the first MOVERS to determine (1) when it occurred, and (2) what impact this had on MOVERS scores.

In most cases, clients were able to complete the first MOVERS during the first contact (85.9%; n=85). There was no relationship between number of contacts and MOVERS scores at intake. These preliminary findings indicate that the first MOVERS can be assessed after the initial contact, and that advocates can invite clients to participate in the evaluation survey in a trauma-informed way by waiting for about up to 5 contacts. However, given the

small number of clients whose first MOVERS occurred after the first contact, DVP should track and re-analyze this when there is more data.

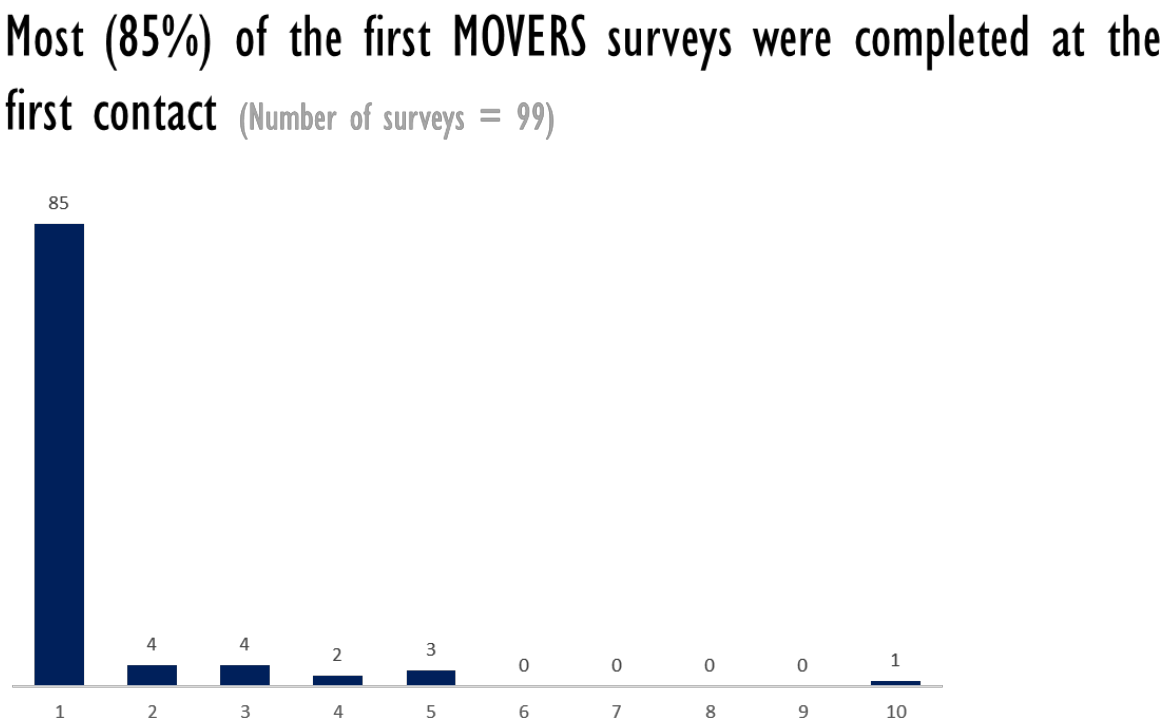

Figure 5.1 Distribution of how many service contacts occurred prior to the first MOVERS

Clients skipped very few questions on MOVERS, indicating that missing data will likely not be a problem for future data collection and analysis. Of the 101 clients at intake, only two did not complete the survey at all. One client was in crisis and not offered the opportunity to complete the survey. The other client declined. Of the 99 who completed MOVERS at intake, only eight clients skipped one or more question. As such, 96% of clients completed the entire MOVERS survey at intake.

Advocates collected a high number of follow-up MOVERS, indicating that a reasonable amount of follow-up surveys can be obtained. In all, 70 clients completed a second MOVERS. Of those clients, 90% (n=63) answered every question. Two clients completed a third MOVERS, and both clients answered every question. In one case a client was in crisis and thus not offered the second MOVERS. The other 19 clients were no longer in services and could not be reached.

Advocates provided time study data for 94 clients at intake and 69 clients at follow-up. Breakdowns are provided below. The time it took to complete MOVERS varied. Intake, which was mostly in person, took between 2 minutes and 1 hour and 23 minutes, with a median time (50% of clients) of 13 minutes. This is a wide range, but for the most part that was because it was part of the intake process and a broader discussion of client needs took place. MOVERS took longer to complete at intake. This was likely because intake is a key time advocates use to build rapport with clients. Indeed, 75% of the clients finished within 20 minutes, and fewer than 8% needed more than 45 minutes. The follow-up times were shorter, with the median time being 8 minutes, and with 89% of clients finishing within 20 minutes. The follow-up completion time range was also shorter: 1 minute to 41 minutes.

MOVERS Basics

When it was completed?
For 86%, at intake and usually after the needs assessment (though sometimes MOVERS came first). For the remaining 14%, it was done between the 2nd-10th contact)

How was it completed?
Clients were given the option to complete it by themselves, or by having the advocate ask the question and then choosing their answer

How long did it take?
Not long at all! The median time was only 13 minutes.

At intake, 75% were done in less than 20 minutes, and at follow-up, 89% were done in less than 20 minutes.

Table 5.1. Time to Complete MOVERS

	Intake (n=94)	Follow-up (n=69)
5 minutes or less	18.1%	40.5%
6-10 minutes	13.8%	21.7%
11-20 minutes	43.5%	27.2%
21-30 minutes	10.7%	4.2%
31-40 minutes	3.2%	4.2%
41-50 minutes	6.6%	1.4%
51 minutes or longer	4.3%	0%

** Percentages do not equal 101 due to missing data.*

5.3 Clients' Experiences with Completing MOVERS

The developers of MOVERS originally intended it to be used for *either* advocacy practice or evaluation. This is because if clients are asked to complete a survey to evaluate the services they received, their responses should be anonymous to ensure program staff never have access to clients' answers. DVP, however, was interested in using MOVERS data for both advocacy practice and evaluation. To enable this, advocates had to collect clients' answers in a non-anonymous way. CPR spoke with one of the tool's developers, Dr. Lisa Goodman, to

discuss the potential of using MOVERS for both. It seemed like a promising idea as MOVERS does not directly ask clients to report on the services they received from that program or advocate. Rather, clients report on their current situation and skills. To test whether MOVERS could be used for both purposes, we asked clients to indicate the degree to which they could be honest about their answers.

Clients' Experiences with MOVERS

In the anonymous survey given to clients, 92% said they were comfortable in answering all the questions honestly.

70% said that it wasn't confusing, which shows that some work may be needed to make MOVERS easier to complete.

Clients completed an anonymous survey after they completed MOVERS for the first time. We received 118 completed anonymous surveys. This is because some clients opted out of having their identifiable data sent to CPR, but gave permission for their anonymous survey to be sent to CPR. Advocates were instructed to allow clients to place their surveys in a sealed box or to seal the surveys in an envelope and then place the surveys in the box. The survey, like MOVERS, was available in English or Spanish, and 74% were completed in Spanish.

Clients were asked, "Do you feel like you could be honest with your advocate about your answers?" Most (92.5%, n=109) chose "Yes, I was comfortable answer all questions honestly." Another 5.9% (n=7) chose, "Somewhat: I was comfortable answering some of the questions honestly but not all of them." The remaining 1.7% (n=2), chose "No: I was uncomfortable answering these questions." These results indicate that MOVERS shows promise for being used as an evaluation tool, even if advocates are aware of their clients' answers. However, more training about how to introduce MOVERS may help ensure that more clients feel they could answer all questions honestly.

There were also some concerns that clients might have difficulty understanding MOVERS questions. We also asked clients, "Were these questions confusing or hard to understand?" Most (70.3%; n=83) chose "Not at all confusing." An additional 24.6% (n=29) chose "somewhat confusing." The remaining 5.1% (n=6) chose, "very confusing." There were no statistically differences in these responses based on whether the survey was in English or Spanish. Most clients in the pilot came from a center that serves the Latinx community and, therefore, the difference may be due to the small sample of English surveys.

Finally, the last question was "Is there anything else you would like to share about your experience?" In 72% (n=85) of the surveys, clients left this blank or wrote "*nada*" or "nothing." Another 8% (n=9) stated something positive, such as "very helpful," "it's fine," or

"*todo bien*." In 4% (n=5) of the surveys, clients commented negatively, such as "questions were a bit repetitive" or "*no entiendo*." The remaining 16% commented on something other than MOVERS.

5.6 The Reliability of MOVERS

Reliability is the foundation of data accuracy. Reliability means that the same situation is rated the same way every time. Without a minimum amount of reliability there is no chance that the data will be accurate. CPR tested the reliability of each MOVERS scale and found that each had sufficient reliability.

Specifically, the reliability of subscales is comparable to the Cronbach's alpha (for the entire scale) reported by the survey developers (.80; Goodman, Fauci, Sullivan, DiGiovanni, & Wilson, 2016). Given the different patterns between subscales, we tested the reliability of each one and found that alphas were adequate (samples sizes are different because reliability tests exclude clients who skipped one or more questions):

- Internal tools at intake (.941; n=94) and follow-up (.828; n=65)
- Expectations of support at intake (.884; n=95) and follow-up (.723; n=66)
- Tradeoffs at intake (.800; n=94) and follow-up (.796; n=68)

5.7 MOVERS Data

We present MOVERS data for the non-residential sample (n=90) in this section. Of the initial 90 clients, 70 clients at least partially completed the second MOVERS. Two clients completed a third MOVERS. We used the "last" MOVERS score in this section.

Clients who did not complete two MOVERS are included in the "missing" column. It is important to first assess—and report—how many clients are unrepresented in the follow-up. Typically, anything above 20% warrants at least some caution in interpretation (40% or higher would raise major concerns of biased data). In this pilot we have a little over 20% missing data across MOVERS questions, which is a promising starting point for a pilot. This percentage will likely be reduced with additional training and experience.

Table 5.5 Internal Tools MOVERS Scores at Intake and Follow-up

INTAKE (n-90)	Never true	Sometimes true	Half the time true	Mostly true	Always true	Missing
1) I can cope with whatever challenges come at me as I work to keep safe.	7.8% (7)	12.2% (11)	12.2% (11)	20.0% (18)	43.3% (39)	4.4% (4)
2) I know what to do in response to threats to my safety.	8.9% (8)	10.0% (9)	7.8% (7)	18.9% (17)	51.1% (46)	3.3% (3)
3) I know what my next steps are on the path to keeping safe.	10.0% (9)	11.1% (10)	15.6% (14)	13.3% (12)	47.8% (43)	2.2% (2)
4) When something doesn't work to keep safe, I can try something else.	5.6% (5)	7.8% (7)	14.4% (13)	15.6% (14)	52.2% (47)	4.4% (4)
5) When I think about keeping safe, I have a clear sense of my goals for the next few years.	12.2% (11)	5.6% (5)	15.6% (14)	11.1% (10)	52.2% (47)	3.3% (3)
6) I feel confident in the decisions I make to keep safe.	7.8% (7)	12.2% (11)	6.7% (6)	17.8% (16)	53.3% (48)	2.2% (2)
FOLLOW UP (n-90)	Never true	Sometimes true	Half the time true	Mostly true	Always true	Missing
1) I can cope with whatever challenges come at me as I work to keep safe.	1.1% (1)	6.7% (6)	5.6% (5)	16.7% (15)	47.8% (43)	22.2% (20)
2) I know what to do in response to threats to my safety.	1.1% (1)	10.0% (9)	5.6% (5)	8.9% (8)	51.1% (46)	23.3% (21)
3) I know what my next steps are on the path to keeping safe.	-	8.9% (8)	3.3% (3)	16.7% (15)	46.7% (42)	24.4% (22)
4) When something doesn't work to keep safe, I can try something else.	2.2% (2)	2.2% (2)	11.1% (10)	12.2% (11)	48.9% (44)	23.3% (21)
5) When I think about keeping safe, I have a clear sense of my goals for the next few years.	-	4.4% (4)	7.8% (7)	10.0% (9)	53.3% (48)	24.4% (22)
6) I feel confident in the decisions I make to keep safe.	-	1.1% (1)	3.3% (3)	15.6% (14)	53.3% (48)	26.7% (24)

Table 5.6 Expectations of Support MOVERS Scores at Intake and Follow-up

INTAKE (n-90)	Never true	Sometimes true	Half the time true	Mostly true	Always true	Missing
1) I have a good idea about what kinds of support for safety that I can get from people in my community (friends, family, neighbors, people in my faith community, etc.)	7.8% (7)	12.2% (11)	13.3% (12)	14.4% (13)	50.0% (45)	2.2% (2)
2) I feel comfortable asking for help to keep safe.	4.4% (4)	7.8% (7)	8.9% (8)	12.2% (11)	62.2% (56)	4.4% (4)
3) I have a good idea about what kinds of support for safety I can get from community programs and services.	6.7% (6)	7.8% (7)	8.9% (8)	16.7% (15)	55.6% (50)	4.4% (4)
4) Community programs and services provide support I need to keep safe.	4.4% (4)	5.6% (5)	6.7% (6)	18.9% (17)	61.1% (55)	3.3% (3)
FOLLOW UP (n-90)	Never true	Sometimes true	Half the time true	Mostly true	Always true	Missing
1) I have a good idea about what kinds of support for safety that I can get from people in my community (friends, family, neighbors, people in my faith community, etc.)	1.1% (1)	10.0% (9)	6.7% (6)	10.0% (9)	50.0% (45)	22.2% (20)
2) I feel comfortable asking for help to keep safe.	1.1% (1)	1.1% (1)	6.7% (6)	11.1% (10)	55.6% (50)	24.4% (22)
3) I have a good idea about what kinds of support for safety I can get from community programs and services.	-	1.1% (1)	3.3% (3)	11.1% (10)	57.8% (52)	26.7% (24)
4) Community programs and services provide support I need to keep safe.	-	1.1% (1)	4.4% (4)	6.7% (6)	61.1% (55)	26.7% (24)

Table 5.7 Trade Offs MOVERS Scores at Intake and Follow-up

INTAKE (n-90)	Never true	Sometimes true	Half the time true	Mostly true	Always true	Missing
1) I have to give up too much to keep safe.	18.9%	17.8%	10.0%	21.1%	30.0%	2.2%
	(17)	(16)	(9)	(19)	(27)	(2)
2) Working to keep safe creates (or will create) new problems for me.	31.1%	14.4%	17.8%	11.1%	21.1%	4.4%
	(28)	(13)	(16)	(10)	(19)	(4)
3) Working to keep safe creates (or will create) new problems for people I care about.	27.8%	16.7%	13.3%	7.8%	27.8%	6.7%
	(25)	(15)	(12)	(7)	(25)	(6)
FOLLOW UP (n-90)	Never true	Sometimes true	Half the time true	Mostly true	Always true	Missing
1) I have to give up too much to keep safe.	17.8%	16.7%	10.0%	4.4%	28.9%	22.2%
	(16)	(15)	(9)	(4)	(26)	(20)
2) Working to keep safe creates (or will create) new problems for me.	34.4%	14.4%	11.1%	4.4%	12.2%	23.3%
	(31)	(13)	(10)	(4)	(11)	(21)
3) Working to keep safe creates (or will create) new problems for people I care about.	38.9%	6.7%	12.2%	5.6%	13.3%	23.3%
	(35)	(6)	(11)	(5)	(12)	(21)

5.8 Change in MOVERS over time

To determine whether MOVERS could be a useful outcome measure for DV services, we considered two key factors: (1) what type of change do we see over time and (2) which DV services are related to change in MOVERS over time?

Change in MOVERS Scores

We report average change in MOVERS scores from intake to "last" in the following table.

Table 5.8. Change in MOVERS Scores (N=69)

	M(SD)	Range
Internal Tools	-.54 (1.56)	-4.00 to 3.33
Expectations of Support	.35 (1.01)	-1.25 to 4.00
Trade Offs	.41 (1.06)	-1.83 to 3.50

One way to report MOVERS data is to calculate how many clients improved, had no change, or worsened from their first to last assessment. Only clients with both a pre- and post-score would be included for this type of analysis. Like before, the "last" MOVERS score

was used in this subsection. When reporting, it is important to disclose how many clients were excluded because they did not complete a second MOVERS.

To determine the change in MOVERS scores we calculated each client's average score (for each subscale). Then we calculated the difference between the first and last MOVERS. An average is preferred over a summed score because some clients skipped a few questions, which means their total score could never be as high (or low) as those who answered all questions. By definition an average will be adjusted automatically because the denominator is how many individual questions were answered.

The range of scores is 0 to 4. Internal Tools and Expectations of Support run "positive," meaning that higher scores are better; for tradeoffs, lower scores are desired. As mentioned earlier, two clients completed a third MOVERS. Therefore, this calculation is based on the *last* MOVERS. In our pilot 70 clients completed at least two MOVERS. For two clients, this reflects their third MOVERS; for the remaining clients, it is their second MOVERS.

Table 5.9. MOVERS Means and Standard Deviations

	Intake N=99	Second MOVERS N=70	Third MOVERS N=2	"Last" MOVERS N=70
	M(SD)			
Internal Tools	2.93 (1.18)	3.40 (.74)	2.75 (.35)	3.41 (.72)
		Range: 1.67-4.00	Range: 2.5-3	Range: 1.67-4
Expectations of Support	3.11 (1.09)	3.55 (.66)	2.50 (.71)	3.55 (.65)
		Range: 2-4	Range: 2-3	Range: 2-4
Trade Offs	1.92 (1.32)	1.58 (1.32)	1.50 (.24)	1.54 (1.30)
		Range: 0-4	Range: 1.33-1.67	Range: 0-4

70 clients completed at least two MOVERS. For two clients, this reflects their third MOVERS; for the remaining clients, it is their second MOVERS.

It is difficult to interpret these findings using means alone, as by default an average muddies individual differences. Therefore, DVP may find it more practical and useful to categorize each client in terms of whether their average subscale score improved, did not change, or worsened. No change may reflect that clients already chose the highest (or a high) score.

Table 5.10. Broad Change in Average Subscale Score

	Improved	No change	Worsened
Internal Tools	47%	33%	20%
Expectations of Support	37%	44%	18%
Trade Offs*	45%	22%	33%

** An increase in scores is considered a "decrease" in condition, as a higher score means clients reported that the tradeoffs were too high (e.g., they had to give up too much to gain safety).*

This breakdown indicates that 47% of clients increased in internal tools, 37% increased in expectations of support, and 45% increased in tradeoffs. On the other hand, 33% of clients showed a decrease in tradeoff scores. One downside of this simple categorization is that even if a client's average score decreased by .01, they would be in the "worsened" category even though this change is unlikely to be statistically or practically significant.

Another way to represent change over time is to create more categories that will show smaller degrees of change. For example, a "slight" improvement could be less than 1 point difference, whereas an "improvement" could need to be 1 point or more. Using this standard for improvement, we see that of the clients whose scores showed a change the largest improvements were in The Tradeoffs subscale, with 35% increasing their mean at least one entire point. Note that this is just an arbitrary example of how setting a cutoff can add nuance to data reporting. The cutoff between "improved" and "slightly improved" does not necessarily indicate a real or practical difference in clients' lives or well-being. It is resource intensive to determine clinically (practically) significant cutoffs, and is beyond the scope of this pilot.

Table 5.11. Degrees of Change in Average Subscale Score

	Improved	Slightly improved	No change	Slightly worsened	Worsened
	1 point or more	Less than 1 point		Less than 1 point	1 point or more
Internal Tools	22%	25%	33%	16%	4%
Expectations of Support	17%	20%	44%	9%	9%
Trade Offs	35%	10%	22%	18%	15%

Services Related to CHANGE in MOVERS

In this step we wanted to test whether change in MOVERS scores was related to the delivery of services. For example, if we found that more types of services was statistically unrelated to any change in MOVERS scores, it would cast doubt on whether MOVERS would be an adequate outcome measure to serve DVP's intended goals.

For each subscale, we tested what other factors (e.g., parental status, demographics) relate to MOVERS scores at intake, follow-up, "last" MOVERS, and change in MOVERS. Only the significant relationships are described here. Please see Appendix D for the correlation matrix, and Appendix E for a breakdown of services provided to the full sample (including those without a send MOVERS). Each subscale was related to different factors so they are presented separately.

Please note that correlations do not speak to individual client experiences. Nor do they indicate which variable "caused" the other. Correlations only point towards trends and indicate which variables tend to go together when looking at the entire group of clients in the study.

Change in Internal Tools

An increase (improvement) in internal tools was positively related to: four core services (crisis intervention, safety planning, advocacy, counseling), two targeted services (mobile advocacy and immigration services), number of needs at intake, number of priorities at intake, number of core services provided, total number of services provided, total number of service contacts, number of service contacts between the first and second MOVERS, and total number of service contacts.

SERVICES RELATED TO IMPROVED MOVERS SCORES

Clients who received the following services (reported as "yes or "no") showed a larger improvement in MOVERS from baseline to follow-up.

Internal Tools
Crisis intervention, Safety planning, Advocacy, Counseling, Mobile Advocacy, Immigration assistance

Expectations of Support
Crisis intervention, Safety planning, Advocacy, Mobile Advocacy

Trade Offs for Seeking Safety
Mobile Advocacy

SERVICES RELATED TO DECREASED MOVERS SCORES

Clients who received the following services (reported as "yes or "no") showed a decline in MOVERS from baseline to follow-up.

Internal Tools
Navigating human services

Interestingly, clients who did *not* navigate human services with their advocate showed greater improvement over time; clients who did navigate human services with their advocated showed a decrease in Internal Tools over time. The reason for this finding is unclear with the current available data. Human services includes social net programs (e.g., Medicaid, SNAP, TANF) as well as child welfare services.

Change in Expectations of Support?

An increase (improvement) in expectations of support was related to: three core services (crisis intervention, safety planning, and advocacy), one targeted service (mobile advocacy), number of needs at intake, number of priorities at intake, and total number of services provided.

Change in Tradeoffs?

An improvement in tradeoff scores was related to receiving one targeted service (mobile advocacy). Surprisingly, survivors who were in services for a longer period of time or had more days between their first and second MOVERS had a decrease in tradeoff scores over time. It could be that survivors with lower tradeoff score changes are those who tend to need access more services because they encounter more barriers.

5.9 The Impact of Format on MOVERS

We tested whether method of administration had an impact on mean scores for MOVERS at each time point. Most of the intake MOVERS were completed in person and most of the follow-up MOVERS were completed over the phone. At intake, most (83.8%; n=83) were handed to the client. An additional 13.5% (n=13) were asked the questions by their advocate. The remaining 2% (n=2) were asked the questions by their family members or completed over phone or (1%; n=1). In contrast, 74.3% (n=52) completed MOVERS over the phone at follow up. An additional 20% (n=14) of follow-ups occurred in person, independently by the client. The remaining 5.7% (n=4) were asked the questions by the advocate.

HOW SHOULD MOVERS BE COMPLETED?

In the pilot, clients could complete MOVERS on their own or with their advocate asking the questions. There may be a difference in scores based on this format.

Intake

At intake, most clients completed it on their own. Format did not impact MOVERS scores

Follow-up

At follow-up, most clients answered the questions over the phone. Clients were more likely to report higher scores for internal tools and expectations of support. There was a marginally significant impact for tradeoffs.

We recoded these into whether the client completed MOVERS on their own or with someone else (e.g., over the phone). At intake, there were no differences in any of the MOVERS subscales based on how it was completed. However, we did find that clients who answered MOVERS over the phone were significantly more likely to report higher scores on internal tools and expectations of support. This difference approached significance for tradeoffs. This raises concerns that conducting MOVERS surveys over the phone may contribute to higher scores on MOVERS. At the very least, the format of MOVERS should be collected by DVP and these differences should be reanalyzed with a larger and more representative sample of clients.

5.10 Advocates' Experiences with Using MOVERS

MOVERS Can Provide DV Advocacy Organizations with Useful Outcome Data

Many advocates thought MOVERS could provide valuable evaluation data that would be useful for advocacy organization reports and funding proposals. This is discussed further in the implications section.

MOVERS May Not Be as Helpful for Advocacy Planning or Practice as Intended

Although some advocates acknowledged that MOVERS occasionally sparked conversation, the consensus across sites was that MOVERS did not provide useful information to help with advocacy planning or practice. As such, there was a general dissatisfaction with asking clients to complete the survey. Although some advocates reported that the tool may be valuable for showing clients progress or as a means of encouraging broad reflection, this did not occur during the pilot period of three months.

Some advocates reported that their organization's aim to limit paperwork to build client-advocate relationships was in direct conflict with asking clients to complete MOVERS. Relationship-building is, indeed, a critical factor in the effectiveness of advocacy practice for DV survivors (Goodman, L. A., Fauci, J. E., Sullivan, C. M., DiGiovanni, C. D., & Wilson, J. M., 2016). Organic, conversation-based advocacy was unanimously considered more effective than asking clients to complete a survey and discussing the clients' answers. In addition, some advocates reported that counseling practice based in mindfulness was in direct conflict with asking clients to think analytically and report their experiences in numeric form.

It is possible that additional training on how to implement and use MOVERS scores in a more conversational manner would help mitigate some of these issues. However, advocates across sites reported that their current practice is effective in building relationships with clients, identifying client needs, and addressing client needs. Therefore, DVP should continue to work with DV advocacy organizations on a case-by-case basis regarding the tools they use to create advocacy plans.

Future training should provide more guidance to advocates on what to say when giving the survey to clients. Some clients became upset while taking the survey, saying things like, "*Is it bad that I don't feel this way*?" There was also shame involved for clients struggling with literacy barriers, who seemed embarrassed about needing to ask the advocate for help. Additional instructions at the top and/or more scripts to combat potential feelings of shame will be helpful.

5.11 Potential Uses for MOVERS Data

Potential Uses for MOVERS Data

Change in MOVERS over time may provide DVP, CDHS, and DV organizations with useful data. The effectiveness of county or statewide changes to policies and procedures could be tested using long-term MOVERS data. For example, we found that scores worsened for survivors when they navigated human services with their advocates. If additional resources can be obtained, and DVP gains the support from other CDHS programs, more research on the cause of this finding would be helpful for identifying a way to address this issue. Policy and procedure interventions in specific counties could be implemented, and then MOVERS data analyzed to determine if they are associated with any changes. DVP could use MOVERS data to identify counties where MOVERS scores tend to be lower, and then work with programs to identify the organizational and community factors that may be contributing to these lower scores.

DV organizations could also do a deeper dive into their own MOVERS data over time. For example, if an advocacy organization reviews its MOVERS data after six months and finds that scores are not improving to the degree it expected, the advocacy organization can have internal discussions and planning sessions to identify ways to improve responses to individual questions or subscales. Depending on their database infrastructure, individual DV advocacy organizations could compare MOVERS scores by client demographics and services provided allowing for a richer and more contextualized analysis of change in MOVERS over time.

Cautions about Interpreting MOVERS Data

MOVERS does not speak solely and directly to the quality of DV services—a low MOVERS score does not necessarily mean the client received poor quality advocacy. While advocacy is one of the factors that contributes to changes in clients' scores, so do many other things. We must also caution against using *only* MOVERS data to compare the *quality of services* provided by DV organizations. There are many other important organizational and community factors that would have an impact on MOVERS scores. These would need to be statistically controlled for before concluding that one organization is providing higher quality advocacy than another. Some of these factors include: (1) types of services provided; (2) organizational resources and capacity; and (3) county-specific policies, procedures, and resources.

MOVERS Recommendations

MOVERS shows great promise for the evaluation of DV services.

It is quick to complete, reliable, and shows a reasonable amount of change over time.

MOVERS scores at least somewhat related to services, and provide some support for the idea that advocacy can have a positive impact on survivors' well-being, even if concrete needs are not met.

To simplify the tool:

1. **Rearrange by subsection.**
2. **Work with the next pilot site to develop an implementation plan that addresses the issues raised in this pilot.**

To improve data accuracy:

1. **Collect data on how many contacts occurred before the first MOVERS.**
2. **Collect data on how the answers were provided.**
3. **Reanalyze with a larger sample to determine whether these factors influence the scores.**
4. **Standardize and implement a way for programs to use their own data for evaluation and grant proposals.**

6.0 Phase II Conclusions and Lessons Learned

The committee developed and tested a set of tools in three DV programs for this phase II pilot. The needs assessment can be useful for training and advocacy practice. This should be determined on a program by program basis, especially for programs that already have a working comprehensive needs assessment process in place. The case closure tool shows promise in providing a way for advocates to report on which domains they worked on with clients, and which of those domains organizations were able to address with available resources. There is an interest among programs to rework the section about barriers on the case closure tool and to pilot it again. Finally, MOVERS demonstrated acceptable reliability and appeared to be related to the provision of advocacy services. Thus, it is a promising and relevant outcome evaluation tool for domestic violence programs in Colorado.

Phase II addressed several concerns raised by advocates in Phase I. First, we moved closer to identifying an efficient and practical way for advocates to report on their advocacy without negatively biasing the data. We are now better able to report on the percentage of needs met only for those who worked on that domain. Second, we implemented a brief outcome measure that was specifically designed for domestic violence programs, as well as generates useful information while minimally burdening clients.

Although we have made great improvements, these tools are not yet ready for broader implementation. Some revisions are required, and those changes will require testing. Additional testing is also needed with clients from residential services. DVP should also conduct additional testing to determine whether they should use both MOVERS and the case closure, or just one of those tools.

Table 6.1. Initial DVP Goals

What	How	Why / Measurable Results	Why / Impact
Set of tools	**Efficient**	**Useful, Valuable + Meaningful**	**Benefits survivors**
• Outcome measure • Assessment tool	• Practical + realistic • Easy to learn • Easy to use	• Communicate program/advocate activities • Drive more effective advocacy • Drive better access to community resources	• Increased well-being for survivors

Were These Tools Efficient?

It is difficult to determine whether we met this goal, and several elements of the pilot were specific to the pilot study. Although each individual tool was relatively straightforward to implement, and the time study showed that each did not take too long to complete, most advocates said that the entire process took too long to complete. DVP is expected to streamline this process through the use of CAFÉ, and because research elements (e.g., the consent form) will not be in place.

DVP launched the Client Assessment, File & Event (CAFÉ), a Salesforce application, in 2015. The CAFÉ protects sensitive client data and is available at virtually no cost to the community-based programs that receive DVP funding. The CAFÉ is the first comprehensive statewide database that all DVP-funded programs can use for reporting and case management. The purpose of the CAFÉ is twofold:

- To improve efficiencies in the way the DVP and funded programs effectively manage contracts including submission of monthly and quarterly data, contract reimbursement, and monitoring and compliance;
- To enhance collection and record keeping mechanisms for data at each funded program creating systems that efficiently track client served, demographics, completed assessments, service contacts, and activities in the communities served.

Do These Tools Provide Useful, Valuable, and Meaningful Data?

We are on track to meet the goal to "communicate program and advocate activities." There were some misunderstandings about how to report activities, such as when a need was met, but with changes to the training format and tool, we are optimistic that this goal will be met.

The goals to "drive more effective advocacy" or "better access to community resources" are more challenging to assess. MOVERS scores can decrease even with high-quality advocacy. Advocates stated that MOVERS did not provide them with additional information to inform their advocacy. However, it is possible that with more time, supports, and practice, this may change. MOVERS demonstrates change. If collected on a statewide level across programs, it could become a valuable source of data that could be used (with other data sources) to test the impact of community or policy interventions. For example, our preliminary analysis showed that *providing* services was generally related to an increase in MOVERS scores *even when needs were not met.* In fact, the number or percentage of needs met was *unrelated* to MOVERS scores at any time point, or changes in MOVERS scores. This may be due to our limited sample and an underreporting of needs met. Alternatively, this provides additional support for national research showing that how DV services are

provided matters just as much as what services are provided (Sullivan, 2011). If this is the case, there would likely be substantial interest among DV programs in and out of Colorado in an outcome survey that allowed them to demonstrate this type of client improvement.

6.1 Revise the Tools and Conduct Additional Testing

In this section, we make recommendations for additional testing. Due to federal confidentiality laws, DV advocacy organizations cannot share identifiable data with outside organizations—including CDHS DVP—without written consent from each survivor. As such, this pilot included an IRB-approved informed consent process. The benefit of this addition was that we were able to obtain additional data that will not be available to DVP for a potential statewide implementation. The downside of this approach was its burden on programs. Our focus groups revealed advocate frustration with several time-consuming aspects of the pilot study such as the consent form, the time study, and the collection of client demographics. Repeating these elements of a pilot study in additional testing risks generating advocate opposition that would be conflated with the materials that could be used on a statewide basis.

Another concern is underrepresentation of clients. Only 27% to 51% of clients were invited to participate in the Phase II pilot study. Most clients in our sample were recipients of long-term services, which is not representative of the clients served by DV advocacy organizations. In focus groups, advocates attributed this low invitation rate to the lengthy nature of pilot study. Underrepresentation of DV clients in a pilot limits the reliability and accuracy of the data and reduces the applicability of results. The exclusion of many clients from the pilot means that potential challenges or barriers may go unidentified, leaving DVP unable to address or prepare for them.

For these reasons, we recommend that to the extent possible, additional testing should mirror the conditions that will be in place when DVP implements these tools. Simplified procedures should be used so that it is possible to determine whether advocates' experiences with the Case Closure and MOVERS are satisfactory. Additional testing should also explore whether building data collection through the CAFÉ may be an effective way to address the challenges identified in this pilot. For example the CAFÉ will simplify and standardized the data collection process for advocates, and provide a way for advocates to document their work with clients easily and frequently. The CAFÉ will also allow multiple advocates from one agency to enter client data, so it could reduce the burden on any given

advocate. Finally, the CAFÉ will simplify and/or automate the reporting process, which will streamline the process for advocates and DVP.

6.2 Recommended Changes to the Needs Assessment Tool

We do not recommend specific changes to the needs assessment tool. However, we do recommend that this data not be submitted to DVP. Given that the case closure tool provides an opportunity to provide this data, it may be more accurate at that time point.

6.3 Recommended Changes to the Case Closure Tool

We recommend that the case closure tool be retained. If completed correctly, it is possible to calculate how many domains were a priority for clients. Per the input of advocates, we recommend that the following changes be made to the tool:

- Revise the tool so definitions and instructions are on the tool rather than in a manual,
- Remove the "in progress" option because it was not used by advocates,
- Rename the column labelled "was this need met,"
- Remove the options labelled "other priorities emerged" and "left services,"
- Add another option labelled "community barrier."

6.4 Recommended Changes to MOVERS Implementation

We recommend that MOVERS be retained, that the challenges with implementing it be addressed, and that it be retested. The following steps should be taken:

- Reorganize MOVERS by category to eliminate the confusion some clients experienced due to mixing up questions across subscales. Although it is common practice to mix up questions from subscales, client comfort with the measure is an overriding priority.
- Conduct more training to help advocates introduce MOVERS to clients and respond to client questions or concerns.
- Request that advocates report on the number of service contacts they have with clients prior to the first administration of MOVERS, and conduct an analysis to determine whether scores are impacted by this number.

- Request advocates to report on how the MOVERS was completed (e.g., over the phone) and conduct an analysis to determine whether scores are impacted by this format.

6.5 Co-create Implementation Plans with Each Site

The successful implementation of the case closure and MOVERS in DV programs will require buy-in and coordination with advocacy leaders, effective communication strategies, additional data over time, and a demonstration of the positive impact of this data on DV programs. Without these elements, advocates will likely view these tools as mandatory, unnecessary, and burdensome paperwork. In short, DVP should generate additional feedback from advocates so that these are valuable tools that can help advocates and their advocacy organizations improve client outcomes.

We recommend that DVP collaborate with each DV program on the implementation of these tools and that flexibility be extended to individual programs wherever feasible. While some implementation components need to be standardized, others can be individualized at the program level without jeopardizing the integrity of the data.

Core Components to Standardize across Sites

In terms of establishing adequate reliability of the data collection process, the following components should be standardized and consistent across DV programs:

- There must be a way to ensure that data on unique clients is sent to DVP and that the same client is not included multiple times with a different ID number.
- All domains from the case closure must be completed across sites. Programs can add more information to their intake, but the domains chosen by DVP should be considered a minimum for which data must be provided.
- The difference between "no" and "not applicable" must be accurately reported and DVP should frequently assess this type of reliability.
- MOVERS must be completed by the clients and they must choose their own answers. Staff may ask clients the questions and report their answers, but it is critical that staff never influence clients' scores.
- All sites should use the same time period for when follow-ups are completed, give or take two weeks. The minimum time between the first and second MOVERS should

be four weeks. DVP can choose the maximum time, though we recommend that this be between 8-12 weeks, and that this time frame continue to be tested.

- A cutoff should be determined for when the first MOVERS assessment is completed after clients begin working with their advocate. We recommend that this be the same date as the cutoff for when programs are required to complete a needs assessment (currently, this is 7 within days).
- Dates of each MOVERS assessment must be collected to confirm that the cutoff dates are followed and to analyze differences in how time impacts MOVERS scores.
- The format of MOVERS (e.g., in phone, asked by advocate) should be collected to conduct an analysis of how format impacts MOVERS scores.
- The number and proportion of clients invited to complete MOVERS information should be noted.

Factors that can be adjusted within each site, as they are less likely to have a significant impact on reliability, include:

- Which clients will be invited to complete MOVERS;
- Which clients will have case closure data reported about them;
- Exactly when clients are invited to complete MOVERS (up to the cutoff date);
- How advocates collect the information that will eventually be reported on the case closure; and
- Who will be responsible for each part of the data collection and reporting process.

We recommend that the first three months of data collection at an individual DV program be closely monitored for completion, accuracy, and reliability. Additionally, DVP should work with programs to set goals regarding the percentage of clients included in this data collection effort. DVP should work with sites to track how many new clients accessed advocacy services and, of those, how many were invited to complete MOVERS. DVP can then track how many clients are being missed and unrepresented in the data that DV organizations send to DVP. The data provided during this implementation period should be interpreted with caution.

About six months to one year after programs have reliably and accurately collected data, DVP should conduct statistical analyses on:

- Whether the timing of the first MOVERS impacts scores;
- Whether the format of MOVERS impacts scores;
- An ideal time frame between each MOVERS assessment;

- An ideal time frame between the first MOVERS and last MOVERS assessment; and
- The reliability of MOVERS.

We recommend that the needs assessment tool piloted in Phase II be used as a starting point for DVP to work with each advocacy organization to develop and/or revise their current intake process. DVP provided this level of support for one of the pilot sites during Phase II. During the focus group with this site, staff mentioned how useful it was to have DVP's help with revising their forms. This technical assistance can be used to ensure that both (1) programs are collecting the information they need to complete the case closure tool accurately, and (2) there is no duplication in the intake process. From there, we recommend that DVP work with programs to co-create an implementation plan. Tailoring the exact process with each site will enhance the quality of data because the process will be more aligned with service provision.

Questions to Work Through When Completing the Implementation Plan

Buy-in

- How do you like your current intake and needs assessment process? Are there things we can help you improve or streamline?
- Who will be your internal champion for the implementation of these tools?
- How could this information be helpful to your program? For improving services? For grant reporting? Grant applications?
- What capacity do you have to create internal reports? Would it be helpful for DVP to create reports for your advocacy organization?
- How will this pilot be communicated to advocates?
- What training or supports would you like to help you conduct more thorough analyses of these data? For example, would you be interested in doing some internal analysis on the relationship between MOVERS and services you provide?

Training and Reliability

- Who will be the designated person to track which advocates have completed their online training?
- Who will provide us with monthly data about how many new clients received advocacy and how many clients were invited to completed MOVERS?
- Who will be the designated person to implement the in person follow-up component to the online training?
- Who will be the designated person who determines whether advocates need to complete "booster" training (e.g., re-watch the online trainings)

- What support is needed to train staff on how to use the CAFÉ?

CAFÉ and/or Data Collection Prior to Case Closure

- What tools and/or systems can we put in place so that the information that will go on the case closure will be accurate and updated during service provision?
- What tools and/or systems can we put in place to do reliability and accuracy checks of this information?
- Who will be the designated person to identify missing data and follow-up with advocates to have that missing data entered (when possible)?
- Who will be collecting/writing down the data about services provided while working with clients? What training and support do they need?

Program Capacity

- What resources do you have available to implement this data collection and reporting process? How many staffers can you dedicate? How many hours per week or month can they spend on this effort? What is their role within the advocacy—is it reasonable to expect that they can focus on accurate and reliable processes, data collection, and reporting?
- Do you experience fluctuations in how many advocates you have? How will this process remain in place even during periods where you do not have as many advocates?
- Which advocates may have the hardest time completing these tools because of the work they do? For example, will residential advocates face greater barriers because their daily activities may be more chaotic? What supports can we provide to help with this?

MOVERS and Case Closure Completion

- Which clients will be invited to complete MOVERS? How will you track the clients who were never invited?
- Which clients will have case closure data completed about them? How will you track the clients who were excluded?
- What are some reasonable goals we can set for these percentages (of how many clients are included in the data)?
    - *Note: we recommend that at least 75% of clients are included in the data.*
- When will the first MOVERS be completed? How will programs ensure that no clients complete MOVERS after the cutoff date?
- Where will the hard copies of MOVERS be stored? How secure is it?

- What tools will programs implement to track the information needed for the case closure?
- Will there be paper copies of the case closure?
- Who will be responsible for timing and tracking each MOVERS assessment?
- When would it make sense to do the follow-up MOVERS, and does that vary by service?
- What is the best way to collect the dates of each MOVERS in order to account for time between assessments?
- Who will enter the case closure data into the CAFÉ? What training and support do they need?
- How will programs reassess reliability? What will this look like, and how often will it occur?

Data Reporting to DVP

- Who will enter the case closure data into the CAFÉ? What training and support do they need?

6.6 Suggested Improvements to the Training Process

The training for the Phase II pilot consisted of a single, four-hour session that covered both the new tools as well as procedures pertaining to the research process and the informed consent procedure. There was only limited time for advocates to role play how to complete the tools. As such, there are several ways the training process can be improved to (1) increase data quality and accuracy, and (2) promote longer retention.

Training Content Recommendations

In addition to training on how to complete each aspect of the tools, we recommend that additional training content be included to address the most challenging aspects of the pilot:

- What the difference is between "no" and "not applicable";
- What counts as "meeting a need"; and
- What counts as a community barrier.

It may also be helpful to create printable handouts that advocates can use as a reference.

Training Format Recommendations

In general, one-time brief training sessions have limited effectiveness for long-term retention—particularly related to data collection. However, a longer (e.g., day-long) training

is not necessarily the solution because it is even harder to retain new information after prolonged periods of time. Indeed, it is more effective to provide short lessons over an extended period of time, with "booster" sessions to recalibrate reliability.

A single, longer training program also does not address: (1) the problem of high staff turnover and the need to train new advocates quickly; (2) the challenges advocacy organizations have in engaging all staff and volunteers in a single, in-person training session, given the need for an advocate to be available at all times to respond to client/survivor needs; nor (3) that in-person trainings, by default, will not be 100% standardized (e.g., advocates will ask different questions at each training). Finally, although no training on informed consent will be needed, future training will still need to include a technical component that covers how to track the data and/or enter it into the CAFÉ. Given these complexities, we recommend that the training format follow a two-pronged approach, such as one described next.

1. Deliver the Core Curriculum via an Online Course Format

First, we recommend that the core training be delivered to advocates in a prerecorded, online course format. Online training will provide the standardization and reliability needed for quality data collection.

This online course would include video lessons on:

- The background and history of the tools;
- The importance, and potential uses, of the tools and the data that will be collected;
- An overview of each tool and how to complete it;
- Technical training on how to add this information into the CAFÉ and generate reports;
- Practice scenarios and/or quizzes (and the answers); and
- Reliability checks and additional practice scenarios with answers so advocates can "recalibrate."

The more information that can be created in advance and prerecorded, the more standardized, consistent, and effective the training will be. It will also be easier to translate into multiple languages and/or make accessible via captions. Breaking up the information into manageable pieces and allowing advocates to complete the core training over a set period of time (e.g., within one to two weeks) will promote better retention of the information. DVP will be able to create new and ongoing "booster" trainings (e.g., new scenarios and quizzes, a webinar answering new FAQs), and make them available to all

sites at once. Furthermore, advocates will be able to login and rewatch specific short lessons as needed, over time, which will strengthen reliability.

2. Develop In-Person and Ongoing Support Opportunities

In-person components would also be helpful and should be developed based on the expertise of DVP and the capacity of each site. For example, the timing and format of an in-person component would likely vary depending on whether the program is located in the Front Range versus in a more rural area.

One option for DVP is to implement a "train-the-trainer" model, where a designated staff person at each program is trained on how to follow-up and assess retention for advocates who completed the online training. For example, the trained advocate will have a packet of test scenarios and will role play with the new advocate. Note that DVP should also frequently schedule "booster" trainings with these people to ensure that they continue to accurately train others and answer their questions.

Another option is for DVP to schedule follow-up calls or meetings with programs to do an in-person assessment of how advocates are doing with the tools. This could be added to DVP's regular site visits, or scheduled on a case-by-case basis. These supports should be provided based on an individual program's needs. For example, visits could be scheduled to coincide with the loss of summer interns and the training of new groups of advocates.

A third option is to leverage training opportunities with existing statewide meetings. Many DV advocates attend CAIA and COVA each year, and DVP could host an annual workshop at one (or both) events where they present the data they have collected in the past year and discuss how it was used. Workshop time could also be allocated to answering questions and/or doing role plays/scenarios to assess how accurate and reliable advocates' responses are. In addition to satisfying training needs, these workshops might boost advocate buy-in regarding the new tools.

6.7 Reassess Expectations, Requirements, and Goals

Several tools were reviewed as potential outcome measures for the pilot study. Only one tool met the criteria set by CDHS and CPR: MOVERS. Specifically, the committee was required to find a measure that could:

- Be administered by advocates to clients (i.e., no anonymous client feedback surveys);
- Provide pre-/post- data;
- Measure one of DVP's outcomes;
- Be relevant and appropriate for DV programs; and
- Have the potential to be reported monthly for the CDHS C-Stat meetings.

Our pilot demonstrated that MOVERS is related to DV services. However, these services are only a small part of the reason MOVERS scores changed. MOVERS questions assess more than DV services and also reflect partially on community resources and the community response to DV in general. For example, survivors' experiences with family court, criminal court, and county human services all likely have an impact on survivors' MOVERS scores. As such, MOVERS scores alone do not directly tell programs or DVP whether (or which) services need to be improved. Although there are three surveys in the literature that would appeal to DV programs because they directly measure the quality of services in a way that would inform actions, they conflict with two of the CDHS criteria because they do not yield pre-/post- data and they are not administered by advocates. If CDHS finds that a more direct measure of the quality of DV services would be more helpful, CDHS should consider reassessing its criteria.

In all, however, DVP has a new process tool and an outcome measure to conduct additional testing with. These tools show great promise for achieving the goals set by the committee.

7.0 Appendices

Appendix A: National Landscape of Evaluating DV Services

There are many challenges (some unique, some shared with other fields) involved when conducting research or evaluation on the impact of DV services (Goodman, Bennett Cattaneo, Thomas, Woulfe, Kwan Chong, & Fels Smyth, 2015; Kulkarni, Bell, & Rhodes, 2012; Macy, Giattina, Sangster, Crosby, Johns Montijo, & 2009; Macy, Giattina, Parish, & Crosby, 2010; Macy, Nwabuzor Ogbonnaya, & Martin, 2015; Macy, Rizo, Johns, & Ermentrout, 2013; Macy, Johns, Rozi, Martin, & Giattina, 2011; Song, 2012; Sullivan, 2011; Sullivan, 2016). Some unique challenges that remain a significant barrier for research and evaluation on DV services, particularly multisite or state-level evaluations, are summarized next. In all, these challenges make it challenging and costly to conduct quality evaluations of DV services (Sullivan, 2011).

Serious and Unique Safety Concerns

While many fields may have to deal with some safety concerns, DV clients' and their children's lives can be in danger **due to seeking services**. This is because the dynamics of abuse involve one partner who seeks to control their partner or ex-partner using a combination of physical violence, coercive control, emotional/psychological violence, and economic abuse. When survivors seek services, then, abusers may perceive this as a threat to their control over the victim and escalate their abuse.

Many survivors seek services while they are in crisis and/or their immediate safety is at risk. In turn, many DV services are designed to specifically address this immediate crisis. This is an **inappropriate or unsafe moment to collect data from survivors for an evaluation** (Sullivan, 2011). This is why collecting baseline data is a particularly unique challenge for DV programs—not all DV clients can reasonably invited to participate in an evaluation (Sullivan, 2011). Furthermore, many DV services are short term and focused on the resolution of the crisis, and many survivors may not return to the program to eventually participate in an evaluation.

These safety concerns also create additional **challenges for follow-up** evaluation surveys, as such ongoing contact could put the lives of survivors and their children at risk or be perceived as stalking (Sullivan, 2011).

Federal Statutory Safeguards on Data Protection and Safety

While other fields, such as Child Welfare, may have a large administrative database of client data to analyze (e.g., reviewing process or outcomes by child age, race, or gender), this is not possible for DV programs. Federal statute (by the Violence Against Women Act and the Family Violence Prevention and Services Act) prohibits DV programs from disclosing any identifiable information about their clients.

In some cases, de-identifying data simply means the removal of names, birthdates, and addresses. This is not the case for DV programs. **Even data such as race, gender, and/or age is considered identifiable and cannot be submitted to a third party**, including DVP. While these protections are critical the safety of survivors and their children, they also create challenges for an initiative such as a statewide evaluation using existing administrative data. While some data may be submitted for analyses, there will likely be an inherent limitation in what the data can answer. For example, many may want to know the *why* or *for whom and under what conditions does this service work?* A standalone, adequately funded, evaluation may be needed to analyze differences in program outcomes by factors such as program **activities** (e.g., fidelity), **organizational** factors, local **geographic and contextual** factors, as well as **client** race, ability, gender, age, sexual orientation, and citizenship.

No Universal Service or Outcome

There is no universal service provided to clients and there is an ongoing and unresolved national debate about which outcomes are appropriate for DV programs (Sullivan, 2011). First, DV services are designed to help people who have been and/or continue to be affected by *others'* behaviors (Smith & Hope, 2014). That is, unlike family resource centers and other fields, the type of change that is reasonable to expect from DV clients may look different than the type of change expected in other fields.

Second, DV services are client-driven, and services provided can vary by client. DV survivors have a wide variety of needs and outcomes must be based on the services requested by survivors (Kulkarni, Bell, & Rhodes, 2012; Sullivan, 2011). While other fields may struggle with standardizing services or identifying outcomes, the nature of their services allows for a broader range of appropriate universal client outcomes. For example, family resource centers provide family-driven services and must contend with several similar challenges to evaluating services (e.g., client-driven). However, even they tend to have some standardization of services and clients. Family resource centers only serve families (i.e., where there is at least one parent and one child). They also have a universal service—*parent education* (California Family Resource Center Learning Circle, 2000).

Furthermore, this service is designed to increase the specific skills and ability of the parent, which has an identifiable and measurable outcome (i.e., an increase in client's parenting skills).

In contrast, DV programs work with a range of clients and their services are so individualized and varied that they have been referred to as a "**black box."** (Macy, Johns, Rozi, Martin, & Giattina, 2011; Macy, Rizo, Johns, Ermentrout, & 2013; Sullivan, 2011). In other words, much more work needs to be done to develop a standardized description or way to measure DV services look like, in addition to outcomes.

Appendix B: Instruments Used in Pilot

INFORMED CONSENT for a VOLUNTARY research project

The Center for Policy Research invites you to help with a research study.

[AGENCY NAME] is one of three sites participating in this study to evaluate the **impact of our services**. Our goal is to learn how to make our services better for survivors of domestic violence in Colorado.

We are **pilot testing** some new measures and will be asking clients some new questions. **We believe these questions will help advocates better understand your unique situation, and provide services that better fit you.**

As part of this study, we would like to share some of the information from your client file with an independent research firm, the Center for Policy Research. Specifically, we would share:

1. A summary of your service needs at intake.
2. Your answers to a survey that asks questions about your safety.
3. Your feedback on the survey that asks questions about your safety.
4. A summary of services provided to you.
5. A summary of whether we met your services needs and, if not, why.
6. Your demographics, such as age and race/ethnicity.

This study is **VOLUNTARY** and your information will be **CONFIDENTIAL**. Center for Policy Research will NEVER know what YOUR specific answers were.

This study will include about 100 clients across 3 sites, and results will be reported using group aggregates or summaries. You do not have to answer any questions you do not want to and you can opt out of this study at any time.

This is **COMPLETELY VOLUNTARY.** That means you **DO NOT HAVE TO AGREE TO RELEASE YOUR INFORMATION TO RECEIVE SERVICES.** There are no foreseeable risks to releasing your information for this study, and the potential benefits are that you will help us improve our services.

☐ **Yes, I give consent:**

- Share some of my information with Center for Policy Research. I understand all personal information will be kept confidential.
- I understand all responses are voluntary and my name will not be used in any reports. I also understand that whether I agree or not has no effect on the services I will receive through this agency or any other service agency.

☐ **No, I do NOT authorize the release of any information to Center for Policy Research.**

Client Signature: _____ Date: _____

For questions about the research study, contact Dr. Echo Rivera (Principal Investigator) at Center for Policy Research: 330-837-1555

For questions about your rights as a research participant, contact SolutionsIRB: 1-855-226-4472

*This study is funded by the Domestic Violence Program at the Colorado Department of Human Services

A: Client Needs & Self-Identified Priorities Intake

Site ☐ RAV ☐ SPAN ☐ SDLR **Unique ID** _____ **Intake Date** _____

Advocate Name _____ **Opt In** ☐ **Start Time** _____ AM / PM

Advocates should complete this form with input from the client. Use the Guide to help with the framework in using this tool.

Be sure to answer all questions for each domain.

1. Is this domain a need for the client?
2. Does the client want to work on this need at this time?

Domain	Is this a need?			Does the client want to work on this now?		
Financial / Economic	**Y**	**N**	**M[1]**	**Y**	**N**	**M**
Housing	Y	N	M	Y	N	M
Food	Y	N	M	Y	N	M
Direct Financial Assistance	Y	N	M	Y	N	M
Employment	Y	N	M	Y	N	M
Transportation	Y	N	M	Y	N	M
Life / Health						
Mental Health (Client)	Y	N	M	Y	N	M
Physical Health (Client)	Y	N	M	Y	N	M
Substance Abuse	Y	N	M	Y	N	M
Social Support System	Y	N	M	Y	N	M
Education / GED	Y	N	M	Y	N	M
Safety Planning	Y	N	M	Y	N	M
Legal						
Victim Comp / VRA	Y	N	M	Y	N	M
Immigration	Y	N	M	Y	N	M
Criminal Justice Services	Y	N	M	Y	N	M
Civil Legal Services	Y	N	M	Y	N	M
Child Protection Services	Y	N	M	Y	N	M
Child / Family-Focused	☐ **N/A for Entire Section**					
Child Care	Y	N	M	Y	N	M
Mental Health (Child)	Y	N	M	Y	N	M
Physical Health (Child)	Y	N	M	Y	N	M
Parenting Support	Y	N	M	Y	N	M
Other Needs (Optional)						
	Y	N	M	Y	N	M
	Y	N	M	Y	N	M
	Y	N	M	Y	N	M

End Time _____ AM / PM

[1] M = Missing: If the client does not answer one of the questions, indicate that the information is missing as you do not know if this is a need or not for the client.

B: Client Needs & Self-Identified Priorities Exit

Site ☐ RAV ☐ SPAN ☐ SDLR **Unique ID** _____ **Exit Date** _____

Advocate Name _____ **Start Time** _____ AM / PM

Advocates must complete this form upon client exit. Use the Guide to help with the framework in using this tool.

☐ Client left services before any needs were met

Domain	Was this need worked on?			Was this need met?				If need was not met, why? (Select all that apply)							
								Safety Barrier		Community Barriers		Other Priorities Emerged		Left Services	
Financial / Economic	Y	N	N/A[2]	Y	N	IP[3]	M[4]	Y	N	Y	N	Y	N	Y	N
Housing	Y	N	N/A	Y	N	IP	M	Y	N	Y	N	Y	N	Y	N
Food	Y	N	N/A	Y	N	IP	M	Y	N	Y	N	Y	N	Y	N
Direct Financial Assistance	Y	N	N/A	Y	N	IP	M	Y	N	Y	N	Y	N	Y	N
Employment	Y	N	N/A	Y	N	IP	M	Y	N	Y	N	Y	N	Y	N
Transportation	Y	N	N/A	Y	N	IP	M	Y	N	Y	N	Y	N	Y	N
Life / Health															
Mental Health (Client)	Y	N	N/A	Y	N	IP	M	Y	N	Y	N	Y	N	Y	N
Physical Health (Client)	Y	N	N/A	Y	N	IP	M	Y	N	Y	N	Y	N	Y	N
Substance Abuse	Y	N	N/A	Y	N	IP	M	Y	N	Y	N	Y	N	Y	N
Social Support System	Y	N	N/A	Y	N	IP	M	Y	N	Y	N	Y	N	Y	N
Education / GED	Y	N	N/A	Y	N	IP	M	Y	N	Y	N	Y	N	Y	N
Safety Planning	Y	N	N/A	Y	N	IP	M	Y	N	Y	N	Y	N	Y	N
Legal															
Victim Comp / VRA	Y	N	N/A	Y	N	IP	M	Y	N	Y	N	Y	N	Y	N
Immigration	Y	N	N/A	Y	N	IP	M	Y	N	Y	N	Y	N	Y	N
Criminal Justice Services	Y	N	N/A	Y	N	IP	M	Y	N	Y	N	Y	N	Y	N
Civil Legal Services	Y	N	N/A	Y	N	IP	M	Y	N	Y	N	Y	N	Y	N
Child Protection Services	Y	N	N/A	Y	N	IP	M	Y	N	Y	N	Y	N	Y	N
Child / Family-Focused	☐ N/A for Entire Section														
Child Care	Y	N	N/A	Y	N	IP	M	Y	N	Y	N	Y	N	Y	N
Mental Health (Child)	Y	N	N/A	Y	N	IP	M	Y	N	Y	N	Y	N	Y	N
Physical Health (Child)	Y	N	N/A	Y	N	IP	M	Y	N	Y	N	Y	N	Y	N
Parenting Support	Y	N	N/A	Y	N	IP	M	Y	N	Y	N	Y	N	Y	N
Other Needs (Optional)															
	Y	N	N/A	Y	N	IP	M	Y	N	Y	N	Y	N	Y	N
	Y	N	N/A	Y	N	IP	M	Y	N	Y	N	Y	N	Y	N
	Y	N	N/A	Y	N	IP	M	Y	N	Y	N	Y	N	Y	N

End Time _____ AM / PM

[2] N/A = Not Applicable: Only select N/A if this was not an identified need at intake, and never became a need for the client.
[3] IP = In Progress: Select if any needs are currently being worked on but were NOT met at the time of closure / exit.
[4] M = Missing: Select if you do not know if the need was met or not.

Survey: Questions About Your Safety

You may be facing a variety of different challenges to your safety. When we use the word **safety** in the following statements, we mean safety from physical or emotional abuse by your current/former intimate partner.

Please circle or check the box of the number that best describes how you think about your and your family's safety at this moment in time. When you are responding to these questions, it is fine to think about your family's safety along with your own if that is what you usually do.

Statements	Never true	Sometimes true	Half the time true	Mostly true	Always true
	0	1	2	3	4
1. I can cope with whatever challenges come at me as I work to keep safe.	0	1	2	3	4
2. I have to give up too much to keep safe.	0	1	2	3	4
3. I know what to do in response to threats to my safety.	0	1	2	3	4
4. I have a good idea about what kinds of support for safety that I can get from people in my community (friends, family, neighbors, people in my faith community, etc.)	0	1	2	3	4
5. I know what my next steps are on the path to keeping safe.	0	1	2	3	4
6. Working to keep safe creates (or will create) new problems for me.	0	1	2	3	4
7. When something doesn't work to keep safe, I can try something else.	0	1	2	3	4
8. I feel comfortable asking for help to keep safe.	0	1	2	3	4
9. When I think about keeping safe, I have a clear sense of my goals for the next few years.	0	1	2	3	4
10. Working to keep safe creates (or will create) new problems for people I care about.	0	1	2	3	4
11. I feel confident in the decisions I make to keep safe.	0	1	2	3	4
12. I have a good idea about what kinds of support for safety I can get from community programs and services.	0	1	2	3	4
13. Community programs and services provide support I need to keep safe.	0	1	2	3	4

Questions About Your Safety Survey: Office Use Only

Site ☐ RAV ☐ SPAN ☐ SDLR **Unique ID** _____

Advocates must complete this form when Questions About Your Safety surveys are offered to clients. Only complete one of the three sections below based on which Questions About Your Safety survey was offered (i.e., if this is the first Questions About Your Safety survey offered, you will complete the Questions About Your Safety #1 section).

Survey #1

☐ **Was Survey #1 Completed?** _____ _____

IF NO: Why not?
- ☐ Did not offer because client was in crisis
- ☐ Offered but client refused / declined to complete
- ☐ Other: _____

IF YES: How was it completed?
- ☐ (In-person) Handed to client to complete on their own
- ☐ (In-person) Advocate asked client the questions & client gave answers
- ☐ (Phone) Advocate asked client the questions & client gave answers over the phone
- ☐ Other: _____

Advocate Name: _____

Number of contacts between first day of service and this Questions About Your Safety **#1 survey**
_____

Start Time _____ **AM / PM** **End Time** _____ **AM / PM**

Survey #2

☐ **Was Survey #2 Completed?** _____ _____

IF NO: Why not?
- ☐ Did not offer because client was in crisis
- ☐ Offered but client refused / declined to complete
- ☐ Client no longer in services
- ☐ Other: _____

IF YES: How was it completed?
- ☐ (In-person) Handed to client to complete on their own
- ☐ (In-person) Advocate asked client the questions & client gave answers
- ☐ (Phone) Advocate asked client the questions & client gave answers over the phone
- ☐ Other: _____

Advocate Name: _____

Number of contacts between Survey #1 survey & Questions About Your Safety **survey (#2)**
_____

Start Time _____ **AM / PM** **End Time** _____ **AM / PM**

Survey #3

☐ **Was Survey #3 Completed?** _____ _____

IF NO: Why not?
- ☐ Did not offer because client was in crisis
- ☐ Offered but client refused / declined to complete
- ☐ Client no longer in services
- ☐ Other: _____

IF YES: How was it completed?
- ☐ (In-person) Handed to client to complete on their own
- ☐ (In-person) Advocate asked client the questions & client gave answers
- ☐ (Phone) Advocate asked client the questions & client gave answers over the phone
- ☐ Other: _____

Advocate Name: _____

Number of contacts between Survey #2 survey & THIS survey (#3)
_____

Start Time _____ **AM / PM** **End Time** _____ **AM / PM**

Feedback Opportunity: Anonymous & Voluntary

Please share your thoughts with us!

Thank you for answering these questions about your safety.

Please take a moment to let us know what it was like to answer these questions about safety. This is a new survey and we want to know if we should keep using it. Your feedback will help us decide how to improve our services.

This is completely **VOLUNTARY**. You do not have to write anything if you do not want to. Your responses will be **ANONYMOUS**. They are being sent to an independent, third-party evaluator. Your advocate will not see your answers and your answers cannot be linked back to you.

1. **Were these questions confusing or hard to understand?**

   ☐ Very confusing

   ☐ Somewhat confusing

   ☐ Not at all confusing

2. **Did you feel like you could be honest with your advocate about your answers?**
   Reminder: your advocate will not be able to see your feedback on this form.

   ☐ Yes: I was comfortable answering ALL questions honestly

   ☐ Somewhat: I was comfortable answering some of the questions honestly, but not all of them

   ☐ No: I was uncomfortable answering these questions (Please explain why in the space below)

3. **Is there anything else you would like to share about your experience?**

When you are done:

- Place this feedback into the envelope provided
- Seal the envelope and place it into the provided box / basket / bucket / etc.

C: Client Information at Exit

Site ☐ ACVAP ☐ SPAN ☐ SDLR **Unique ID** _____ **Exit Date** _____

Advocate Name _____ **Start Time** _____ AM / PM

Advocates must complete this form after the client has left services.

Client Age	_____	**Total # Contacts**	_____	**Type of Service**	☐ Residential ☐ Non-Residential
Race / Ethnicity ***Check all that apply***	☐ African American / Black ☐ White ☐ American Indian / Alaskan Native ☐ Asian ☐ Hispanic / Latinx ☐ Native Hawaiian / Pacific Islander ☐ Middle Eastern ☐ Bi-racial or Multi-Racial ☐ Race or ethnicity not listed ☐ Unknown	**Sex**	☐ Female ☐ Male ☐ Intersex ☐ Unknown	**Gender**	☐ Woman ☐ Transgender ☐ Non-binary gender ☐ Man ☐ Gender not listed ☐ Unknown
		Self-Identified Disability	☐ Yes ☐ No	**Rural Area**	☐ Yes ☐ No
Victimization	☐ Domestic Violence ☐ Sexual Violence ☐ Stalking ☐ Elder abuse ☐ Caregiver abuse ☐ Human trafficking ☐ Other: _____	**Sexual Orientation**	☐ Straight/heterosexual ☐ Lesbian ☐ Gay ☐ Bisexual ☐ Queer ☐ Sexual orientation not listed ☐ Unknown		
		Language	☐ English ☐ Spanish ☐ Other: _____		
Core Services Provided to Client	☐ Crisis Intervention ☐ Safety Planning ☐ Information & Referral ☐ 1:1 Advocacy ☐ Shelter: Facility ☐ Shelter: Hotel ☐ Support Group ☐ Therapeutic Counseling ☐ Civil or Criminal Court Advocacy ☐ Transportation ☐ Medical Accompaniment ☐ Language Services	**Targeted Services Provided to Client**	☐ Mobile Advocacy ☐ Parenting Support ☐ Immigration Assistance ☐ Civil Legal Representation ☐ Supportive Housing (e.g. Transitional Housing) ☐ Navigating County Human Services (e.g., child welfare, TANF, etc.) ☐ GED / Adult Education ☐ Substance Abuse Support ☐ Other: _____		

End Time _____ AM / PM

Feedback Opportunity: Advocate Input

Please share your thoughts with CPR

Please answer the following questions about your experience with completing the assessments and surveys with the client.

1. Were there any specific challenges to completing the assessments and surveys?

2. What did you like about the assessments and surveys?

3. If you could change anything about these assessments and surveys, what would it be?

Please use this space to leave additional notes for the CPR evaluation team. For example, this can include notes about what it was like to use these forms, whether they were helpful or unhelpful, questions that came up, difficulty answering a specific item, etc. **Use the back of this sheet if you need more space.** Please be as specific as possible and please note that these will only be reviewed AFTER the pilot has been completed. If you have more urgent questions/concerns, please share them with the point person at your organization.

Appendix C: Definition of Core Services and Targeted Services

[This handout was provided to advocates at the training]

You will select which of these services was provided to the client. If the service is offered by your organization but this individual client did not access it, you will not select it on Form C.

Core Services:

Crisis Intervention: Staff or volunteers may provide emotional support and/or safety planning with a victim of domestic violence or on the behalf of a victim.

Safety Planning: After identifying sources of risk, engaging in a conversation with a client about what they have tried, and talking about additional strategies that may enhance their ability to safely navigate batterer- and life-generated risks.

Information & Referral: After identifying sources of need, engaging in an educational conversation about the dynamics of domestic violence and/or engaging in conversation regarding potential community resources and providing the name and contact information for other service entities.

1:1 Advocacy: An array of services that a program may provide for an individual client. Services include advocacy, counseling and therapy. This category is distinctly different from crisis intervention in that it goes beyond providing immediate crisis intervention assistance.

Shelter - Facility: Provided overnight accommodations at a shelter building which is owned or rented by the advocacy organization.

Shelter – Hotel: Provided overnight accommodations at a location which is a hotel or motel where such lodging is paid for by the advocacy organization.

Support Group: Refers to the category of supportive services for two or more individuals, which can be facilitated by staff, volunteers, and/or peers. Types of support groups include and are not limited to women's support group, men's support group, or financial assistance group.

Therapeutic Counseling: Refers to clinical services provided at the organization by a licensed mental health worker whose position is to provide mental health care to clients of the organization.

Civil or Criminal Court Advocacy: Refers to the category of advocacy services in which information about court systems is provided, and/or a client is accompanied by an advocate to court proceedings. This does not include legal representation, nor does it include legal referrals.

Transportation: Refers to an employee or volunteer driving a client to an appointment or errand, or paying for the client to access other transportation (ie. public transportation vouchers, taxis).

Medical Accompaniment: Refers to when a client is accompanied by an advocate to a medical appointment.

Language Services: Refers to utilization of an interpreter, bilingual advocate, or other technological means to facilitate meaningful advocacy for a client who is a speaker of a language other than English.

Targeted Services:

Mobile Advocacy: Refers to employees or volunteers, as part of their job duties, meeting clients at venues other than a Residential or Non-residential service site for the purpose of conducting advocacy. Such venues include locations chosen to accommodate the safety and convenience of the client (e.g., going to a client's home, meeting at a library or restaurant). This box should not be checked if the Offeror's employees or volunteers only travel to meet clients at locations where the employee or volunteer is providing social service or court accompaniment.

Parenting Support: Refers to a distinct offering, such as a curriculum-based group, provided by the advocacy organization which focuses on supporting survivors in their parenting role. This does not include providing child care or a children's group.

Immigration Assistance: Refers to services provided by the advocacy organization which meaningfully facilitate a survivor's access to immigration legal services (ie. as a BIA immigration provider). This does not include making a referral to an immigration advocacy organization or immigration lawyer.

Civil Legal Representation: Refers to legal representation services provided by an attorney on staff at the advocacy organization.

Supportive Housing (e.g. Transitional Housing): Refers to provision of longer-term (beyond emergency) housing which is provided by the advocacy organization for domestic violence survivors. Supportive housing also includes longer-term housing which is paid for by the advocacy organization on behalf of domestic violence survivors.

Navigating County Human Services (e.g., child welfare, TANF, etc.): Refers to the category of advocacy services provided by an employee who works for a dedicated portion of their time at a social service location (e.g., a TANF program, or Child Welfare office) in which information about human services is provided, and/or a client is accompanied by an advocate to a human service appointment.

GED / Adult Education: Refers to services provided by the advocacy organization to assist domestic violence survivors in advancing their educational attainment (i.e. individual tutoring or GED classes are conducted by organization employees or volunteers). This does not include making referrals for education services.

Substance Abuse Support: Refers to services provided by the advocacy organization alone or jointly with a community substance abuse treatment organization in which domestic violence survivors receive group or individual support for use of chemical substances (i.e. a Seeking Safety group, an AA group hosted at the advocacy organization location, a recovery-oriented group co-run by an advocate and Clinical Addictions Counselor).

Other – _____ : If there is another targeted service provided by the advocacy organization which was provided but is not included in the list above, please write in the service name here.

Appendix D: Correlation Matrix

Correlations Among Services and Average Change in MOVERS First and Last Assessments (N=69)

		Internal Tools (*n*=69)	Expectations of Support	Trade Offs◊
Service Length (days)		*ns*	*ns*	.293*
Number of contacts between first and last MOVERS		.268*	*ns*	*ns*
Percentage of needs met		*ns*	*ns*	*ns*
Number of core services provided		.425**	.306*	*ns*
Number of targeted services provided		*ns*	*ns*	*ns*
Total number of services provided (core + targeted)		.384**	.288*	*ns*
Total number of contacts		.246*	*ns*	*ns*
Core Services	%(n) received this service (N=69)			
Crisis intervention	51% (35)	.314**	.243*	*ns*
Safety planning	67% (46)	.353**	.293*	*ns*
Information & referral	86% (59)	*ns*	*ns*	*ns*
Advocacy	52% (36)	.405**	.356**	*ns*
Support group	10% (7)	*ns*	*ns*	*ns*
Counseling	39% (27)	.263*	*ns*	*ns*
Court advocacy	48% (33)	*ns*	*ns*	*ns*
Transportation	4% (3)	*ns*	*ns*	*ns*
Language	4% (3)	*ns*	*ns*	*ns*
Targeted services				
Mobile advocacy	20% (14)	.334**	.361**	-.337**
Parenting support	13% (9)	*ns*	*ns*	*ns*
Immigration	49% (34)	.276*	*ns*	*ns*
Supportive housing	16% (11)	*ns*	*ns*	*ns*
Civil legal representation	48% (33)	*ns*	*ns*	*ns*
Navigating human services	46% (32)	-.261*	*ns*	*ns*
Adult education	6% (4)	*ns*	*ns*	*ns*

** p < .05, ** p < .01* -- Shelter, medical accompaniment, and substance use support are not included due to low sample size of clients who received this service (i.e., 0-2 client only). ◊A negative change over time in trade offs represents an *improvement* in survivors' empowerment related to safety. Note that this is pilot data and should be interpreted with caution.

Appendix E: Services Provided

Number of Percentage of Clients Who Received Core and Targeted Services (N=90)

Core Services	%(n) received this service (N=90)
Information & referral	82% (74)
Safety planning	63% (57)
Crisis intervention	49% (44)
Court advocacy	46% (41)
Advocacy	43% (39)
Counseling	32% (29)
Support group	8% (7)
Transportation	6% (5)
Language	4% (4)
Targeted services	
Immigration	49% (44)
Navigating human services	43% (39)
Civil legal representation	39% (35)
Mobile advocacy	24% (22)
Supportive housing	13% (12)
Parenting support	11% (10)
Adult education	4% (4)

Appendix F: References

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