Assessing needs and measuring outcomes for survivors of domestic violence

Final report of the Colorado self-sufficiency matrix evaluation

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About CPR

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Contents

Executive Summary

The Colorado Domestic Violence Program (DVP) contracted with the Center for Policy Research (CPR) to evaluate the self-sufficiency matrix (SSM) in Colorado's DVP programs. This report details Phase I of the evaluation, which includes (1) a literature review, (2) a survey of DVP-funded programs' staff, (3) interviews with DVP-funded programs' staff, and (4) interviews with subject matter experts.

Method

The literature review yielded little research on the SSM, and no articles addressed its use with DV populations. Most of our data on the SSM in DV settings comes from our interviews with 44 DVP-funded programs (**92% response rate**). Participants included executive directors, supervisors, case managers, administrative staff, and frontline advocates. Approximately 64 individuals participated in the interviews. We also interviewed 5 national and local experts.

The SSM for Case Management

Perspectives on the SSM for individual case management with survivors varied. Those who had the most **positive experiences** reported (a) the SSM scores were co-created through conversations between advocate and survivor, (b) the SSM was used with long-term clients where there was an opportunity for change to show, and (c) the SSM was a useful guide for service delivery. DVP-funded program staff reported more **neutral experiences** when their existing intake process was considered more useful, so the SSM was perceived as duplicative and time consuming. Finally, participants reported **negative experiences** with the SSM when it was (a) perceived as a barrier to building trust with survivors, (b) given to survivors as a self-administered survey, or (c) used with clients who were short-term, where there was not enough time to see change.

Implementation Reliability of the SSM

Participants discussed several **training and implementation** issues, which led to inconsistency in SSM implementation. Participants shared their confusion over (a) the purpose of using the SSM; (b) how to adjust the tool to work with DV clients; (c) how to ask questions and gather information to score the SSM; (d) how to implement the SSM into practice, including which domains to use and when to assess clients; and (e) proper training protocols, including how to train new advocates. As a result, implementation of the SSM varied across programs and advocates within programs.

The **domains** used by programs and with clients varied, often with each client being assessed on different domains—sometimes different domains at post than at pre. Notably, there was no

single domain that was used or rated consistently—not even relationship safety. The **process** used to collect SSM data also varied. Some programs provided the SSM to clients like a survey, with no advocate input; others programs had staff complete the tool without direct survivor input. Most programs completed an SSM assessment with a flexible combination of approaches designed to enhance efficiency, which varied within and between clients.

Provided with limited guidance, programs developed their own **timing and systems for the baseline, follow-up, and exit assessments**. Although nearly all of the programs with shelters completed SSM assessments with shelter clients, SSM administration with other clients and services (e.g., nonresidential services) varied. The timing of assessments also varied, as DV services can range from 1 to 2 contacts, to months or years of contact. Finding an appropriate time to do the assessment is another challenge because many survivors access services when they are in crisis and it would be inappropriate and unsafe to conduct an SSM. As a result, baseline assessments were taken (a) after a specific number of contacts, (b) retroactively, or (c) days or weeks after accessing services. Notably, existing SSM baseline data includes both pre and "during services" assessment. Follow-up assessments were taken (a) after a specific number of contacts; (b) retroactively; (c) days, weeks, or months after accessing services; (d) when advocates felt changed occurred; or (e) when survivors obtained a specific SSM score.

The Accuracy of the SSM as Applied to Domestic Violence

Participants noted that **the SSM does not accurately capture the needs of or additional barriers to accessing resources for the most overburdened, marginalized, or underserved populations.** Populations mentioned include undocumented survivors, survivors whose first language is not English or who do not speak English, LGBTQ survivors, minor and elderly survivors, survivors of color, rural survivors, and survivors with a disability/different ability. In general, participants felt the SSM focused on clients who can access resources, qualify for public assistance, and do not have language or other barriers.

DVP-funded program participants and SMEs expressed near unanimous concern that the SSM does **not accurately account for DV,** including (a) the safety of survivors and their children, (b) abusers' control over or impact on survivors' SSM scores, or (c) the tradeoffs and non-linear paths involved in survivor well-being, safety, and self-sufficiency. For some survivors, a positive change score in an SSM domain reflects a decrease in overall well-being. For others, a negative change score in an SSM domain can reflect an increase in overall well-being. Because the SSM is worded to measure family or household self-sufficiency, it may not work well with DV clients, where abusive partners typically control household self-sufficiency resources. Finally,

respondents do not believe that the SSM captures the most important aspects of DV (e.g., safety, control), nor does it speak to the type, quality, or impact of services provided by DV programs.

Resources Required to Implement the SSM

Many respondents reported concerns about the amount of time it takes to generate SSM data, which was estimated to take about 1 hour per assessment. In addition, 35% (*n*=17) of programs mentioned that the SSM created duplicate work. Another efficiency concern is the great number of baseline SSMs completed with clients who only receive 1 to 2 contacts and do not engage in services long enough to complete a follow-up.

Summary of Findings and Recommendations for Phase II

The SSM holds promise as an additional tool in a DV advocates' case management "toolbox." To improve its utility, respondents recommend additional adjustments to the tool, such as improving its cultural relevance. Our evaluation findings are clear, however, that the SSM is not an effective tool for describing or evaluating DV program performance.

Given the wide variety of service needs and the survivor-driven nature of DV services, there is no standardized or coordinated needs assessment form being used across Colorado programs or at the national level. A standardized needs assessment tool would be useful to DVP, CDHS, and DV programs, as well as contributing to the national literature. We also recommend that Phase II include a pilot of an existing client-level outcome survey, MOVERS (Measure of Victim Empowerment Related to Safety; Goodman, Thomas, & Heimel, 2015). MOVERS is a promising tool because it measures empowerment, which is 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 extensive DV stakeholder input specifically to measure the impact of DV services and has been subjected to a quality validation and reliability study.

For Phase II, CPR proposes to (1) review existing needs assessment tools in use by DVP-funded programs and draft a shared tool that captures the most common needs stated in existing tools; (2) review, edit, and finalize the tool with DVP and stakeholder input; and (3) design and conduct a small pilot at 1 to 2 sites. This pilot will seek to identify (a) the reliability and accuracy of the new Colorado DV Needs Assessment; (b) the applicability and fidelity of MOVERS in Colorado programs; (c) the time and resources required to implement the new Colorado DV Needs Assessment and MOVERS; (d) the best practices and guidelines for implementation of the new tool and MOVERS, including the timing of assessments and their integration with existing practices; and (e) the best practices and guidelines for data analysis and reporting to DVP.

1.0 Introduction

1.1 Evaluation Project Overview

In March 2014, the Colorado Domestic Violence Program (DVP) initiated a task force and hosted a forum 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. As a result of this task force, five outcomes were chosen:

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.

However, there were very few measures available for DVP to review, which reflects the national landscape of DV services evaluations (see next section). After a review of available tools, DVP chose the self-sufficiency matrix (SSM) for advocates to measure outcomes 2 and 3 for reporting back to DVP. The SSM consists of 21 domains (e.g., food, housing, relationship safety, employment), each ranging from 1 (in crisis) to 5 (thriving).

As part of this ongoing process to identify appropriate outcomes and tools for DV programs in Colorado, DVP contracted with the Center for Policy Research (CPR) to evaluate the SSM, its implementation, the appropriateness of its use in Colorado's DVP-funded programs and, if necessary, possible alternatives to the SSM. Please see Appendix A for the SSM provided to programs.

This report details the method and results from Phase I of the evaluation. For Phase I, CPR collected, analyzed, and summarized data with the following approaches:

1. a survey of DVP-funded programs' staff,
2. a literature review,
3. interviews with DVP-funded programs' staff, and

4. interviews with subject matter experts with a "Member validation"[1] presentation and solicitation of feedback about the preliminary results.

1.2 The National Landscape of Evaluating DV Services

Increasingly, policymakers and funders request information from nonprofit programs to demonstrate that services improve the well-being of clients (Macy, Giattina, Sangster, Crosby, & Montijo, 2009). DV programs have been increasingly building their capacity to conduct evaluations of their services, even though there is no dedicated federal funding source for DV programs to do so. Most work on the impact of DV services comes from time-limited research and evaluation projects, typically funded through a single grant.

So far, research demonstrates that DV services are linked to positive outcomes for DV survivors and their children (Sullivan, Warshaw, & Rivera, 2013; Sullivan, 2012a-c; Sullivan, 2016; Warshaw, Sullivan, & Rivera, 2013). Furthermore, an evidence-supported theory of change describes *how* services are linked to these outcomes (Sullivan, 2016). There are, however, challenges (some unique, some shared with other fields) to conducting research or evaluation on DV services (Sullivan, 2011). These unique challenges have served as a significant barrier for research and evaluation on DV services, particularly multi-site or state level evaluations, and include:

See Appendix B for more about why these are unique to DV services, and why they create unique barriers for evaluation.

- unique and serious **safety** concerns for many reasons, including that client safety can be at risk *due to seeking services*;
- **federal statutory safeguards** on client data; and
- **no universal service** provided to clients, as well as an ongoing and unresolved national debate about which outcomes are appropriate for DV programs.

Recognizing these unique challenges, in 2015-2016 the U.S. Department of Health and Human Services, Assistant Secretary of Planning and Evaluation, funded a special project to identify areas of opportunity to address these challenges. Center for Policy Research and the National Resource Center on Domestic Violence partnered on this project, which involved (a) a systematic literature review on DV services and interventions evidence; (b) a framing paper describing the current evidence, challenges to evaluating DV services, and areas of opportunity for addressing these challenges; (c) a roundtable of SMEs (on DV research and practice, as well as representatives from non-DV related fields) and federal staff; and (d) an internal paper of key

[1] Member validation is a technique to check preliminary interpretations with the key stakeholders and to confirm that the interpretations match the experiences of the group. In this project, member validation occurred with staff from DVP-funded programs.

areas of opportunity and research/evaluation priorities of the DV field. Still, there are currently **few outcome measures that are appropriate for DV program evaluation** (Goodman, Cattaneo, Thomas, Woulfe, Chong, & Smyth, 2015; Kulkarni, Bell, & Rhodes, 2012; Song, 2012; Sullivan, 2011). This evaluation sought to determine whether the SSM had potential to address this gap.

1.3 A Literature Review of the Self-Sufficiency Matrix (SSM)

In late 2015, CPR conducted a literature review about the self-sufficiency matrix. The following search terms were used in a variety of combinations: self-sufficiency, matrix, tool, outcome, evaluation, needs, client, assessment, case management, measure, domestic violence, intimate partner violence, and intimate partner abuse. Using these terms, we (1) searched electronic, peer-reviewed journal articles in ProQuest; (2) searched electronic, peer-reviewed journal articles in Google Scholar; (3) then expanded the search in ProQuest to include non-peer reviewed articles and dissertations; and (4) due to an absence of literature, searched publicly available research and evaluation reports via simple Google searches.

History and Development of the Self-Sufficiency Matrix (SSM)

The history of the SSM development is **not well documented**, but several sources indicate SSM development began in the 1990s in the U.S., and that the work of Pearce and colleagues was instrumental in setting self-sufficiency standards (Fassaert et al., 2014; Pearce, 2011).

This history of the SSM development is not well documented or widely available.

The Snohomish County SSM (2004) may be the original version of the SSM used today, although the SSM development timeline is somewhat unclear. This 25-domain SSM was developed by a taskforce in Snohomish County, Washington. The report recommends that the SSM be used to measure family progress or maintenance at three points in time.

In addition, the Snohomish County taskforce set forth a vision for SSMs as tools for:

- case management,
- self-assessment,
- organizational management,
- measurement, and
- communication and dissemination to the broader community and funders.

However, we were unable to find an empirical study or evaluation to confirm whether the SSM should be used for these purposes. In addition, we did not locate any empirical study on the use

of this tool, nor its psychometric properties (e.g., reliability, validity). We located three manuals for SSM implementation (Colorado Family Support Assessment 2.0, 2015; Lauriks, Buster, de Wit, van de Weerd, Theunissen, Kikkert, Schonenberger, & Fassaert, 2013; Snohomish County SSM, 2004), only one of which included details about follow-up timing intervals (Colorado Family Support Assessment 2.0, 2015).

This manual specifies the following:

- Families must **consent** to completing the CFSA before collecting data.
- The SSM is designed for **families with children**.
- The baseline should be completed **before service receipt**.
- A **minimum of 30 days is** required between assessments, with the following recommendations:
    - the first follow-up is **90 days post-baseline**,
    - the second follow-up is 180 days post-baseline (90 days after first follow-up), and
    - ongoing follow-ups occur every 3 to 6 months.

Overall, there was surprisingly little detailed information about the SSM, including its development, populations it has been used with, guidelines for use, and reliability or validity studies. While we found some information about other various forms of an SSM (see Appendix C), these studies used a different version than the one used by DVP. In addition, we were unable to find information about the use of any SSM with a DV client population.

1.4 Survey of DVP-Funded Program Staff

In September 2015, CPR conducted a survey of DVP-funded program staff at the Colorado DVP orientations. The goals of the survey were to learn more about (1) DVP-funded programs' use and perceptions of the SSM, and (2) the current met and unmet needs of DVP-funded programs' clients.

CPR administered the survey to program staff at four statewide orientations conducted by DVP and held in Pagosa Springs, Denver, Avon, and Fort Collins, Colorado in September 2015. A total of 63 staff completed a survey, generating a 73% response rate. Most respondents were executive directors (49%), followed by direct services staff (19%). Overwhelmingly, most staff (79%) reported that their program used the SSM to assess client needs and track progress. Although it was not a specific question on the survey, during analyses we found that 16% of respondents reported that their agency used multiple tools to assess client needs and track progress.

In all, 43% said that the SSM was the most effective tool for assessing client needs and tracking progress. In addition, 86% reported that their staff is at least somewhat satisfied with the SSM. **However, 51% either skipped the question about their satisfaction with the tool or wrote "I don't know" on the survey.** Thus, there may be some mixed feelings or uncertainty about the SSM. Overall, however, this survey demonstrated that many participants were either hopeful about the SSM's potential in DV settings and/or willing to work with DVP to give it a try.

In the final section of the survey, respondents first listed the top 5 needs of their clients. Second, they were asked whether their program provided that service, and whether their program should provide that service. Finally, they were asked whether the community provided that service, and whether the community should. Unsurprisingly, the top need was **housing** (*n*=44). **Legal services** were another top need among clients (*n*=29), and public and private **transportation** (*n*=25) was another. More details about the results from this survey are reported in Appendix D.

Many participants were either hopeful about the SSM's potential in DV settings and/or willing to work with DVP to give it a try.

We made every effort to keep this final report brief. This document focuses on the main evaluation findings. However, you can find more detail in the appendices about:

- the SSM provided to DVP-funded programs,
- unique challenges to evaluating DV services,
- the CPR evaluation method,
- findings from both the literature review and DVP-funded program staff survey, and
- quotes from DVP-funded program staff and subject matter experts on issues related to implementation, the accuracy of the SSM for DV settings, and resources needed to implement the SSM.

2.0 SSM Evaluation Method

2.1 Guiding Evaluation Questions

CPR's evaluation was centered on learning from DVP-funded programs about their experiences with using the SSM or reasons the program chose not to use the SSM. Overall, our guiding evaluation questions were as follows:

1. Can the SSM be used as a case management or supervision tool?
2. Can the SSM be used to describe, monitor, and/or evaluate the performance of domestic violence programs and/or community resources/barriers to community resources?
3. For each of the above questions:
    - If so:
        - with what clients or populations?
        - at what intervals?
        - using what process?
        - how the data are best analyzed and reported?
        - what modifications would improve its usefulness?
    - If not:
        - why not?
        - would modifications help?
        - what else could be used for this purpose?

2.2 Participant Recruitment and Sample

DVP-Funded Program Staff

All 48 DVP-funded programs were invited to participate via an email. This email specified that we were an independent evaluation agency, participation was voluntary, and they would receive a $25 e-giftcard to Starbucks for participating. Most interviews were 30-60 minutes, and 1-3 people participated in each interview.

We conducted interviews with 44 programs (92% response rate). Geographic representation was good, with 82% of urban (n=9), 100% of suburban (n=11), and 92% of rural (n=24) programs included in the study. In addition, 80% of specialized programs (n=8) were included in the study. Interviews included executive directors, supervisors, case managers, administrative staff,

and front line advocates. In all, approximately 64 individuals participated in the interviews (some additional staff joined late or left early).

Subject Matter Experts

92%

of DVP-funded programs in Colorado participated in an interview.

We sought national and local experts in the topic of conducting evaluation and assessments of program performance of DV agencies. In addition, we sought the expert experience of someone who had experience with using the SSM data at a countywide level. Interview topics varied slightly, depending on the specific background of the participant; however, the main purpose of these interviews was to obtain subject matter experts' (SME) feedback on whether the SSM is an appropriate tool to use in DV agencies for statewide program performance assessment and evaluation. See Appendix E for a list of the national experts.

Qualitative Data Analysis and Quality Assurance: Member Validation

Qualitative data were analyzed following the five-phase cycle described by Yin (2011). As part of the process, we completed a member validation check. Preliminary interpretations of the data were then presented back to DVP-funded programs. Specifically, CPR's Dr. Echo Rivera presented the preliminary themes to an audience of DVP-funded program staff (including some of the actual interview participants) in Vail, Colorado at the conclusion of the Colorado Advocacy in Action Conference (June 2016). Then, the presentation was recorded and made available to all DVP-funded programs. All participants were provided a feedback form and asked to respond to four questions. A total of 36 responses were submitted (21 feedback sheets from the in-person presentation and 15 online surveys that were available after the in-person presentation). Overall, respondents clearly indicated that the evaluation findings confirmed their experiences, perspectives, and recommendations. For more detail about the qualitative analysis and member validation, please see Appendix E.

"The findings overall confirmed what we have experienced."

"She captured everything our agency communicated."

-Member validation responses

3.0. The SSM for Case Management

We asked programs about their use of the SSM for individual case management and for supervision purposes. Lessons learned about the SSM for case management are presented in the following categories: (1) the SSM as a useful and empowering tool, (2) neutral perspectives about the SSM for case management, (3) negative perspectives about the SSM for case management, and (4) lessons learned about the SSM for case management. Please see Appendix F for more quotes related to this chapter.

Case Management Categories Presented in this Chapter

1. The SSM as a useful and empowering tool
2. Neutral perspectives about the SSM for case management
3. Negative perspectives about the SSM for case management
4. Lessons learned about the SSM for case management

3.1 The SSM as a Useful and Empowering Tool

Some participants discussed how the SSM was a useful and empowering tool for their program and clients. Overall, the following factors contributed to programs' positive experiences with the SSM as an individual case management tool:

- The SSM scores were **co-created** through conversations between advocate and survivor.
- The SSM was used with **long-term clients** where there was enough opportunity to see change on the SSM.
- The SSM provided the agency with a new, or additional, **quick "at-a-glance"** guide.

These positive experiences are highlighted below:

> You can go back later with the client and show them how they are doing so much better than they were initially. It can take that "my life sucks" attitude and segment it out a little bit, and **show the client that they are working hard and things are getting better**.

> It helps us to remember all the moving parts. It touches on every piece of a life, a healthy life. It creates a big picture, **helps us look at the little picture and big picture in one assessment.**

"It can take that 'my life sucks' attitude and segment it out a little bit, and show the client that they are working hard and things are getting better."

-Advocate

The SSM is useful. We can keep track of the victim, if they are getting better, if their situation is improving. For example, safety issues. At first they might be in-crisis but **after three months,** they might not be and will feel safer. Maybe because they got a restraining order or are in a shelter or not living with abuser, **it is good to see those changes**.

3.2 Neutral Perspectives about the SSM for Case Management

Several programs had more neutral perspectives about the SSM. Generally speaking, participants stated neutral experiences with the SSM when their intake or case management process already included the information on the SSM. Their existing method was considered more useful to that agency, so the SSM was perceived as duplicative work that did not improve case management practice:

"My impression was 'eh.' We are already doing this."

-Advocate

One of the things we do is extensive case management with our clients. The SSM didn't propel us into doing more case management with our clients than what we were already doing.

It is more of a general guideline for conversation when we talk about their needs. We are talking about a lot of that anyway. It didn't change anything.

3.3 Negative Perspectives about the SSM for Case Management

Participants also reported more negative experiences with the SSM. In general, programs that had negative experiences with the SSM for case management services reported that:

- the SSM was perceived to be a **barrier to building trust** with survivors, which research has already shown is positively linked to positive DV client outcomes.
- the SSM was given to survivors as a survey with **no conversation** with advocates.
- the SSM was used with clients who were **short-term** where there was not enough time to see change on the SSM, particularly if there was no **follow-up assessment**.

These issues are highlighted below:

"It can make them distrusting of our services..."

-Advocate

It can make them **distrusting of our services** if we tell them they are vulnerable, in-crisis, or how they feel.

So, if a survivor says they only want to talk about one thing**, it means we are taking control to switch to something on the**

matrix. It begins to feel like a **loss of self-determination**. They are used to a very scripted intake because of what they have to go through just to get services**. I don't want clients to feel like they have to be answering all these questions that they don't want to be talking about just to get services.**

It's not an open conversation. They think going over the specific questions on the form is more like being at DHS filling out a form, rather than having a conversation about where they want to go or what they want to talk about.

3.4 Lessons Learned about the SSM for Case Management

Based on these findings and our literature review, it appears that the SSM may be **only useful as a case management tool for clients who are in services for at least 90 days**.

At the same time, our interviews suggest important limitations to the utility of the SSM in Colorado DVP-funded programs:

- It was useful as a **complementary** tool, used in combination with their case notes and personal experience/memory working with an individual client. Advocates did not talk about the SSM as a useful standalone case management tool.
- The SSM was useful when the program did **not find the SSM to be redundant** with their existing process. If the SSM is retained as a case management tool, we recommend that DVP review the alternative tools used by programs in an attempt to avoid redundancy.

Can a tool used for case management also work as an outcome evaluation measure?

While the economy of using the same tool for case management and evaluation purposes is appealing, each of these have different criteria to determine if they work. As a case management tool, staff can supplement the SSM with case notes and adjust their service delivery accordingly. As an outcome evaluation tool, however, context and nuance are gone and the reliability and accuracy are of critical importance. Simply put, if a tool is not giving you accurate or reliable data about program services and outcomes, then it should not be used for evaluating program performance. Furthermore, there are other factors—such as the anonymity of clients' responses that—must be considered.

4.0 Implementation Reliability

Because we were unable to identify a previous study on the reliability or accuracy of this version of the SSM with DV client populations or any population, our evaluation is a first step in this process. The remaining sections are organized by findings about the experiences of DVP-funded programs with using the SSM, and both programs' and SME perspectives about the use of the SSM for program evaluation.

This section includes what we learned about the reliability of the SSM. These findings include information from both staff/advocates at DVP-funded programs and SMEs. In all, 40 programs implemented the SSM by the time we conducted the interviews, 2 were in the planning phase and preparing to use the SSM and the remaining 2 were not using the SSM. The length of time programs had used the SSM varied: (a) from 7 or more years, (b) for a few years, (c) since October 2015 (approximately 6 months; most programs), and (d) a couple of months. Please see Appendix G for more quotes related to this chapter.

To learn about the reliability of the SSM, we asked each program about how they implemented the SSM at their agency. We organized implementation practices into the following categories: (1) What type of SSM training did/do programs receive?; (2) What domains are used?; (3) How is the SSM completed?; (4) Which clients receive an SSM, and when?

Reliability Categories Presented in this Chapter

1. What type of training did/do programs receive?
2. What domains are used?
3. How is the SSM completed?
4. Which clients receive an SSM, and when?

4.1 What Type of SSM Training Do/Did Programs Receive?

The initial training, provided by a DVP-contracted trainer, was conducted through four recorded webinars so that any who did not attend could access the recordings.

Participants noted several challenges with this initial SSM training, including:

- unclear messaging about the **purpose** of the SSM implementation, including whether the SSM data would or would not be linked to DVP funding;
- limited clarity about how to **adjust** the core structure of the tool to work with DV programs (e.g., household versus individual assessments);
- limited guidance about **how** to ask questions and gather information from clients;
- limited guidance on **core implementation details** (e.g., which domains to use, when to take assessments, with which clients); and
- most advocates did not complete the initial/official training (as they were not required), but rather received **informal training** from other advocates at their agency.

Part of the reason training content did not include key instructions on how to implement the SSM was because some of these procedures were not yet identified and/or so that programs could tailor the tool for their needs. Aware of these issues with this initial training, DVP conducted a series of follow-up webinars and made themselves available to provide ongoing technical assistance. Participants who took advantage of these opportunities **overwhelmingly found them to be helpful**,[2] and the follow-up webinars cleared up some misconceptions programs had about how to implement the SSM. Still, participants stated that their overall perception of the SSM was that its use was premature.

> **"It does often feel like DVP kinda jumps the gun in requiring something before the tool is fully developed."**
>
> -Advocate

> I think sometimes it feels like **DVP implements a requirement first before the tool has been adequately developed.** So it would definitely help us make sure that the SSM was being implemented in a consistent way, which would make the data much more reliable if we had those guiding questions prior to implementing the SSM. And even our organization we waited a long time to implement the SSM, I think we were supposed to start using it October of last year and now it's April and **we still don't have those guiding questions**. So it's really hard, we're doing it now to the best of our ability, but if we get those guiding questions next week it may change the way we use the SSM at our agency and then what does that mean for the data that we've already collected, is it completely useless? Is it inconsistent? So, it does often feel like DVP kinda jumps the gun in requiring something before the tool is fully developed.

[2] DVP staff capacity was somewhat limited in this area because staff did not directly have experience using the tool with DV survivors and had only received the same web-based training that was available to funded programs.

These findings demonstrate that there were some challenges with SSM training and implementation. As part of our evaluation we learned that Boulder County implemented the SSM in all publicly-funded programs in the county. According to participants, Boulder's initiative to gather evidence with the SSM fueled interest in choosing the SSM for use among DVP-funded programs. The factors cited to explain Boulder's successful experience with the SSM included clarity in the goals and purposes of the initiative by leadership, as well as the stated focus on the SSM as a tool for information gathering on county resources rather than for program evaluation. Another strength of the initiative was the time (years long) and effort spent to pilot the SSM, including staff training and attention to reliability. In addition, staff received comprehensive training on the SSM and a system was in place to provide ongoing training to new staff, as well as monthly "cohort meetings" for ongoing discussions about questions and challenges with rating the tool. Finally, follow-up assessments occur every 90 days, and the expectation was that programs would only complete a baseline assessment with clients where long-term case management was likely. For example, on the third or fourth visit, when services began to extend beyond an immediate safety crisis.

4.2 What Domains Were Used?

In light of the varied, survivor-driven nature of domestic violence services, DVP instructed programs to choose the domains that made the most sense for the work that their program does. Our evaluation found tremendous variation in the domains that programs used. For example, no single domain was chosen by all programs—not even the relationship safety domain.

No single domain was chosen by all DVP-funded programs.

Within programs, there was variation in the domains used for individual clients. Although many programs kept the 21-domain SSM, they changed the domains actually assessed from client to client. For example, a program may not have removed any domain from the SSM form, but the advocate would only rate the priority areas identified by the survivor (which is consistent with survivor-defined advocacy). However, with a different client, that same advocate might also rate domains that were not the survivors' priority, but because the advocate had the information they reported it on the SSM. There were no mechanisms in place for advocates to report this process to DVP, so the degree to which empty domains are missing versus not applicable versus not a priority is unknown.

> DVP told me not to fill out each domain, I said that to [advocates], to ask the client what they want to work on. **Figure out their priority—pick the specific ones.** ***[Question: So advocates are only filling out domains that are goals of the clients?]*** **Yes, though some fill out all of**

them. There was a drastic drop in information that was reported after we had that conversation—when advocates were only reporting priority domains.

One result of tailoring the domain for each setting and client is that nearly all programs were using different tools—often a different tool for each client, and at each assessment. This highlights the unique complexities and challenges involved with identifying a standardized or common service and/or outcome across multiple DV agencies or clients within agencies.

> **"I haven't removed any of the domains, but I may depending on the client."**
>
> -Advocate

4.3 How Is the SSM Completed?

With respect to the data collection process, programs reported that they had limited guidance on the process that should be followed to complete the SSM assessments. Resource limitations at the program level also affected the data collection process. Thus, programs used a variety of approaches to collect each SSM assessment.

Some **key highlights** from our evaluation include:

- Practice was ongoing and programs engaged in a process of implementation, reflection and learning, and adjustment.
- Some programs provided the SSM to clients like a survey, with no advocate input or ratings.
- Some programs completed an SSM assessment without direct survivor input.
- Most programs completed an SSM assessment with a flexible, undocumented combination of approaches designed to enhance efficiency, which varied within and between clients. These practices include:
    - conversations with clients
    - clients rate first, with a follow-up discussion
    - complement case notes with other sources of information
    - conversations with other advocates working with the survivor

Often as a cost efficiency measure, most programs were highly flexible and varied in the process used to collect each SSM assessment.

As with extreme variation in the domains used for each client, there were also variations in data collection practices, which lead to additional issues related to reliability. The following quotes highlight various methods used to complete the SSM and include (a) no survivor input, (b) self-administration by the survivor, and/or (c) a combination/mixed approach.

We don't sit down with a client and go through it. The clients we are having enough contact with and feel we can provide that information in the SSM, staff fill-out based on ongoing interaction with client. They know enough about what is going on in the client's life to fill out the information. Let's use a criminal client as an example: the legal advocate will spend time with them in the courtroom and probably after that time would fill out the baseline after they have spent time with them that day. At the end of the day or week, they fill it out based on their conversations with clients.

The majority of the time, they **hand it to the client** and the client might ask for clarification if they need. It is more of a survey for the client.

I would say probably **about 50/50 on whether the client is involved or we're doing it after we meet with the client.** It depends on the type of contact we have with the client. Some clients are very brief, and/or we don't have the depths of contact with them as we do with the other clients. So, I can look at the matrix and answer those questions without even asking the client on a lot of the domains after meeting with them for a while and knowing what their situation is.

> **"[It's] about 50/50 whether the client is involved or we're doing it after we meet with the client."**
>
> -Advocate

4.4 With Which Clients Is the SSM Used, and When?

Provided with limited guidance, programs developed their own timing and systems for the baseline, follow-up, and exit assessments. Nearly all of the programs with safehouses/shelters completed SSM assessments with shelter clients. For all other clients and services (e.g., nonresidential services), there were some differences in which clients were assessed. In addition, the timing of assessments also varied.

Baseline Timing

- specific number of contacts
- within a few days/same day
- weeks (e.g., 2 to 4 weeks)
- retroactive

Follow-Up/Exit Timing

- specific number of contacts
- weeks (e.g., every 2-4 weeks)
- months (e.g., every 30-90 days)
- when advocates believed change occurred
- when survivors obtained certain score ("exit" even if still in services)

Timing the assessment was challenging for DV programs. One complicating factor is that DV services range in length, with most services involving 1-2 contacts, but it can also extend to months or years of contact. Another challenge is finding an appropriate time to do the assessment. Many survivors reach out to programs when they are in crisis, and it would be an

inappropriate and unsafe time to focus on something like an SSM assessment.[3] The following comments illustrate this point.

> We do don't this on first meeting. People are in trauma and then it would be revictimzing. We work harder on deescalating and safety planning on first meeting. They have to feel safe and trust us before we can talk about some of these things.
> Because our first point of contact is in-crisis, it would be more of the fifth contact. We can look at where they were when we met and what their needs were then. Even the first three contacts are still crisis-mode and we find it inappropriate to have those conversations while still in crisis. At the fifth time, we can say ok now that you are through that, what do you feel like you need. We don't necessarily think people can think about their long-term needs in those moment so we wouldn't get that information anyway.

When an SSM baseline was actually completed varied across clients within a program, including the following criteria:

- after a specific number of contacts,
- days (or less than a day),
- weeks (e.g., 2 to 4 weeks), and
- retroactive assessment (e.g., at follow-up, their baseline scores were rated).

The net result is that the existing SSM baseline data includes clients who completed a baseline assessment before they had services or time to build a trusting relationship with their advocate; **SSM data also includes clients who had already received services or established this relationship**. While this is not necessarily an issue for case management, it is an evaluation problem because it results in baseline data that includes a combination of "pre" data, "during services," and/or "post" data.

> We used to joke that when people came to [The Agency], and they answered the question about substance abuse…They had no issues with substance abuse at all. **And then suddenly 30 days or a few months after they started working with the center, they developed a serious substance abuse problem, 'cause that's what the data shows. 'Cause you have that trust effect.**

Timing assessments is challenging, and right now the SSM baseline data includes a combination of both "pre" and "during services" data points.

[3] The focus of services at this time is to stabilize the crisis and engage in safety planning. An in-depth needs assessment, like the SSM, comes *after* an immediate crisis is mitigated and only when the survivor is ready to engage in that conversation.

For similar reasons, it was challenging to complete follow-up/exit assessments. Programs used different criteria:

- number of contacts,
- days (or less than a day),
- weeks (e.g., 2-4 weeks),
- months (e.g., every 30-90 days),
- when advocates felt changed had occurred, and/or
- when survivors obtained a specific rating (e.g., "stable").

These varying follow-up time points are highlighted in the quotes below:

> It is anywhere from **7 days after intake and beyond**, that is the mark we are using. It is such small numbers. If it is after 10 days and I am talking to someone, I can start to gauge their follow-up scores.

> During the first appointment, sort of evaluate how long we think we might be working with someone based on what we're trying to accomplish. So, and then assigning a midpoint to that. So we sort of do that **arbitrarily**, but **on a case by case basis.**

> **I determined when I believe they're stable, then I don't think I need to do them anymore.** That's sort of how I looked at them. **They're still coming** to the group because they really need that social support, they're learning, they're learning how to move on with their lives, **but they're stable, so I just don't see a need to continue to do [SSM assessments]**.

In addition, many participants discussed additional challenges with follow-up assessments, including (a) not realizing they were required, (b) lack of guidance on when they should be completed, and (c) difficulty with remembering to do the follow-up/exit assessment.

"It's anywhere from 7 days after intake and beyond."

"So we sort of do that arbitrarily, but on a case by case basis."

"I determined when I believe they're stable, then I don't think I need to do them [SSMs] anymore."

-Advocates

5.0 The Accuracy of the SSM as Applied to Domestic Violence

Reliability is about how a measure is implemented and can often be improved through training, additional resources, and ongoing monitoring. Validity (or accuracy), however, is about whether the tool can tell us what we want to know. That is, **can the SSM accurately describe, monitor, and/or evaluate the performance of DV programs?** To gauge whether the SSM generates information that is useful to assess DV clients, we asked stakeholders about its accuracy in DV program settings. Please see Appendix H for more quotes related to this chapter.

We organized accuracy-related findings into the following categories: (1) Is the SSM culturally relevant?; (2) How well does the SSM capture domestic violence?; (3) How well does the SSM measure individual DV survivors?; and (4) Does the SSM work as an outcome measure for DV services?

Accuracy Categories Presented in This Chapter

1. Is the SSM culturally relevant?
2. How well does the SSM capture domestic violence?
3. How well does the SSM measure individual DV survivors?
4. Does the SSM work as an outcome measure for DV services?

5.1 Is the SSM Culturally Relevant?

Participants raised concerns **the SSM does not fully work for the most overburdened, marginalized, or underserved populations**. Specifically, participants discussed how the specific needs of and additional barriers to resources and safety—which are related to self-sufficiency—were either not captured at all or not captured fully in the SSM for:

- undocumented survivors,
- survivors whose first language is not English or who do not speak English,
- LGBTQ survivors,
- minor and elderly survivors,
- survivors of color,
- rural survivors, and
- survivors with a disability/different ability.

In general, the concern with the SSM data is that it may tell the story of those who can access resources, but does not include some of the *most important* barriers for self-sufficiency faced by some of the most underserved DV clients. This limits the ability to use the SSM data to identify the most urgent or most impactful areas of opportunity to address these significant barriers to self-sufficiency or well-being. Please see Appendix H for more quotes.

> If you don't know the language, it is important because… **Some people think that they don't want to move ahead in life, but when you go to apply for benefits, they don't have forms in Spanish or people don't want to help them or talk to them.**
>
> It might show that LGBT folks aren't moving very far on the scale, **but it might not address the actual barriers preventing that from happening, like the institutionalized oppression and violence**. In terms of the tool identifying trends, it won't help us show experiences that are especially terrible like with law enforcement having an especially homophobic response.

"It's really telling the story of those who can access resources, qualify, and don't have language or other barriers."

-Advocate

5.2 How Well Does the SSM Capture Domestic Violence?

There was near unanimous concern from DVP-funded program participants and SMEs that the SSM does **not accurately account for DV**[4]. The main concerns were that the SSM does not account for (a) the safety or safety concerns of survivors and their children, (b) abusers' control or impact on survivors' SSM scores, nor (c) the tradeoffs and non-linear paths involved in survivor well-being, safety, and self-sufficiency.

Survivor Safety

Interview participants shared examples of how the SSM domains did not appear to be developed in a way that took DV survivors' safety into account.

> **Somebody feels safe in their home *some* of the time? [Yet] They're considered *safe*?** There's a number of examples around that where you look at that and say, 'Who in the world came up with these categories?'" (SME)

[4] Again, the SSM was not intended to be used specifically by DV advocates with DV clients. This is not a critique of the initial developers of the SSM, but rather highlights the complexities involved with applying a tool in a non-DV setting to a DV-setting.

For example, childcare. Let's say that it is the **abuser's mom who is the caretaker**, the safety of the kids would continue to be jeopardized. Because the abuser knows where the kids are or the mom is making the survivor feel guilty for leaving. **So it doesn't present a clear picture** to score. We try to score at this moment in time, with the caveat that the situation could change.

Abusers' Control

Participants also discussed how the SSM does not account for the ways abusive partners or ex-partners control the survivor or the survivors' self-sufficiency ratings.

A lot of the questions **don't account for the ways the abuser could manipulate or control the survivor**. So you are scoring the person in front of you but a lot of the score has to do with the abuser's behavior. It continues to be a weakness in the tool.

> **"A lot of the questions don't account for the ways the abuser could manipulate or control the survivor."**
>
> -Advocate

Well [consider the domain] Life Skills... We have some ladies who come in here who have never managed money. Never. The husband kept the checkbook. They might have even worked, but they weren't even allowed to go to the bank with it. They had to hand it over to the husband. But on the flip side, they kept an immaculate home. They cooked, they cleaned, they were great parents. So as far as their house skills and capacity to manage household, they have that. But as far as money management, they'd be a two.

Trade-Offs and the Non-Linear Path to Safety and Well-Being

Finally, participants challenged the applicability of the SSM's linear path of well-being to DV clients. They note that DV survivors have unique challenges, including that ending an abusive relationship does not always end the abuse, improve their self-sufficiency, nor increase their well-being.

The word "success" concerns me a bit because a lot of times **people may slip backward by no fault of their own**. Let's say we're working with someone and she has a job so she scores a five. **But then the perpetrator won't let her go to work so she loses the job and she's back down to a one**. I wouldn't consider that a failure and so the word success kind of intimates a failure associated with it, so that would be my only concern.

Clients with their abuser come in employed because they have transportation. But they may leave unemployed because they no longer have access to transportation, so they will go down. **They had to give up their situation to be in a shelter. To be safe, they had to give up certain things—like employment, childcare.** In shelter, we can't pay for that. So their situation changes in shelter and might reflect badly on us.

As a result, for some survivors, a **positive** change score in an SSM domain can actually mean a **decrease** in overall survivor well-being, safety, and/or self-sufficiency. For others, a **negative** change score in an SSM domain can actually reflect an **increase** in overall well-being, safety, and/or self-sufficiency. For example, the relationship safety domain may increase if the survivor ends the relationship. At the same time, the abuser may stop making payments on the car as a form of post-separation violence—both of which indicate a negative SSM change score in the transportation domain.

A -SSM change score could actually mean there was also an increase in overall survivor well-being, safety, and/or self-sufficiency.

A +SSM change score could actually mean there was also a decrease in overall survivor well-being, safety, and/or self-sufficiency.

5.3 How Well Does SSM Measure Individuals?

The SSM is worded, and typically used, to measure family or household self-sufficiency of clients in a family resource center (where there is at least one parent and one child). The assumption within that is that the individuals within the household share self-sufficiency and can readily have one shared SSM score. Participants noted, however, that this did not apply well to their DV clients.

> **"You are having to carve the abuser out and score the remaining family, and that is not exactly how it works."**
>
> -Advocate

In DV situations, an abusive partner often controls or withholds the self-sufficiency resources within the household. As a result, there were many situations where, due to the abusers' control, survivors could have two different SSM scores within the same domain. For example, the household may technically own a car, but the abusive partner controls when the survivor can use the car. As one advocate said:

> The tool in its purest form is about the family. [But, for DV clients] you are having to carve the abuser out and score the remaining family and that is not exactly how it works.

5.4 Does the SSM Work as an Outcome Measure for DV Services?

Finally, and perhaps most importantly, respondents do not believe that the SSM captures the most important aspects of DV, DV survivors' well-being or self-sufficiency, or DV services. **An outcome is a change in clients' knowledge, attitude, skills or other areas that occurred due to the services provided by a program** (Rossi, Lipsey, & Freeman, 2004; Smith & Hope, 2014, p. 42;

Sullivan, 2011, p. 35). **The SSM data, however, do not speak to the type, quality, or impact of services provided.**

> And we all know that a lot of these issues have to do with factors outside of the program's control. If they're interested in understanding what programs are doing to assist people and make their lives better, this type of tool doesn't do that because there's no link with what the program did. (SME)

This is because a change in SSM scores could reasonably be due to any combination of the following:

- survivors' priority at the time,
- survivors' motivation to work on that domain (if a priority),
- survivors' later disclosure of a stigmatizing behavior (e.g., details only emerge after baseline already complete, after trust was developed),
- abusers' previous behavior (e.g., damaged survivors' credit),
- abusers' ongoing behavior (e.g., stalking survivor at work),
- program performance and services provided,
- available community resources for all community members (e.g., transportation infrastructure),
- community barriers for DV survivors (e.g., SNAP eligibility or application policies that put survivors' safety at risk), and
- discrimination and inequity that disproportionality burdens marginalized survivors.

> **"And we all know that a lot of these issues have to do with factors outside of the program's control."**
>
> -Subject matter expert

Indeed, we also learned that baseline SSM data from the Boulder county initiative have been useful in better understanding shared needs of clients at the time of services. Boulder county uses SSM data for ongoing discussions about community resources and attention to safety net resources for Boulder county residents. However, it has been more challenging to interpret the causes of and take action based on SSM change scores. At the time of the interviews, Boulder County was working on ways to better understand what, specifically, influences the change scores. In addition, after approximately 7 years of working with the SSM, Boulder County is now moving towards the adoption of a different (but similar) tool—the Colorado Family Support Assessment 2.0.

6.0 Resources Required to Implement the SSM

Finally, participants talked about the resources required to implement the SSM. These are presented in the following categories: (1) time taken to complete the SSM, and (2) most clients do not receive a follow-up SSM. Please see Appendix I for more quotes related to this chapter.

Resource Categories Presented in this Chapter

1. Time taken to complete the SSM.
2. Most clients do not receive a follow-up SSM.

6.1 Time Taken to Complete the SSM

Many respondents reported concerns about the amount of time it takes to generate SSM data. In many cases, it took about 1 hour per assessment[5], which is approximately 3 hours total per survivor who completes a baseline, follow-up, and exit (1 hour per assessment, 3 assessments). In addition, 35% (*n*=17) of programs mentioned that the SSM created duplicate work. Naturally, this is seen by programs as taking away valuable time from advocacy and support services.

> If you calculate the time to do 200 initial SSMs and then another 100 drop-off (no follow-up) that is 200 hours plus follow-up which maybe takes half hour and you do 3 follow-ups in a year. **An organization is spending hundreds of hours. We could all hire our own part-time researcher with all that time.** And DVP isn't offering more money to do this since it is taking away from services and then finding the resources that they are needing. It is an **inefficient** way to get what they want.

> **"A lot of programs don't have that time but have the pressure of getting it done."**
>
> -Advocate

> It takes at least an hour to complete it. It is very time-consuming. **A lot of programs don't have that time but have the pressure of getting it done** so that would lead to the matrix being completed inappropriately. **They will find a way to get it done but it won't be accurate.**

[5] While it is likely that this time estimate is most applicable to situations where all 21 domains were asked of a client, we were unable to confirm this pattern due to the finding that the number of domains used varied by client, within a program.

6.2 Most Clients Do Not Receive a Follow-Up SSM

Another downside to using a time-consuming tool like the SSM is its limited applicability to most DV program clients, because many only receive 1 to 2 contacts that are focused on the resolution of an immediate crisis, such as assistance with an order of protection or safety plan. Yet, SSM data reported to DVP and C-Stat[6] are limited to clients who received at least two SSMs.

> I would say it's a **small percentage** [that get a follow-up]. And that is one of the frustrations of what at times feels like limitations with the matrix. So very few get a second one.

Because it is unknown whether a survivor will end services within a few contacts or if the survivor will engage in services more long term, advocates completed a baseline assessment with as many clients as possible. Despite this "wide net" effort for baseline data collection, follow-up data was collected on a small fraction of clients because most clients do not engage in services long enough to complete a follow-up. Asked to estimate what percentage of their clients actually receive a follow-up assessment, respondents reported percentages ranging from 5% to 75%. For many programs, this translates into very tiny sample sizes, sometimes as low as 1 to 6 clients per month.

> **"I would say it's a small percentage. And that is one of the frustrations... so very few get a second one."**
>
> -Advocate

> We serve 600-700 clients a year, **many with just 1-2 contacts.** We do some clients with ongoing services but it is hard for us to determine which clients we should implement the matrix with. **We won't know if we will ever talk to them again.**

> A lot of time, they come in with initial crisis and then don't come back, ever. Advocates were asking **why they would spend time filling it out for a limited-stay client**?

[6] C-Stat is an initiative of the Colorado Department of Human Services (CDHS). Executive leadership and CDHS office staff meet on a regular basis to discuss the performance and outcomes of CDHS departments and programs.

7.0 Summary of Findings and Recommendations for Phase II

7.1 Summary of Findings

The goals of making data-driven decisions and improving services using evidence are admirable, and have been earnestly undertaken by DVP and DVP-funded programs. These goals are particularly challenging in the context of DV services because relatively few DV-specific outcome measures exist. With limited options available nationally, Colorado implemented a tool that has been used in other settings to see how it might apply in DV settings. DVP contracted with CPR to conduct an evaluation of whether this tool works well (or holds promise) in DV settings. This is the first known assessment of whether the SSM can consistently, efficiently, and accurately (a) describe DV survivors' self-sufficiency, (b) capture change in DV clients' overall self-sufficiency and well-being, (c) assess DV program performance, and/or (d) identify community barriers related to DV survivors and DV programs' ability to promote DV survivor well-being (including self-sufficiency).

> **"And it does take some time to absorb the complexity of this challenge. I wish there was a simple way to explain and to offer a set of suggestions, but it's all so contextually dependent. There are so many layers of complexity. I see why states who are responding to their own pressures feel like, 'you've gotta give us some evidence that you're working' but it's hard to say, 'here's the way you should do it.'"**
>
> -Subject matter expert

CPR's interviews with 64 directors and staff (92% of DVP-funded programs) and 5 subject matter experts reveal that the SSM holds promise as an additional tool in a DV advocates' case management "toolbox." That is, some advocates found that the SSM was helpful for some survivors when it was used to complement other existing services, forms, or procedures. To improve its utility, respondents recommend additional adjustments to the tool such as improving its cultural relevance.

We recommend that a new, DV-specific tool be used to describe, monitor, evaluate, and/or assess DV program services.

Our evaluation findings are clear that the SSM is not an effective tool for describing or evaluating DV program performance. Subject matter experts, including Colorado DVP-funded program advocates, provided clear and convincing data that combining SSM assessments across clients or programs has great risk of producing a misrepresentation of DV survivor well-being and self-sufficiency, as well as DV program performance. This risk is due to its highly questionable reliability and accuracy (validity), details of which are provided throughout the report. Taken together, these findings highlight the complexities involved when attempting to implement a tool designed for a different purpose and population and apply them to a DV setting. Given these complexities, as well as the national landscape of previous and ongoing work to describe and evaluate DV services, **we recommend that a new, DV-specific tool be developed and used to describe, monitor, evaluate, and/or assess DV program services**.

While the results of the evaluation of SSM may be disappointing, it is important to note that this endeavor is part of an ongoing process to increase evidence-based decision making to maximize survivor wellbeing and demonstrate that the services provided by DV programs improve the well-being of Coloradans. Indeed, this is part of the "developmental arc" described by the Center for the Study of Social Policy:

> Such efforts involve phases that begin with an absorption of new ideas and approaches; the development of coalitions to lead and support the community's intensified progress toward specific results; small-scale testing and implementation of strategies; course corrections; and then the gradual implementation of strategies at fuller strength and greater scale. It would be useful to make this developmental arc more widely known to public and private funders so they can stage their expectations accordingly. (Schorr & Farrow, 2011, p. 43)

All stakeholders involved in this project share the value for data-driven decision making. CPR will work closely with DVP in Phase II of the project to develop and implement a tool that will meet DVP's goals in a way that is DV-specific, accurate, and cost-efficient. There is strong momentum in the DV field to build the evidence base for DV services and interventions, and Colorado has the infrastructure and statewide interest that, if leveraged, could increase the capacity of DV programs to evaluate their services and contribute to long-term, sustainable evidence-based decision making in Colorado DV programs. CPR's recommendations for placing Colorado at the forefront of this national momentum are presented in the next section.

7.2 Recommendations for Phase II

For Phase II of the DVP evaluation, CPR proposes the following approach.

Identify and Define Shared Goals

CPR proposes to work closely with DVP to develop a DV-specific tool for use with Colorado DVP programs. Given the national landscape of DV services evaluations and Colorado's needs, CPR recommends that the focus of Phase II be to develop a tool that accurately measures clients' needs at the time of services and whether those needs are met. We also recommend the addition of a client-level pre/post outcome measure to the tool.

This will describe and evaluate DV services in a way that follows best practices. Specifically, the tool will be designed to be appropriate and meaningful for the DV field, with particular emphasis on documenting that the components of a theory of change are in place (Schorr & Farrow, 2011; Sullivan, 2016).

Develop a Colorado DV Needs Assessment Tool

Currently, DV programs report whether they conducted a needs assessment within the first 7 days of working with a survivor (DVP Outcome #1). However, **there is no standardized or coordinated needs assessment form across Colorado programs**, or nationally. Because of the wide variety of services needs and the survivor-driven nature of DV services, capturing all of DV survivors needs within one tool has been a significant barrier for DV programs in Colorado, as well as nationally.

A standardized needs assessment tool would be useful to DVP, CDHS, and DV programs. Data on the statewide needs of DV survivors at the time of services would help CDHS and DVP:

- better support DVP-funded programs and other state agencies to address the specific needs of DV survivors.
- improve community and state response to DV survivors, which will promote survivor self-sufficiency, safety, and well-being.
- identify needs and outcomes by county to identify local barriers and gaps.
    - For example, DVP could to compare food assistance outcomes (e.g., the percent of DV clients who wanted and obtained SNAP benefits) by county. If differences in these outcomes were found by county, DVP could work with the local SNAP office to identify what possible barriers may exist for DV survivors in that county.

DV programs would be able to use reliable and accurate data on client needs and outcomes to:

- demonstrate the need for funding.
- identify unmet needs of their clients.
- develop new program practices or resources to better meet survivor needs (those within the program's control to impact).
- improve their capacity to incorporate evaluation activities into agency practice.

The standardized needs assessment would be completed by the advocate. We anticipate that the post-assessment would reflect the services provided (e.g., advocacy, safety planning, counseling) and identify whether specific client needs were met (e.g., obtained SNAP benefits). In addition, questions could be added to the post-assessment to measure whether there was an impact on *clients' access to community resources* (DVP Outcome #3), as well as provide data related to community barriers.

Implement a Client-Level Outcome Survey

An evidence-based, common, and appropriate goal of DV programs is the empowerment of DV survivors (Goodman, Bennett Cattaneo, Thomas, Woulfe, Chong, & Smyth, 2015). Empowerment is an appropriate and useful outcome measure for DV services because it is a component of the theory of change for DV services, *and* it directly measures a change in clients that programs hope to achieve as a result of service provision. Furthermore, **research shows that empowerment is related to survivor well-being and positive long-term outcomes** (Bennett Cattaneo & Goodman, 2010; Johnson, Zlotnick, & Perez, 2001; Zweig & Burt, 2007; Goodman, et al., 2015).

As a result, CPR recommends that Phase II include a pilot of a client-level outcome survey that will measure DVP Outcome #2 (*increase in clients' skills*). Specifically, we propose to implement 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 availability support, and believes that moving towards safety does not create equally challenging problems." (Goodman, Thomas, & Heimel, 2015, p. 7). Increases 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;
- 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 (e.g., interviews, focus groups) 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 can be completed with **short-term** DV clients (minimum at least 3 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**.

We anticipate that this survey will occur at the same time as the needs assessment, but may not necessarily be embedded in the needs assessment. We will work with programs to develop a process that maximizes cost efficiency with client confidentiality.

Proposed Activities for Phase II: The Colorado DV Tool

CPR proposes to design and conduct a small-scale pilot (i.e., 1 to 2 sites in the Denver Metro area) of a standardized Colorado DV Needs Assessment Tool and MOVERS implementation. CPR will take the following steps:

1. Identify any promising needs assessment tools already in use in the DV field and determine their applicability for adaptation and use in Colorado.
2. Collect the needs assessment tools used by DVP-funded programs and review them for common domains.
3. Draft a standardized needs assessment tool that prioritizes an ability to generate consistent data across programs about the most important or urgent needs of DV survivors at the time of services.
4. Review, edit, and finalize the tool with DVP and DVP's Advisory Committee.
5. Conduct a small 3-month pilot (1-2 DVP-funded programs) in the Denver metro area on:
    a. the reliability and accuracy of the new Colorado DV Needs Assessment
    b. the applicability and fidelity of MOVERS in Colorado programs
    c. the time and resources required to implement the new Colorado DV Needs Assessment and MOVERS
    d. identification of best practices and guidelines for implementation of the new tool and MOVERS (e.g., appropriate intervals between assessments, how to integrate into existing practice, how to ensure client confidentiality of outcome survey, how to enter and report data)
    e. identification of best practices and guidelines for analysis and reporting to DVP

Proposed Activities for Phase II

1. Identify existing DV needs assessments
2. Draft standardized needs assessment for DVP-funded programs
3. Edit and finalize tool with DVP and stakeholder input
4. Conduct a small pilot of the tool to test accuracy, implementation, and resources required. Also pilot the implementation of MOVERS

In Phase II, CPR will employ the following best practices:

- Allow enough time for **planning and development**. Front-end and formative resource development saves a significant amount of time and resources in the long-term.
- **Plan for initial, ongoing, and maintenance training from the beginning.** How will the training be implemented with new advocates over time?
- Implement or develop a tool that is **DV-specific and measures appropriate program practices and outcomes**:
    - A DV-specific tool that works in the DV program context: (a) builds on the current evidence-supported theory of change, and (b) is developed through the experiences and perspectives of **subject matter experts** (which includes DVP-funded program advocates). Embed these perspectives at multiple levels, as this is a useful strategy to enhance the validation of the tool and increase the likelihood of its reliable use throughout the state.
- Review the **resources** needed to implement the tool and confirm that clients will not suffer a loss of services as a result of the new process.
- Conduct a small **pilot** in 1 to 2 programs, with a process evaluation component. Pilots help identify and contextualize potential problems, unintended consequences, and/or best practices for a statewide implementation (e.g., what resources might be needed for statewide implementation). The pilot could seek to build confidence that the tool is **effective, elegant, and efficient.**

Best Practices for Innovation and Implementation

- Invest in planning and development.
- Have a plan for ongoing training and fidelity.
- Develop/use a tool made for the setting/population.
- Meaningfully include and value perspectives of subject matter experts.
- Account for available resources.
- Pilot and test whether the tool is effective, elegant, and efficient.

7.3 Conclusion

CPR conducted an evaluation of the implementation and applicability of the self-sufficiency matrix (SSM) in Colorado DVP-funded programs. From the comprehensive data collected during Phase I of this evaluation, CPR concluded that with appropriate edits, the SSM can be used as a useful case management tool; however, it should not be used to describe or evaluate DV program services and outcomes. In Phase II, CPR will work closely with DVP and stakeholders to develop, implement, and conduct a small pilot of a Colorado DV tool that will build the capacity of DVP-funded programs to describe and evaluate their services. This tool will put Colorado on track to be a national leader in the movement to describe and evaluate DV programs.

Appendix A: The Self-Sufficiency Matrix Provided to DVP-Funded Programs

This appendix includes the sample SSM provided to DVP-funded programs. As described in the results sections, programs were able to modify this to suit their program and individual clients.

COLORADO
Office of Children, Youth & Families
Domestic Violence Program

Self Sufficiency Matrix

SAMPLE

Domain Name	1 – In Crisis	2 – Vulnerable	3 - Safe	4 - Stable	5 - Thriving	Score
Food	No food or means to prepare it. Relies to a significant degree on other sources of free or low-cost food.	A majority of household food is purchased with food assistance. Household relies significantly on free or low-cost food.	Can meet basic food needs, but requires occasional assistance from a supplemental food program.	Can meet basic food needs without assistance.	Ability to purchase food and household desires.	
Housing	Currently homeless, in temporary housing or shelter, or involuntarily doubling up with other (or has an eviction notice).	In substandard housing, or facing threatened eviction or foreclosure or monthly rent is 41% or more of monthly income (after taxes).	Living is steady subsidized or transitional housing, or monthly rent is 36-40% of monthly income (after taxes).	Secure homeownership or renting private housing with limitations of choice due to moderate income and/or monthly rent is 31-35% of monthly income (after taxes).	Homeownership or renting private housing in a neighborhood of choice and/or rent is 30% or below of monthly income (after taxes).	
Income	No income. Basic needs not met.	Income is inadequate for meeting basic needs.	Income is adequate for meeting basic needs.	Income is sufficient and stable, adequate for paying monthly bills, provides for some saving, ability to purchase non-essential items.	Income is sufficient and stable, adequate for paying monthly bills, provides for substantive savings, ability to purchase non-essential items often.	
Relationship Safety	Household is unsafe. Someone in the household feels unsafe at home at all times.	Household safety is in jeopardy. Someone in the household feels unsafe in home most of the time.	Feels safe in household some of the time.	Feels safe in the household most of the time.	Household always feels safe.	
Transportation	Does not have transportation needs met and has no access to available public transportation, a car, or regular ride.	Rarely has transportation needs met through public transportation, a car, or regular ride.	Has transportation needs met some of the time through public transportation, a car, or regular ride.	Has transportation needs met most of the time through public transportation, a car, or regular ride.	Always has transportation needs met through public transportation, a car, or regular ride.	
Employment (May not apply if individual is not employable due to disability or age.)	No job.	Temporary, seasonal, or part-time employment with inadequate pay and no benefits.	Employed full-time (or for as many hours per week as desired) but inadequate pay with few or no benefits.	Employed full-time (or for as many hours per week as desired) with inadequate pay and benefits.	Maintains permanent employment (for as many hours per week as desired with adequate pay and benefits.	
Health Care Access	No medical coverage and immediate need exists for any member of the household.	No medical coverage and great difficulty accessing medical care when needed. Some household members may be in poor	Some family members (e.g. children) have medical coverage but adults lack coverage.	All family members have medical coverage and can access care when needed but may strain budget.	All members are covered by affordable, adequate medical, vision, and dental health care coverage and can access	

		health.			care when needed.	
Adult Education (May not apply if individual is not employable due to disability or age.)	No GED or high school diploma and is not enrolled in literacy, high school, or GED program and/or has not learned to read or write in any language and preform basic math.	No GED or high school diploma and is enrolled in literacy, high school, or GED program and has basic reading, writing and math skills.	Has high school diploma or GED and basic use of English and/or is enrolled in ESL program if applicable.	Enrolled in post high school vocational education, technical, or professional training or some college credits.	Obtained a professional certification or training, and/or obtained an Associates, Bachelors, Masters, or Doctorate degree.	
Child Education (May not apply if family does not have school aged children.)	One or more school-aged children not enrolled in school.	One or more school-aged children enrolled in school, often has truancy or behavioral issues or not meeting academic expectations.	Enrolled in school, but one or more children has occasional truancy or behavioral issues and is meeting academic expectations.	Enrolled in school, and attending classes most of the time and reports no challenges with truancy or behavior and is meeting academic expectations.	All eligible children enrolled in classes and attending most of the time. Children are excelling in school performance.	
Child Care (May not apply if family does not have children.)	Needs child care but none is available or accessible and/or child is not eligible.	Child care is unreliable, unaffordable, and/or inadequate, or supervision is a problem for child care that is available.	Affordable or subsidized child care is available, but limited resources available to support narrow choices.	Reliable, affordable child care is available. Non need for subsidies.	Able to select quality child care of choice. No need for subsidies. Changes to child care can be made when desired. Backup child care plan is developed.	
Parenting Skills (May not apply if family does not have children.)	Current known or suspected safety concerns regarding parenting skills.	New to parenting and/or has limited parenting skills. Is not familiar with child development concepts, may have unrealistic expectations, still developing parenting skills. Could benefit from parenting classes.	Parenting skills are adequate and open to identified areas of growth. Willing to take parenting classes.	Parenting skills are solid.	Parenting skills are optimal. Feels confident in knowledge about health/nurturing parenting.	
Support System	Has no personal support systems and no knowledge of available community supports.	Has no personal support system, but knows where to go in the community for help when experiencing a need or crisis.	1-3 personal supports and basic community networks are available in times of need.	3-5 personal supports available and is connected with at least one community support network (i.e., non-profit, church, support group, etc.).	Has 5 or more personal supports readily available and is able to give support in return; is active and/or highly knowledgeable about community support networks.	
Substance Use	Severe alcohol abuse and/or chemical dependence; institutional living or hospitalization may be necessary. Help not sought.	Significant abuse of substances, resulting in chronic family/work difficulties.	Occasional abuse of substances. Use has a tendency to lead to an abuse pattern and negative consequences. Currently participating in substance abuse services.	Occasional use of substances but no evidence of dangerous or continued use.	No drug use. May use alcohol minimally and prescription drugs as prescribed.	
Physical Health	Untreated and chronic medical and life threatening conditions	Chronic medical conditions, potentially life threatening, with	Chronic illness generally well managed and attempting to make and	No chronic illness or stable chronic illness and maintaining good	No chronic illness and maintaining proactive preventative medical and	

	with inconsistent to minimal follow-up care.	inconsistent follow-up care.	keep routine medical and dental appointments.	preventative medical and dental care practices.	dental care practices.	
Mental Health	Experiencing severe difficulty in day to day life due to mental health challenges. Mental health needs are not being met. Doesn't know where to go to get help.	Feels that mental health symptoms may get in the way of daily living. Not sure what to do or where to go for help. Could benefit from mental health services.	Identified mental health need and working towards getting them met. Is accessing mental health services.	Mental health needs are being managed. Only minimal symptoms that are expected responses to life stressors.	Feels good about mental health – does not need any assistance in this area. Knows where to go for affordable assistance if help was needed.	
Workplace Skills (May not apply if individual is not employable due to disability or age.)	Negative or no work history, unable to obtain and retain employment in any industry.	Limited or inconsistent work history of less than 1 year.	Established work history of 1-2 years and some skills that offer potential for obtaining a comparable position.	Established work history of 2-5 years and skills that offer potential for obtaining a comparable position.	Established work history of 5+ years at a single place of employment or single occupation.	
Functional Ability	Because of functional disabilities, current living situation is unsafe and individual is unable to live alone. Assistance is not available.	Because of functional disabilities, individual is at risk living alone. Requires limited assistance or supervision. Assistance is not available.	Not able to perform activities of daily living (ADL) but is in a safe and supportive environment; or requires extensive or total assistance and assistance is available with back-up support.	Fully able to perform most ADL's or fully able to perform ADL's with assistance or support and assistance is available with back-up support.	Fully able to perform all ADL's without assistance or support.	
Criminal Justice System	Current outstanding warrants or tickets; or has had a felony conviction or arrest in the past year.	Current charges / trial pending; noncompliance with probation / parole; or has extensive criminal history.	Currently on probation/parole and is fully compliant; or has a moderate criminal history.	Has successfully completed probation/parole within past 12 months with no new charges files; or has minor criminal history.	No criminal history.	
Legal (Non-Criminal)	Has significant legal problems and is not addressing them or does not understand that the problem involves legal issues.	Has identified legal problems but is unable to proceed without legal assistance.	Has responded to legal issues with appropriate legal assistance.	Has legal representation and issues are moving towards resolution.	No legal issues or legal issues have been fully resolved.	
Money Management	No knowledge or implementation of money management skills.	Know it is important to understand basic money management matters, has limited knowledge and implementation of money management skills.	Some knowledge and implementation of money management skills.	Able to save sporadically; solid knowledge and implementation of money management skills.	Able to save consistently; comprehensive knowledge and full implementation of money management skills.	
Life Skills	Has not learned skills and has significant challenges managing a household.	Has limited skills or capacity to manage household.	Has some skills and capacity to manage household; or requires extensive or total assistance and assistance is available with back-up support.	Has solid skills and capacity to manage household; or support and assistance is available with back-up support.	Has comprehensive skills and capacity to manage household.	

Appendix B: Unique Challenges to 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 C: Studies on Other SSMs

In this appendix, we describe some of the other SSMs identified in the literature. These are different versions of the SSM, and these differences are significantly and limit their applicability to the SSM used by DVP-funded programs.

The Colorado Family Support Assessment 2.0 (CFSA 2.0) is an SSM matrix largely based off the Snohomish County SSM, and then modified using a collaborative process (researchers and practitioners) (Richmond et al., 2015). This is an **assessment** tool developed specifically for **family resource centers** (FRCs). The structure of the CFSA is slightly different than the rest of the SSMs, however, as some of the domains are assessed using complementary tools. Specifically, this tool is in three parts: (a) the Domain Matrix (14 domains), (b) The Protective Factors Survey (PFS), and (C) family readiness to change and goal setting

Rather than assessing parenting, social support, and relationship safety as part of the matrix, these factors are measured in Part B with the PFS (FRIENDS National Resource Center, 2011) as part of protective factors against child abuse and neglect. The interrater reliability assessments of the Part A only (i.e., the SSM, but not parts B or C where relationship safety are assessed) CFSA 2.0 were tested on Colorado FRC staff. Participants were provided with 10 case studies based on authentic cases from California and used the CFSA 2.0 to assess the case. They found that Part A of the CFSA 2.0 demonstrated sufficient interrater reliability.

The SSM-D is an 11-domain, Dutch-language matrix based on the Arizona SSM (Fassaert et al., 2014). Factor analyses indicated that these 11 domains (activities of daily life, housing, income, legal, daily activities, mental health, physical health, household relations, addiction, social network, community involvement) measured the one construct of self-sufficiency and results correlated with other related constructs (e.g., HoNOS; CANSAS). However, so far the SSM-D has only been studied on populations of people who are homeless (Lauriks et al., 2014) and clients receiving intensive mental health services (Fassaert et al., 2014). Furthermore, intimate partner violence is only assessed within the context of the household and between those who live together, which excludes many other forms of IPV (e.g., dating violence, post-separation violence).

CPR identified some articles or reports about locally tailored SSMs; some excluded safety as a domain entirely (Santa Clara County Collaborative 2010). Others included safety as part of domestic relations and/or housing (Bannik et al., 2015; Fassaert et al., 2014; Lauriks et al., 2014;

Richmond et al., 2015; Scannapieco, Smith, & Blakeney-Strong, 2015; Senteio et al., 2009). There was one SSM that included safety as a social/emotional or psychosocial domain (Missouri Association for Community Action & Annette Backs, 1999; Portwood, Shears, Nelson, & Thomas, 2015). The Missouri Community Action Family Self-sufficiency Scale (1999) modified an SSM and assessed 12 domains (educational attainment, academic skills, income, employment, health insurance, physical health, mental health and substance abuse, housing, food, child care, transportation, psychosocial and environmental stressors). Domestic violence is considered under the "psychosocial and environmental stressors," where DV is combined with several other stressors (e.g. victim of a natural disaster, family member has a felony, problem with neighbors) rather than remaining a separate domain.

Appendix D: Survey of DVP-Funded Program Staff

In September 2015, CPR conducted a survey of DVP-funded program staff at the Colorado DVP orientations. The two goals of the survey were to (1) learn more about DVP programs' use and perceptions of the SSM, and (2) identify the current needs of DVP clients and whether those needs are being met.

CPR administered the survey to program staff at four statewide orientations conducted by DVP and held in Pagosa Springs, Denver, Avon, and Fort Collins, Colorado in September 2015. A total of 63 staff completed a survey, generating a 73% response rate.

Most respondents were executive directors (49%), followed by direct services staff (19%). Overwhelmingly, most staff (79%) reported that their program used the SSM to assess client needs and track progress. Although it was not a specific question on the survey, during analyses we found that 16% of respondents reported that their agency used multiple tools to assess client needs and track progress.

Most were trained in the SSM (64%) and have used the SSM (60%). Of those who used the SSM before, a vast majority (84%) used the SSM with domestic violence (DV) clients. Respondents were asked why they have not used the SSM, or why they have not used the SSM with DV clients. Some common reasons included no training (23%) or not enough training (13%). **These findings, however, should be interpreted with caution, given that 42% said that this question did not apply to their work because they do not work with clients.**

In all, 43% said that the SSM was the most effective tool for assessing client needs and tracking progress. In addition, 86% reported that their staff is at least somewhat satisfied with the SSM. **However, 51% either skipped the question about their satisfaction with the tool or wrote "I don't know" on the survey.** Thus, there may be some mixed feelings or uncertainty about the SSM.

In the final section of the survey, respondents first listed the top 5 needs of their clients. Second, they were asked whether their program provided that service and whether their program should provide that service. Finally, they were asked whether the community provided that service and whether the community should.

Unsurprisingly, the top need was **housing** (*n*=44). Most staff used key words such as "affordable," "permanent," and "stable" for this category, which is why we separated housing from shelter. Those who wrote "shelter" used key words such as "emergency" and "safe" instead. Added together, however, 59 staff said that some type of housing is a top need for clients. **Legal services** were another top need among clients (*n*=29), and this included program services such as legal advocacy or assistance with protection orders. Divorce, custody, and immigration were three specific areas of legal services mentioned by some. Some staff also specified "affordable attorneys" or, broadly, "justice." Finally, public and private **transportation** (*n*=25) was another top need.

While there was missing data throughout this section, the patterns found in the data are illuminating. For all top three needs, respondents felt that the community should be responsible more than the program. Currently, however, the **community does not sufficiently provide these services**. In most cases, staff reported that their program could be doing more to provide housing and legal services (e.g., legal advocacy). In contrast, most programs felt that they were providing more transportation services than they should be, indicating a strong need for better community-level transportation infrastructure and access.

This survey had several limitations that must be noted. First, the results are based on a small sample of mostly financial administrators and, therefore, may not reflect the perspectives of staff who are more involved with direct services or evaluation. Second, missing data throughout the responses limit the conclusions that can be made from these data.

Still, this survey was useful in gaining a preliminary understanding of staff perceptions about the SSM. Importantly, this survey demonstrated that **many participants were either hopeful about the SSM's potential in DV settings and/or that they were willing to work with DVP in order to give it a try**.

Appendix E: Qualitative Data and Analysis

Subject Matter Experts

We greatly appreciate that several local and national experts shared their knowledge, insights, and expertise with us for this evaluation. CPR and DVP discussed options for subject matter experts (SME) to interview for this evaluation. The goal was to include a combination of local and national experts.

CPR sought national and local experts in the topic of conducting evaluation and assessments of program performance of DV agencies. In addition, CPR sought the expert experience of someone who had experience with using the SSM data at a countywide level (i.e., Boulder County). Interview topics varied slightly depending on the specific background of the participant; however, the main purpose of these interviews was to determine whether the SSM is an appropriate tool to use in DV agencies for statewide program performance assessment and evaluation.

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Qualitative Data Analysis

Qualitative data from interviews with DVP-funded program participants and subject matter experts were analyzed following the five-phase cycle described by Yin (2011). First, a qualitative database of all interview transcripts and notes was *compiled* in the qualitative analysis software, NVivo. The second phase involved *disassembly* of the data. The entire qualitative text (e.g., one transcription) was broken down into smaller, more manageable chunks using qualitative coding. Specifically, open coding was used to identify key passages and quotes. Two CPR analysts engaged in the coding progress and implemented a reliability-checking procedure to ensure that data were coded consistently and reliably. As open coding progressed, CPR analysts identified codes that related to one another, leading to category codes, which are a higher level of codes. For example, when an interviewee mentioned that the SSM implementation process was rushed, the open code was "rushed process," which was later grouped with others under the category code "DVP's implementation process." In the third analytic phase, *reassembly*, coded data were reviewed and reorganized, with the goal of identifying major themes or theoretical concepts (i.e., patterns in the data). We created a table or cross-tab of key codes by key characteristics of programs. For example, we reviewed specific codes (e.g., How the SSM was assessed with clients) by whether the program had a shelter.

The final two phases were *interpreting* and *concluding*. Whereas the reassembly phase focuses on identifying themes within in the data, the interpretation phase is about understanding the data as a whole. This phase also included the integration of subject matter expert interview data. Taken together, these preliminary interpretations of the data were then presented back to DVP-funded programs. Specifically, Dr. Rivera presented the preliminary themes to an audience of DVP-funded program staff (including some of the actual interview participants) in Vail, Colorado, at the conclusion of the Colorado Advocacy in Action Conference (June 2016). Then, the presentation was recorded and made available to all DVP-funded programs. All participants were provided a feedback form and asked to respond to four questions. These questions were designed **to test the degree to which CPR accurately understood and reported participants' perspectives and experiences**. This form of "**member validation**" is considered a key strategy to test the completeness and accuracy of qualitative data analysis (Patton, 2002).

- What questions do you have about the findings?
- What surprised you the most?
- What confirmed what you already knew?
- What do you feel is missing or was misunderstood?

A total of 36 responses were submitted (21 feedback sheets from the in-person presentation and 15 online surveys that were available after the in-person presentation). Most questions that respondents had after the presentation were related to what will happen next with the SSM or were minor requests for additional detail (and those details are in this report). Overall, respondents clearly indicated that the evaluation findings confirmed their experiences, perspectives, and recommendations. Few were surprised by the findings, and no respondent reported that any detail was misunderstood or inaccurate. Some responses pointed to information that they felt was missing, but this was due to limited time available in the presentation. In all, these respondents provide confidence that the evaluation results are an accurate depiction of DVP-funded program staff's experiences.

The final step, *concluding*, captures the broader significance of the study. The results were compared to the member checking results, existing literature, our professional expertise (e.g., on matters related to psychometrics and validity), and considered in light of the implications for research, practice, and policy.

"The findings overall confirmed what we have experienced"

"No real surprise except that there was so much agreement across programs"

"It surprised me how well [the evaluator] had captured the concerns of the SSM"

"She captured everything our agency communicated"

—Member validation responses

Appendix F: Additional Quotes About the SSM as a Case Management Tool

Positive Perspectives

There is some good because we have made it part of our routine so we don't have to think about remembering it so much. It keeps us **focused** on a treatment plan, which we didn't really create before. Not that this is a treatment plan, but it **guides** us. It keeps us focus and helps us **identify** where we need to be working.

It's helped us gather more data on the client, but also like... I wanna say almost like you're becoming **more personally involved with the client** as well, so it helps us to walk more **side-by-side,** more of a piece of the puzzle.

I like it. It definitely gets a little more in-depth in some areas than we need to, but it definitely gives the client a chance to rate themselves, and then also it's an **ice breaker** in those areas, 'cause sometimes they don't really think about all these areas we're focused on in the moment, a crisis, and this helps me evaluate the person as a whole.

I think that it's maybe **helped organize** the way we're going about doing it. I don't know if it's necessarily increased, but I think that it's definitely helped us organize and maybe be a little bit more on the same page. **There's not necessarily that huge shift between advocates and how they're dealing with the clients.** Everything is a little bit more consistent.

It's helpful and we can encourage our clients more, especially if we know that they have had criminal history and they're having trouble getting an employment, but now their life's turned around. **We can look at this and go, "Oh, you know what? You're doing a great job." And we can empower them to continue on doing it.**

The minute I picked up that shame, I addressed it with [the client]. For example, in one area [the client] was really low. She dropped her head and that told me she's ashamed. I said "I hate seeing you feel that bad because a lot of people struggle with that area." I said "Of course [you're struggling]! Because we live in a community that these resources are practically dried up. Isn't *you* failed it's that the *resources aren't there*. And look over here [at this other domain], we have a very high unemployment rate and you found a job."

I think it's a really helpful tool. I can see the benefits of our staff looking at, "Wow! Look at all of our, look at what this client has accomplished since they've been here." I think it's an 'atta boy!' in a way,

and if we will be using that with our clients to show them, **"Look at how much you've accomplished since you've been here," I think that would be a boost in confidence for our guests**.

Neutral Perspectives

My impression was "eh," we are already doing this. We weren't using a matrix but we're doing an initial assessment within the first 72 hours to do a program plan. Basically, the same thing that the SSM does, we were already doing. We weren't scoring them though. We were seeing where they are at and what are their priorities.

We were doing all of this anyway in case management. When staff engage with clients, this wasn't new to us. **What was new was having to document it.** We knew this stuff about our clients already. Safety planning goes on daily with our clients. We were already in the process of helping them through crisis or vulnerable position to getting them safe and stable, we just weren't documenting in this way.

We see changes, we see a lot of change, particularly the longer they are with us. **But I don't know that the SSM is helping us see change that we wouldn't see without it.** We are already talking about change with the client. We are talking about changes in safety, how we can get them to a safe place. Those conversations were already happening; we just weren't documenting them

Negative Perspectives

Clients we see once or twice, we won't see any movement on the scale. So we would use it with clients where we see a potential for longevity in services.

We spend **more time wondering if we are filling it out correctly** than really using it to track progress.

The advocate will go over each field, will look at the old matrix to compare. They start going over what has changed and if they are still high-risk. **Sometimes [clients] feel they didn't do a good job because their SSM didn't change.** And I don't want them to feel that because there is just a lot we cannot change.

Even if the document is broken up, it can still be **overwhelming** for a client upon intake. It might turn them off and make them wonder why so much information is being collected. There might be a better way for the paperwork to feel less intrusive.

I understand why DVP wants this matrix and scores to show success and motivate programs. But, our staff are really reluctant to do this. **It is just another piece of paperwork for staff, it hinders relationships with clients.**

It's not an open conversation. They think going over the specific questions on the form is more like being at DHS filling out a form, rather than having a conversation about where they want to go or what they want to talk about. It feels more like applying for food stamps and not a conversation about where you want to go and what you need. **It feels more governmentalized and that is not what non-profits do.** Nonprofits are for the heartfelt conversations.

It makes the conversation different no matter what you do. And then having people fill it out on their own is certainly an option, too, and not necessarily a bad one in every case, but the only concern with that is we just don't want to dump too much paper on people to complete, 'cause we just don't want to **overload** people in that way. And eventually, if you're handed too many pieces of paper to fill out, you stop paying attention.

The way I was trained, we were already asking these questions in more free-flowing, positive way—that's a better way to talk with the clients. This feels **awkward** as you fill out the bubbles. The **wording isn't always right**. It is **not as fluid a conversation** with the matrix compared to before. Before, we didn't have to **pigeon-hole** my client in a box; that is awkward for me.

Nonresidential services find it really difficult, they may only meet with someone once. If they fill it out it, it might not go anywhere. That person is not talking about housing or food, that is not their priority while they are in crisis. During those times, the SSM doesn't fit into what we are trying to do with those clients. For nonresidential, **it is becoming a barrier for us to discuss something they aren't in crisis about. We didn't want to force clients to talk about something that might not matter for them at that moment.** We didn't want to push ourselves on our clients. For residential, it was more of just an extra piece of paper work. They wondered why we needed to fill out a matrix for something we were already doing with the 30-day program. During counseling, they are a bit more lenient about doing it because they do talk about some of the domains. But it is different if they are in crisis and don't want to talk about all domains or **they won't come back.**

Appendix G: Additional Quotes About the Reliability of the SSM

Training and Implementation Fidelity

It's really **unfair** for programs to be asked to provide data for use, and it's not clear what use that will be. (Subject Matter Expert)

The webinars were really bad. It was horrible. We were having difficulty even loading the webinars. The initial training—the webinars were long. We would attend the webinars but you couldn't see them.

The webinar that we sat through, honestly, it felt like a **waste of time.** Not that DVP wasn't organized, I just feel like the information maybe wasn't that helpful. I think the webinar focused a lot on historical knowledge of what the SSM was and why it came about, which is definitely interesting. But as far as the actual use of the tool and how to use it, there seemed to be less time was taken on that training aspect, than was the history of the development of the SSM. And like I said, I find the history interesting and I think it definitely helps to know why we're doing something before we start doing it but it felt like some of that **practical how to use this tool wasn't as much of the focus** of the webinar.

I thought [the training] went **okay**. The information was really helpful with all the examples that they gave on how to fill it out. So, I guess they were good. [But it was] **Too long,** and then it felt like it was a little **redundant** after the first one.

[I took the] online webinars but probably not as much as I needed to or that DVP wanted.

I think overall it's been difficult implementing things from DVP...And one example of that is, **we're still waiting from DVP for a 'Guided Question List for Advocates and Staff' to help engage clients in conversation around the SSM**, which we're excited to get. But I think it's been a few months that we've been waiting for that. So it's been difficult to go ahead and implement and get our system set up when we feel like all the pieces aren't quite there yet.

[Our program] had one advocate watch the webinars and then teach everyone else. With time and meetings, that **never really happened.**

I haven't had any training with exception of [other staff] training me. I have sat in with [another advocate who was] going through the process. She provided me information on how to go through it, how our files are organized. **It is just a piece of the overall training.**

We start our interns on the help line and then wait until they can start seeing clients. They are then given a **one-hour training on all paperwork, where the SSM is covered.**

We have had some **turnover** since using it so **not sure if all the current staff have [been trained].**

Very **informal**, I guess would be the best way to put it. We've discussed it and we had a call with Chelsea Baldwin from DVP a couple of weeks ago about something else, and I asked her just to go over the important stuff with the matrix.

That was another thing with the CFSA [Boulder County's Tool] where eventually they got to the point where they said, **"Okay, we cannot say anything about this data unless we know that it's being filled our consistently."** Like, the same process is being used to complete it across centers. You can't have one center where they fill it out in the lobby by themselves and another one where the worker fills it out after the meeting's over. **That's not the same survey anymore.**

If they require all programs to do it, **we would have to do it the way other programs do** to keep the validity of the tool.

I would like to hope staff are scoring the same but that would probably be something that would be good for DVP to do regular or consistent refreshers on how we should be evaluating. **That way it is accurate and consistent.**

if we are using the same tool then we have statewide results that are the same. If I change housing, my results will be way skewed. So, I'm not changing things for the big picture.

A lot of programs don't have that time but have the pressure of getting it done so that would lead to the matrix being **completed inappropriately. They will find a way to get it done but it won't be accurate**.

What Domains Were Used

We only use **three** domains—support system, mental health, legal.

These were ones that we identified as common needs for the population that we serve, so we focus on housing, transportation, employment, support system and substance use.

We had an in-person training come to us and that was helpful. It was the woman that did the webinars. She told us we **only had to pick five domains.**

The domains that we use to assess our clients are Food, Housing, Income, Relationship Safety, Transportation, Health Care Access, Physical Health, Mental Health. From these, **advocates rate the client on three to five domains that the client needs help with.**

Something we learned afterwards, after the TA (Technical assistance), was that **we didn't have to score every domain** because some don't apply to certain clients. DVP didn't do a good job communicating that. We just do all of them to make sure.

How the SSM Was Completed

I would say that my first impressions were that it was a little bit **overwhelming**. I was concerned about how it would work with our agency and the way that we're structured. I think most DVP-funded organizations from my understanding are actual shelters. And so, they have more clear, I think, guidelines, or rather more clear situations to which the SSM could be applied. Whereas our organization doesn't actually have a shelter and we never exit anyone from our program, **so it's not quite so clear** when to do an initial SSM report, when to do follow-ups, when to do exits.

There was a lot of **confusion** at first.

Using the matrix seemed easy at first but the first time I used it, I wasn't sure about a lot of it. The immediate needs were more straightforward but the other ones were harder to rate them on. It was also about figuring out what questions to ask of the client to get the scores we need. And that could be a training piece that would be helpful.

I assumed that each domain and score was really more open to our interpretation. I thought this was more of a guide rather than something that needed to be followed word-for-word.

No survivor input and/or SSM data are a combination of sources

Well I think we're gathering all the information, it's just a matter of answering it in the way that the Matrix wants us to answer. **we're getting all that information, whether in notes, or in intake, or even anecdotally it's a matter of putting it through the document**.

I have not generally conducted it on an initial assessment. On an initial assessment, I'm trying more to gather the demographic information that's required, and get a sense of what this person's risks are and what their needs are. So I guess from the perspective of doing a needs assessment, **I don't officially use the self-sufficiency matrix,** but through a needs assessment that happens initially, I have a sense of what their needs are and what resources and referrals and support we can provide to help them meet their needs.

…Between staff and volunteers who do those initial outreach, calls and contacts, they fill in the outreach intake, and then [two other advocates] look at them to make sure everything was sort of checked off and completed on the intakes so that when it's reasonable to do a matrix for outreach clients, that information is there for measurement.

The SSM was as a client survey

I can't imagine a scenario where it makes sense to hand it to the client and have them score or tell them you are scoring them. If I were them, I would be thinking about what the right answer is: do I need to be destitute to get help? Does that mean that other people will get help ahead of me? Do I share that I was evicted or that I have a good job?

We started with the advocate filling it out. Starting Monday clients will fill out the matrix themselves. If they have questions along the way or don't understand, then we will help work with them. Then they're feeling like they're in control what putting down there. Tell *us* the story.

By having the clients chose it, **they are the experts in their lives.** It feels uncomfortable for me to choose their scores when they are the ones living it. I can be judgmental as an outside observer. If they feel like the household is safe even though I say it isn't, it doesn't make sense for me to choose. It doesn't lead to an accurate interpretation of their situation when a staff member assigns values. That feels abusive and oppressive.

A flexible, combination/mixed approach

I would say probably **about 50/50 on whether the client is involved or we're doing it after we meet with the client.** It depends on the type of contact we have with the client. Some clients are very brief, and/or we don't have the depths of contact with them as we do with the other clients. So, I can look at the matrix and answer those questions without even asking the client on a lot of the domains after meeting with them for a while and knowing what they're situation is. If it's a client that we have a depth with, it would be with the client that we go over it.

Sometimes, I don't have to ask them what their situation is because they are already telling me and how they are living, so I just check the boxes later. **Sometimes I have to ask them:** how do you feel that you are with money management. The thing is that when people are in these situations, they don't have any income, or if they do it is very little or the abuser is taking it away from them.

I think it's been all over the board. We have so much paperwork anyway that, you pull out another piece of paper and it's like, "Oh now we have to score you on this." But staff are really trying to gauge that and if they feel like, "Oh, jeez I can't pull this out", then they're just having discussion about it and doing the scoring on their own.

There are **some clients that I've actually pulled out the self-sufficiency matrix and asked them**, "Let's look at a couple of these. And how would you describe... Where do you feel like you score?" **And in another situations**, I've just gathered the information in my overall intake process, in conversations with the client, and **I'll go fill in the self-sufficiency matrix myself,** based on what I know to have been their responses.

For the most part, we are giving people the option to rate themselves and make some assessment so that **it becomes co-created**. It isn't us deciding for someone.

It's something I do independently afterwards just because it's stressful already for them to have to meet with us and talk to us. As I'm gathering that information, then I can often do it afterwards. That's how I do it. Now **I'm not sure how [other advocate] will do it because [they] can do it his own way.** So [they] actually talked about sitting down and going over it with the client and talking to the client.

It varies. It is a conversation. Sometimes, during follow-up it is more **structured**. The first time is more **organic**.

Timing of Baseline and Follow-up Assessments

Baseline

Or [baseline] would be more **retroactive**. We would think about where they were at after they have been here, then we would evaluate where they are at now. We have some clients we talk to 30+ times. I don't want to call it a guideline or policy, but maybe once a month we could see if things were changing.

We focus on certain clients. We can't do it with someone we just talk to on hotline or a drop-in to the office who just needs financial assistance. We don't have a broad enough picture of what is going on in their lives to fill out. With civil-legal, criminal, and therapeutic clients, we use it with them.

We fill out one with **everybody for the very first in-person meeting** that we have with them, so we don't actually really count them as a client until they come into the office and meet with us in person.

Probably with **anyone we see over 5 times.** Clients we see once or twice, we won't see any movement on the scale. So we would use it with clients where we see a potential for longevity in services. If our advocates are going to spend time to provide services, we need to collect data on those who will be around.

Follow-Up

With our outreach clients sometimes for most of those clients it's only one, two, maybe three contacts for them so it's kinda **hard to follow up and to keep using this** when we only have a couple of phone contacts.

I didn't realize until recently that, when we are upgraded to the new software, that we can't upload the data unless we have a baseline and follow-up. I thought it was just up to us to do a follow-up. **I didn't realize it was actually required.** So, I haven't been doing the follow-up myself.

We kind of set the guideline **that follow up SSMs would be completed anytime there's a major change in a person's situation.** Let's say someone has been in an abusive relationship for a long time and they decide to leave the relationship and they move in to their own household, that would be

considered a significant change in their situation so a follow up SSM would be completed at that point**. If there are no significant changes, then a follow up SSM would be completed after 30 days from the first SSM being completed and then every 60 days after that.**

Well, it's based on the client so [we re-assess] if we feel like there has been a change. We currently have that we check for the current clients, the clients that are coming in frequently or more often I should say, to look at their file at least every two weeks to see if there has been an improvement but typically if we're going to do the follow-up it's led by us noticing that there is a change.

We weren't basing our decision on the amount of time to see change, we based it on a realistic expectation of how long we would be engaged with the client. It just varies. We want to give it time to change before following-up.

Appendix H: Additional Quotes About the Accuracy of the SSM

Cultural Relevance and Marginalized Survivors

I don't think it addresses anything cultural or linguistic because the counselors are doing it in English; the person filling it out is interpreting everything, not the client so it isn't necessarily culturally responsive. I interpret what I hear from the clients and make it fit with the matrix.

The thing is that **this is English.** For a lot of people who use ASL, English is often a second language so people don't have much proficiency sometimes.

Many of our clients have disabilities and are dealing with being dependent on government assistance for self-sufficiency. A client whose legs were amputated and applies for government assistance doesn't get enough. So even with government assistance, the self-sufficiency aspect is still not met.

The SSM is for the general DV victims. It doesn't account for our group being a minority within that group. The isolation of disability and DV and lack of people giving them credibility—what our clients need from us more than anything is somebody to talk to about their situation with respect and integrity. They need money and food. Our funders want us to provide community resources and safety planning.

For instance, for undocumented people, they can't get documents or legal assistance or housing; it is different for them. [The SSM] is focused on the person that can get all the benefits, those that qualify. [The SSM] **assumes there aren't any barriers to getting these services.**

Being undocumented is what often keeps people in crisis and presents barriers to any movement [on the SSM]. That could set the tone for why someone wasn't able to get benefits. Employment could be hard if they are undocumented. **It is a whole different ball game** when we get undocumented clients. **It changes everything about how you do case management,** having to work around systems that are only designed to help some people.

With healthcare, a lot are **undocumented so they can't buy from the marketplace**. So they might use a discount program—Clinica where they pay $25 for everything. So where would you mark that? So we mark uninsured but that isn't necessarily correct because they are able to get healthcare at clinics for undocumented immigrants.

Because we are in such a **rural area,** we don't have access to a lot of these resources. We don't have a temporary shelter, we put people up in hotels. There are a lot of things we have no control over. We can refer but that doesn't mean our clients will get in. if the closest services are 60 miles from here,

they may not be able to get those services. If they are homeless and there aren't any openings, we don't have anywhere else to refer them to. That is the rural nature of our community. It is a huge issue across services. We run into those roadblocks because there is nothing here.

…how we talked about **multiple families living in one home.** They are stable but that is not their house. And how it is **worded is that they are in-crisis**, but that is not culturally relevant. **That would not align with our community values.**

When I was thinking of the power and control wheel, **we use one for teen dating violence.** When there is a victim—we had a [teenager under the age of 16]. How does that work with the SSM? A lot of this doesn't apply to children. This is made for adults. But [teenager] is a victim, so we count her in other counts. Would we do a matrix with them? … I have worked with a **client [over the age of 70]**. We weren't doing it then though. So some domains just weren't applicable with her.

The barriers question takes on additional dimensions with LGBT folks or those with immigrant populations or those with marginalized identities—for those folks to get into case management or advocacy, our folks by and large can't get into those programs. **Out of the 45 DV safe houses in Colorado, only 5 will accept survivors of all genders.** Last week I had a gay man who was deeply unsafe and was sleeping outside but there was nothing I could do because all the shelters were full. **So he would stay in-crisis because of particular barriers around housing and resources.**

It might show that LGBT folks aren't moving very far on the scale, but it might not address the actual barriers preventing that from happening, like the institutionalized oppression and violence.

Survivors' Safety and Abusers' Control and Impact on SSM Scores

Some of their labels are really **offensive**. For example, if you look at "Relationship Safety", somebody feels safe in their home some of the time? [But] They're considered safe? That's just one example. There's a number of examples where you look at that and say, "Who in the world came up with these categories.?" (Subject Matter Expert)

Sometimes I think it's **a little overboard on the parenting skills,** cause it does talk a lot about parenting skills and child education. And I don't know that that's one of those things. **Is it really that important when we're talking about safety?**

Well [Let's look at the domain] Life Skills… We have some ladies who come in here who have never managed money. Never. The husband kept the checkbook. They might have even worked, but they weren't even allowed to go to the bank with it. They had to hand it over to the husband. But on the flip side, they kept an immaculate home. They cooked, they cleaned, they were great parents. So as far as their house skills and capacity to manage household, they have that. But as far as money management, they'd be a two.

The word "success" concerns me a bit because a lot of times **people may slip backward by no fault of their own**. Let's say we're working with someone and she has a job so she scores a five. **But then**

the perpetrator won't let her go to work so she loses the job and she's back down to a one. I wouldn't consider that a failure and so the word success kind of intimates a failure associated with it, so that would be my only concern.

We have had a few clients who were making good progress…the custody stuff comes up later. **When they realize that offenders will use whatever tactics they can, they realize how hard it will be to fight for custody or divorce, so they think going back will be easier than going through that.** Or employment, that finding employment to sustain two children will be too much. They can't raise their children on that income, having a place, childcare, and keeping them going. So she went back. Those are the general challenges with DV.

Trade-Offs and the Non-Linear Path to Safety and Well-Being

There were still questions about the domains and how they applied to our clients. Like safety, that can vary because they are in emergency shelter. **They are thriving but they aren't stable but they aren't with their abuser either.**

I think the SSM takes the assumption that a client is in-crisis in all these areas when they come in. That is an assumption of the matrix—that people are starting at a 1 and we are going to move them. But that is not the case. **Sometimes they are stable like in employment and go down after they come into shelter.** Shelter creates a lot of hurdles for people.

Another example: they may have a car with their abuser. But it isn't theirs. So they may lose that when they come into shelter. Or it gets repossessed because the **abuser stops making payments.** There are a lot of ways they can move down, that we will be judged on, that isn't part of our jobs. They have to start over in so many ways.

Clients with their abuser come in employed because they have transportation. But they may leave unemployed because they no longer have access to transportation, so they will go down. **They had to give up their situation to be in a shelter. To be safe, they had to give up certain things—like employment, childcare.** In shelter, we can't pay for that. So their situation changes in shelter and might reflect badly on us.

I have had clients that tell me that **now that they are by themselves, they feel more unsafe, like the abuser is looking for them everywhere.** That he is hiding waiting for them. That is DV, that is the reality.

Individuals vs. Families

A lot of the questions **don't account for the ways the abuser could manipulate or control the survivor**. So you are scoring the person in front of you but a lot of the score has to do with the abuser's behavior. It continues to be a weakness in the tool.

Some of them were **confused** about substance use—one advocate marked in crisis but I was thinking it was because the abuser was using alcohol. So the question was pointed toward the abuser not the client/victim.

The SSM as an Outcome Measure for DV Services

It's entirely de-contextualized. **It does not at all take into account the needs of survivors in context.** There could be all the public transportation in the world and the person still would not be able to use it for various specific reasons having to do with domestic violence…It's not actual contextualized valid knowledge. (Subject Matter Expert)

There is **no connection** [between the outcomes and the SSM]. Not even close. (Subject Matter Expert)

At the end of the day, they also **don't get the information** they say they're looking for [about increase in skills or access to community resources] (Subject Matter Expert)

I don't think it would be that complicated to come up with a one-page tool that advocates would complete, which at least would be **less offensive and easier on everybody than the SSM** (Subject Matter Expert)

I sort of feel like the challenge is**, we are being asked to use this model that doesn't really apply in our situation** and my concern is that our scores will reflect poorly on our program that might have impact on our funding, because some of what this is about is just not... They're just not services that our program really is designed to provide for our client.

I know DVP wants the statewide data. It would be nice to hear from them that that is not going to be tied to funding in any way. That makes people nervous. **There can't be a consequence for not getting high-change numbers. That is often out of our control. I don't care how magic you are; you can't impose that on someone else**. Just because we couldn't get them out of crisis in relationship safety, we may still have been able to help build them up in other ways and that should be noted and celebrated.

Appendix I: Additional Quotes About the Resources Related to SSM Implementation

Time Taken to Complete the SSM

It's a very inefficient way of getting that information…very time consuming (Subject Matter Expert)

It takes at least an hour to complete it. It is very time-consuming.

Most Clients Do Not Receive a Follow-Up SSM

Because **not all clients stick around to deal with those longer-term issues,** they just come in and get their immediate need met and they're gone, and we can't really speak to anything else.

We know that the SSM is not appropriate for everybody and it doesn't have to be used. **It is not uncommon for us to see people only once.**

I saw that [rule to only send data with a follow-up], I was like, "Okay. Well **how's that gonna work**?" [chuckle] You know? Not that it wouldn't work at all, but how will it fit **when a lot of clients just don't stay with the organization for long enough to do multiple follow-ups**.

A lot of time, they come in with initial crisis and then don't come back, ever. Advocates were asking **why they would spend time filling it out for a limited-stay client**?

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