PCAR
PENNSYLVANIA COALITION AGAINST RAPE

VICTIM SERVICE PROGRAM EVALUATION

This manual was written by: Kathryn Collins, Ph.D., Ann Emmerling, Deborah McManus, Jamie VanEpps and Gail Witwer

The Victim Service Program Evaluation project was funded by the Pennsylvania Coalition Against Rape.

ACKNOWLEDGEMENTS

The Victim Service Program Evaluation collaborative included:

Blackburn Center, Westmoreland County
Ann Emmerling
Center for Victims of Violence and Crime, Allegheny County
Deborah McManus and Jamie VanEpps
PA Coalition Against Rape
Joyce Lukima, Dwayne Milbrand, Richard Price and Gail Witwer
University of Maryland, School of Social Work
Kathryn S. Collins

Thanks to the individuals and organizations that contributed insight, expertise and time to this project:

Mark Bradley, PA Department of Health
Larry Breitenstein, Ph.D., Adelphoi USA
Cynthia Drenovsky, Ph.D., Shippensburg University Sociology and Anthropology Department
Patricia Hargest, Pittsburgh Zoo and PPG Aquarium
Mary Jo Harwood, MSW, LSW, Center for Victims of Violence and Crime
Dayna Jackson and Delilah Rumburg, PA Coalition Against Rape
Nancy Kukovich, United Way of Westmoreland County
Karen Lang and Linda Anne Valle, Centers for Disease Control
Sally Laskey and Beth Transue, National Sexual Violence Resource Center
Nicole McCormick, MSW
Richard Meltzer, Ph.D., Great Lakes Behavioral Research Institute
Prabha Sankaranarayan, MS
Cindy Snyder, LCSW
University of Maryland School of Social Work

In addition, we thank our Pennsylvania field test agencies:

CVVC, Allegheny County
HAVIN, Armstrong County
Women's Center of Beaver County
Abuse & Rape Crisis Center, Bradford County
NOVA, Bucks County
Passages, Clarion/Jefferson/Clearfield Counties
YWCA Sexual Assault/Rape Crisis Services, Cumberland County
Crime Victims Center, Fayette County
Alice Paul House, Indiana County
SARCC, Lebanon County
YWCA-Victim's Resource Center, McKean County
AW/ARE, Inc., Mercer County
WOAR, Philadelphia County
Rape & Victim Assistance Center, Schuylkill County
HAVEN of Tioga County
Blackburn Center, Westmorland County

TABLE OF CONTENTS

FOREWORD

The Victim Service Program Evaluation project (VSPE), formerly known as the Outcome Based Evaluation Tool Collaboration (OBET), was started in 1996 by six victim service agencies in Western Pennsylvania with the intention of assessing the effectiveness of services and developing a more effective way of demonstrating to funding sources and the public the purpose and impact of providing services to victims of crime. Eleven years later, this second edition manual is the result of years of education, trial and error, and statewide cooperation. It is intended to serve as a guide for victim service agencies wanting to embark on the process of evaluating the services they provide. Before beginning, there are a few items that need to be addressed in order for you as readers to fully understand this manual.

First, we recognize that terminology used to describe an individual who has experienced the trauma of victimization creates considerable debate throughout the field. Is it more appropriate to use "victim" or "survivor" when describing the individuals we serve? We believe there are many reasons, each one valid, for the use of either term. For the purpose of this manual, we will use the term "victim" throughout the document. Additionally, individuals seeking services include victims, witnesses, and significant others. Throughout the manual the term "victim" will include all people who are personally impacted by violence, including direct victims, witnesses and significant others.

Second, this manual can be used by any victim service agency, regardless of location (urban versus rural), type (systems or community based), or population served (domestic violence, sexual assault or other serious crimes). Understand, however, that it is written from the perspective of a community-based victim service agency.

Third, it was written with the intention of evaluating the effectiveness of services in helping victims achieve their own desired outcomes, not as a means of judging a victim's decisions or "progress" in counseling.

Fourth, we understand there are a number of outcomes each agency may be required to track or simply want to track that are not included in our tools. For example, if you are a systems-based agency, you may want to track outcomes pertaining to law enforcement. Agencies providing services to victims of domestic violence may want to track the success of long-term housing options for domestic violence victims. Agencies providing services to sexual assault victims may choose to track the number of requests for medical advocacy services received from local emergency rooms to determine if there is an increase in referrals over time. The outcomes included in this methodology were ones identified by victims as the areas of life most impacted by the trauma of victimization, and focus on areas in which a victim service agency may have impact through the provision of service. Outcomes that aim to measure goals outside of the agency's direct impact, such as "the sensitivity of the criminal justice system to victims of crime" are not included in this model of evaluation. An agency's ability to assist victims to positively cope with and adapt to life with the changes that result from victimization – a goal of agencies providing services to victims – is what we are measuring.

Fifth, we have tested the tools in this methodology for literacy level. They reflect a sixth-grade reading level. If you have a client who does not read at this level, you will need to explore options for them to complete the questionnaire, e.g., having a staff member assist them in reading the questionnaire. With respect to other comprehension concerns, it would not be appropriate to use the tools with individuals with severe to moderate cognitive or psychological disabilities. We encourage you to follow the guidance of any caregivers who may be providing accompaniment or serving as legal guardians or to utilize your professional discretion based on your interactions with the individual coming before you.

Finally, program evaluation is a dynamic process. As the needs of victims and victim service agencies change, so do the services and methods of service provision. It is logical then, that the process of evaluating these services should adapt as well. As such, any tools used as part of the evaluation process should be reviewed at regular intervals to assess their relativity and usefulness.

This manual is not intended to be used as the final source on program evaluation. We encourage you, the reader, to continually educate yourself on this process, examine current literature for new ideas and communicate what has worked and what has not worked for your agency. This manual will take you through our process of developing this methodology, provide practical suggestions for implementation, and conclude with a discussion of the future of this project.

CHAPTER 1

THE HISTORY OF THE PROJECT

In 1992, six victim service agencies from Western Pennsylvania came together after recognizing a need for a statewide, standardized system to enhance the reporting of statistical data to funding sources. The methods of hand-tallying or making template software work "for the most part" were no longer providing adequate evidence to answer questions from funders about the impact of victim services. These six agencies sought to develop victim service-specific software that would enhance their capacity to identify trends, allocate resources, and more effectively administer programming to meet client needs in a time efficient manner. A statewide database of service information would also add credence to the need for continued and even increased financial support.

After four years of work funded by the Pennsylvania Commission on Crime and Delinquency, the group released the R/Client software package for distribution across Pennsylvania. This project changed the way many agencies tracked clients and produced reports on service numbers (e.g., clients served, hours of counseling, days of shelter). However, this was just the first step. The group desired to develop a more robust method of illustrating the effectiveness of victim services beyond anecdotes and hunches or total number of service hours provided. They wanted tools that could be used across the state to measure the impact of services.

In 1996, this group of victim service agencies reconfigured as the Outcome Based Evaluation Tool Collaboration (OBET), and partnered with the Pennsylvania Coalition Against Rape (PCAR) to make the vision a reality. Having succeeded at gathering client demographics and reporting modules through R/Client, the OBET was ready for the next step. Both the OBET and PCAR were seeking opportunities to assess the impact of services and make informed decisions about the best use of available resources in working with victims of sexual violence and other forms of violence. They asked "How do we know that what we do really works, and how do we measure and prove it?"

The goal of the group was to develop a methodology that was client-driven, self-report structured, and specific to the services agencies provide statewide. As its first task, OBET embarked on extensive research into program evaluation and existing tools and processes, to identify resources that would help the group achieve that goal. Was anyone already doing this? Was there a model to follow? What exactly would program evaluation and tool development entail?

In order to measure the effectiveness of victim services, OBET needed to start with a standard list of the services that would be evaluated: which services were provided by all victim service agencies, regardless of the type of victimization or the location of the program, and what comprised those services? To meet this need, OBET used service definitions from PCAR as the basis for their work, which provided both a listing of services and definitions for each of those services.

OBET also recognized that the project required input from a variety of stakeholders in order to determine the impacts of victimization (potential outcome areas) and to clarify expectations regarding outcome measurements. To accomplish this, OBET conducted 12 focus groups across Pennsylvania. The focus groups included victims, victim service providers, law enforcement officials, court officials, policy makers and funding sources. From this information, OBET created: (1) a pre-post service questionnaire methodology to evaluate the outcomes of counseling or therapy services to clients; and (2) a post-service only methodology to evaluate outcomes and satisfaction with all services. The first version of the tools was released in 2002, along with implementation guidelines, to victim service agencies in Pennsylvania. Prior to release, OBET sought input from stakeholders throughout Pennsylvania, and field tested the tools and processes (see "Developing the Methodology" in Appendix VII of this manual).

Shortly after the initial release, OBET sought feedback from a number of experts in the field of program evaluation, from universities to government institutions. Though praise was given to the initial efforts, a common question emerged: How does OBET know these tools are truly measuring what they were intended to measure? And what proof is there that the tools could be used universally with victims of all demographic and victimization categories? Essentially, where were the psychometric data, in other words, the data that proved the tools were reliable and valid?

Based on this feedback, two agencies from the original OBET Collaboration – the Blackburn Center (Westmoreland County) and the Center for Victims of Violence and Crime (Allegheny County) – reconvened with PCAR to undertake the next phase of the project: reliability and validity testing. They set out to do more rigorous testing to lend greater credence to the tools through statistical analysis. In 2004, the leaders of the project partnered with a researcher from the University of Pittsburgh, Dr. Kathryn Collins, who then became affiliated with the University of Maryland. With the guidance of Dr. Collins and many others, the collaborative embarked on a statewide test of the tools, or "norming," using a voluntary group of victim service agencies as sources of data and field testers. The Institutional Review Board (IRB) of the University of Maryland, Baltimore approved the study. It was at this point that the OBET evolved into the Victim Service Program Evaluation Collaboration (VSPE). The project will be referred to as such throughout the remainder of this manual. This manual contains the results of these past three years of testing – and the lessons learned along the way.

CHAPTER 2

PROGRAM EVALUATION: BASICS IN UNDERSTANDING AND THE CONTEXT FOR VSPE

- What Is Program Evaluation? Why is it Important?
- Reliability and Validity
- Ethical and Practical Considerations of Developing an Evaluation System

WHAT IS PROGRAM EVALUATION? WHY IS IT IMPORTANT?

Program evaluation is the method of determining to what extent a program or particular service meets the purpose for which it was designed. It includes an assessment of all aspects of a program – the design, administration, implementation, planning and effectiveness. To some, the term evaluation may appear straightforward. However, the concept is more complex, and there are many possible methodologies for evaluating a program – experimentation, questionnaires, client observation and more. Each method has benefits and limitations.

Additionally, there are different types of information that can be gathered and analyzed, depending on the method of evaluation chosen (e.g., quantitative versus qualitative data; process versus outcome data). It is important to understand the different types of information and what type your agency wants to gather before you decide how to evaluate a program.

The information can be gathered through different types of questions on questionnaires – questions that ask for a yes/no response, others that ask you to rate a service on a Likert scale (scale of 1-5 or 1-10) and items that ask openended questions (seeking comments or suggestions from respondents). Differently structured questions gather different types of information. In Chapter 3, we describe the structure of questions used in the VSPE tools.

What type of information can be gathered?

Quantitative information is very simply information that can be quantified – any information that can be turned into a number. Some examples include the number of clients served, number of service hours provided, percent of clients who report they felt safer after receiving services, etc. Quantitative data is generally gathered via questionnaires, intake forms and statistical data forms.

Qualitative information is any other information gathered that cannot be quantified – such as client statements made to therapists and/or advocates ("I feel like I can't get out of bed in the morning.""I have headaches every day.""I managed to spend time with my kids this weekend and smiled."). Suggestions, positive comments, or complaints filed with administrators or receptionists also fall into this category ("You should provide phone numbers for shelters for women with kids.""Your advocates were a Godsend!""Parking around here is awful.").

All of this information can be vital and offer insight into programming. It is important to note that, beyond this, funders in general are looking for quantitative data to determine effectiveness of service. Numbers and

percentages are the "bread and butter" of program evaluation. However, as evidenced by victim impact statements, personal statements and testimonies (qualitative data) are equally powerful. Qualitative data can be used to encourage staff to keep up the important though stressful work, for community awareness efforts to make the issues more personal, or for writing grants. It is also useful for identifying key issues to further explore quantitatively. We recommend agencies gather both types of data. The Empowerment and Satisfaction Questionnaire (ESQ) we developed was designed to gather both types of information. (This tool will be discussed further in Chapter 3).

What is the difference between process and outcome evaluation?

Simply speaking, process evaluation does just what it says - assesses the process used in providing services to victims. It tracks what resources are used, the kind of services offered and who receives the services. Process evaluation is also a helpful tool for determining a client's satisfaction with the agency and/or services provided. Examples of process evaluation include the number of clients served in a particular period of time, how an agency implements services and activities, or the resources used by staff and volunteers to provide the service. Funding sources may ask organizations to generate annual work plans, or logic models that include the following process evaluation data:

Program activities – for example, distribution of pamphlets to hospitals, distribution of hotline cards to schools;
Program outputs – for example, number of clients served via advocacy services, number of hotline calls taken, number of information fairs attended, number of referrals made, and percentage of clients satisfied with services.

While process evaluation certainly has its place in program evaluation, there are several limitations of using only process evaluation that are important to note.

Process evaluation cannot assess or measure:

- actual progress in a client's recovery from trauma,
- the impact of services, or
- the effectiveness of services in meeting a client's needs.

Historically, all not-for-profit organizations, including victim service agencies, relied on process evaluation alone. Many organizations developed a range of systems to track the amount of service provided and clients' satisfaction with those services. More recently, these organizations have begun implementing outcome evaluation, asking the question: *how have our services impacted the lives of the clients we serve?*

Outcome evaluation measures the impact of the services, not just the process that was used to deliver the services. It asks the question, "Do the clients we serve benefit from those services?"

"Outcomes" reflect the specific changes that occur in participants' level of functioning, knowledge, skills, and status as a result of their participation in the program. Outcome evaluation is focused on the changes that occur in the lives of clients while they are receiving services, often representing changes that clients have identified as goals at the beginning of services. Using specific, targeted indicators, outcome evaluation substantiates the success of a program in helping clients meet their needs or achieve their goals. Service providers using outcome evaluation can examine these changes in the short-term, intermediate-term and long-term.

Unlike most process evaluation items which are fairly easy for a client to report and a program to measure, such as satisfaction with services or the number of counseling sessions attended, outcomes can be more

challenging to measure. Changes in a client's life (e.g., improvement in sleeping habits, increased feelings of personal safety, ability to concentrate) may require a point of reference to be established before change can be measured. For example, how does the client describe sleep patterns at the time they first arrive for service? Has the client then experienced improvement in this area through the course of service? This reference point must be established in the data collection methodology - either by using a pre-post questionnaire method or in a post-only method with written instructions to the client completing the questionnaire to explore changes in a specified time frame.

Why measure outcomes?

Measuring and evaluating outcomes demonstrates an agency's commitment to providing services that meet clients' needs and produce intended impacts, versus just focusing on the volume of services provided. For many years, victim service agencies have provided a high volume of services to victims and have been able to report, in some cases, ever-increasing numbers of clients served and hours of service provided. However, the volume of service does not inform an organization of the effectiveness of these services beyond anecdotal information or client satisfaction responses. Outcome evaluation provides the information needed to implement the changes that are necessary to make service provision more efficient and effective. Evaluation can strengthen existing services by providing feedback that programs can use to adapt, improve, and increase effectiveness.

Benefits of outcome measurement

Improve quality of services.	Evaluating the outcomes of services serves as a tool to improve program quality. It provides data for two purposes: to assess the agency's ability to meet clients' needs, and to compare current operations with agency objectives. The impacts that result from an agency's operations can be compared with external standards or with the agency's own plans, policies, and guidelines.
Recruit and retain talented staff; enlist and motivate volunteers.	The success of the agency, which can be communicated in the outcome data, will be a strong selling point for prospective staff members and volunteers. In addition, staff and volunteer morale increases and retention rates improve when the effectiveness and impact of their work is able to be proven and clearly stated.
Identify training needs.	As a result of outcome data, an agency will be able to identify areas where training is needed for staff or volunteers. Training resources can be allocated in a more focused and productive manner. For example, an agency may note that their counselors are not having the intended impact in responding to clients who report difficulty with anger issues. Based on this information, the agency managers can plan for training to build staff competency in this area.
Prepare long-range plans.	Outcome data can significantly contribute to program development and enhance decision-making about continuing or expanding effective programs and changing less effective services.
Focus board members' attention on programmatic issues.	Board members will be provided with a new perspective on the impact of the services provided by the agency.
Develop and justify budgets.	It is much easier to make decisions about allocation of resources, and to defend those decisions, when data is available about the effectiveness of programs.

Provide required information to funding sources about impact of services.	Funding sources are increasingly holding agencies accountable beyond reporting the quantity of service. Outcome measures provide a mechanism to assess, validate and report on the effectiveness of victim services.
Provide a communication tool to publicize the program's activities and accomplishments and the impact they have on the community.	For many community members, the value of victim services is not always apparent and may seem vague or intangible. This may lead to an erosion of financial and community support for the program's mission. Evaluative data that documents tangible results can have a significant effect on the agency's viability.
Reinforce program accountability.	Knowledge that board members, community representatives, and other supporters can gain about the outcome of services will motivate program staff to greater efficiency.
Increase external support.	When an agency is seeking support from a new funding source, outcome data is a valuable tool in justifying program budgets and demonstrating that the agency's work is effective. This will have a positive impact on decisions by funding sources to support an agency's services.

What to measure?

The victim service field across Pennsylvania and the nation is as diverse as the victims we serve. Programs may be community-based or systems-based; serve an urban or rural population; serve victims of domestic violence or sexual assault, or victims of other types of crime; or provide short-term counseling or long-term therapy. Because victim service agencies are unique in many ways, determining what outcomes to measure should be based on the services being provided. You want to measure the impact that your particular services have on a client – the benefits that a client receives from coming to your agency. In addition, you will want to track process evaluation information (for example, satisfaction with services or number of counseling sessions attended) to assess your efficiency and effectiveness. This is also an indicator of effectiveness within the community you serve.

To determine the benefits a client receives through services, and what evaluation tools should measure, we conducted focus groups in the late 1990s with victims, victim service professionals, and other invested stakeholders to gather input. From those focus groups, common impacts of victimization emerged. From these impacts, we developed outcomes and the tools presented in this manual. We do not expect the tools we have developed to measure every outcome an agency is interested in measuring. These tools may serve as a foundation – measuring outcomes for issues that are common to victims in general, regardless of the type of victimization experienced. The tools may be used in conjunction with other questionnaires or methods to gather information about the impact of services. The process we engaged in to define what to measure is as follows:

Step 1: Define the program's purpose, or goal

Before any outcome is identified, you must have a clear understanding of the purpose/goal of a program. The first questions to ask are, "What are the victim's needs?" "What is the intended impact of this service?" "What do we want to achieve through our services?" and "What are the goals and objectives of our program as they relate to services for victims?" Without this information, it is impossible to know what to measure. The focus group participants answered these questions when the first sets of evaluation tools were developed.

Step 2: Define program objectives
It is important to note the difference between a goal and an objective. Goals may be global and general in nature. For example, "to assist victims in healing from and coping with a traumatic experience" can be one goal of service provision. Objectives, however, must be specific and measurable. Outcomes stem from objectives, not goals. In working with victims of violence, some objectives related to the goal noted above may be "to reduce the physical or emotional effects of trauma", "to increase the client's knowledge in a specific area associated with the trauma", "to enhance coping skills", "to increase the client's ability to function in life roles", or "to increase client satisfaction with services received".

Step 3: Reframe objectives as outcomes
After determining what objectives will accomplish the goal, the next questions to ask get even more specific. Continuing the example from above, these objectives need to be clarified with questions such as, "Has the client's knowledge about what to expect in the legal system and resources in the community increased?" Or, "What are the tangible physical or emotional effects of trauma that we can track with a client?" and "How do we know if a person is functioning as well as they want in life?" Many trauma-related symptoms, such as sleeplessness, nightmares, headaches, stomachaches, etc., are common to survivors of violence. Changes in these frequently-occurring symptoms can be measured. Similarly, changes in a person's ability to function in life roles can also be measured. For instance, to function in the role of an employee or student, one must be able to concentrate on a task. Increased knowledge of systems and resources is also measurable. These specific items translate into the questions that measure your defined outcomes.

RELIABILITY AND VALIDITY

We used focus groups to determine the most relevant outcomes to measure in order to identify the impact of victim services. However, it was not enough to say that the outcomes being measured were identified by "qualified" individuals from first-hand knowledge. The tools developed to evaluate those desired outcomes needed to be proven to be statistically sound in order to report the results as being statistically meaningful. The tools needed to be tested for reliability and validity – two important concepts that were not addressed in the development of the original tools.

What does it mean to say a tool is "reliable and valid"?

Reliability
When a tool is reliable, **it consistently measures the same concept each time a person completes the questionnaire.** That's not to say that the responses from the person are the same each time. However, if the tool is reliable, then over repeated administrations with the same or similar groups of people, the results should be consistent, assuming the conditions that are being assessed have not changed. The items are worded clearly, with little chance of different interpretation of meaning from one reading to the next. Therefore, every person who reads each question understands it to be asking the same thing. This means that there is a very small chance that something random will happen to sway the results. If a client is completing the questionnaire in the morning or evening, in person or over the phone, in a rural or urban area, filling it out themselves or having it read to them by an agency staff member, or having two different staff members administer the questionnaires, they'll understand the questions to address the same concept from one time to the next. The results will be consistent and stable.

Validity
Ensuring that the tools measure what they are intended to measure is called validity. For example, a third grade math test would not be a valid tool to use to measure knowledge for a twelfth grade calculus student.

Similarly, victim services, it is important to know that the tools are evaluating the impact of services, not the impact of other things happening in a client's life (e.g., the impact of going through the criminal justice system or of spending the night in an emergency room following a rape). It would not be valid to say that a woman who was visibly upset the first time she came to your agency benefited from services because the next time she came in she was calm. Nor would it be valid to say the tool was measuring the impact your agency had on improving coping skills if you're only asking questions about one kind of coping (e.g., emotional), but not inquiring about sleeping or eating habits, risky behavior, or school or work functioning.

While a tool may be found to be reliable, it may not be valid. For example, we know that a scale that is balanced correctly is reliable to measure weight. Yet, scales are not a valid measure for height. Finally, for a tool to be considered valid, it must be reliable. For example, if a home scale consistently measured an individual's weight as 15 pounds every time she stepped on the scale, we know that it is reliable. However, if that individual is a 5'4" woman and her doctor's scale consistently measures her weight to be 120 pounds, we know that the home scale is not valid (because it is not calibrated correctly).

ETHICAL AND PRACTICAL CONSIDERATIONS OF DEVELOPING AN EVALUATION SYSTEM

When conducting evaluations, ethical and practical considerations must be taken into account. Different types of services may require different evaluation methodologies to be utilized. The following are issues that should be discussed by your agency before deciding on a methodology for program evaluation:

Timing of evaluation
When to evaluate a service is a difficult decision for many victim service personnel. Considering what was already discussed about the types of information that can be collected, certain services present challenges in collecting a wide range of information. For example, crisis intervention services provided by a 24-hour hotline are appropriate for process evaluation, as are advocacy services that provide immediate support and assistance to victims through the medical and legal systems. However, it is neither practical nor ethical during a one-time hotline contact or during an accompaniment to the hospital or the police station to attempt the pre/subsequent methodology used for outcome measurement.

On the other hand, in-person counseling and therapy provide an ongoing, supportive relationship for clients to work through their victimization, and are appropriate services for both process and outcome evaluation.

However, it is important to keep in mind that the needs of a client should never be ignored or compromised to gather data for evaluation. As such, when a client is in an acute crisis, regardless of how long they have been receiving services or what type of service they are receiving, it is neither practical nor ethical to administer evaluation methodology of any type.

Informed consent
An agency must be attentive to informed consent for clients. When appropriate, inform the client what the purpose of the questionnaire is: to evaluate services. Further, participation in service evaluation is voluntary, and each client should be asked to sign a consent form before participating. An agency should never base the provision of services on a client's willingness to complete the questionnaires. Our clients, because of the tremendous stress in their lives from the victimization, often feel judged or stigmatized by others. It is important that we convey unconditional positive regard for their participation or non-participation in the evaluation of our services.

Confidentiality versus Anonymity

For many victims, confidentiality is imperative. This is not a new concept for the field. However, confidentiality is an issue for program evaluation as much as in service provision itself. If an agency chooses to link pre-post questionnaires to clients' identities and enter data into R/Client or a similar database software, be aware that the questionnaire information remains confidential but becomes part of that client's record, and must be included if the client's record is subpoenaed for court proceedings.

Anonymity is another factor that most experts in program evaluation would tell you increases the honesty and accuracy of answers. When evaluation is not done anonymously, clients may answer in a biased manner – how they think you as the staff person want them to answer. They may also be reluctant to criticize or provide any negative feedback.

Services can be evaluated anonymously by simply omitting identifying information from the questionnaire (demographic information is not considered identifying) and having the person who administers the questionnaires be different from the person who provides the service or enters the data and/or analyzes the information. For victim service agencies, anonymity should not present a problem in most circumstances. However, situations may arise that present challenges. These include, but may not be limited to:

1. If a client discloses a desire to hurt her/himself or someone else, or discloses further victimization anonymously on a questionnaire. As professionals, we have a responsibility to help but would have no way of doing so. To remedy this dilemma, we recommend including a line in the consent form or in the instructions reminding the client completing the questionnaire of the purpose of the questionnaire – that the questionnaire is for program evaluation only, and that a therapist will not see responses or comments.
2. If the agency is short-staffed and does not have enough people for the administrator of the questionnaire to be different from the person providing the service or the data analyzer. In this case, have the client fill out the questionnaire or tool in a separate space from where the staff person is (at home, in another room) and then place the questionnaire in a sealed envelope. Mailing it back would be one option to ensure anonymity (excluding the identification of a return address, of course). If that is not an option, the agency must take into account that the answers may be biased.

We provide you with best practice suggestions for preserving client confidentiality and/or anonymity in Chapter 5.

THE DESIGN: **PLANNING FOR PROGRAM EVALUATION**

CHAPTER **3**

- The Logic Model
- The Tools
- Adapting the Tools
- Scoring the Tools
- Demographics

In the previous chapter we mentioned how important it is to plan before trying to implement an evaluation process. This chapter will take you through our planning process, how we determined what to measure and how we chose the tools.

THE LOGIC MODEL

According to the W.K. Kellogg Foundation's Logic Model Development Guide (Kellogg 2004, p. 1):

> *"A logic model is a picture of how you believe your program will work. It uses words and/or pictures to describe the sequence of activities thought to bring about change and how these activities are linked to the results the program is expected to achieve."*

We have found that clarifying what to use as evaluation measurements is easier when you start with a logic model. A logic model provides a concrete picture of what your organization is trying to accomplish with each service (it is best to use a separate logic model for each service) and what resources you need to provide that service. Logic models can be as complex or as simple as you choose to make them. The more detailed and specific they are, the more accurate a picture they will portray of services. In developing the logic model for a service, be realistic with your projections based on available resources, duration of your services and/or the length of the typical interaction with your client base. Include as many stakeholders as possible in the development of the logic model in order to have a complete description of the service. A comprehensive, accurate description of services, with intended impact of the service defined, makes it much easier to evaluate that service.

We developed logic models for the following services defined by PCAR: Advocacy (legal and medical combined), Crisis and Supportive Counseling, and Therapy. We also developed a logic model for a PCCD-mandated service: Victims Compensation. Through these logic models, we were able to identify both short-term and intermediate-term outcomes. In some cases, the outcome is linked to a specific item in one of the VSPE tools (e.g., increased knowledge). Other outcomes relate to an entire subscale of a tool (e.g., increased coping and sense of empowerment). See the sample logic model on the next page for a crisis/supportive counseling program. We provide a detailed description of scales and subscales later in this chapter. We recommend the W.K. Kellogg Foundation's Logic Model Development Guide for a step-by-step guide to help you create your own program-specific logic models. The model can be downloaded at no cost at www.wkkf.org.

LOGIC MODEL: Crisis/Supportive Counseling Programs

Inputs Certain resources are required to operate the program…	**Activities** If we have these resources, then we can accomplish…	**Outputs** If we accomplish the activities, then clients will receive this extent of products and services…	If we provide the extent of service intended, clients will have increased knowledge and skills, and decreased symptoms due to the impact of their victimization.		
			Short-Term Outcomes *EXAMPLES*	**Intermediate-Term Outcomes *EXAMPLES***	****Long-Term Outcomes *EXAMPLES***
Funding is required to provide: • Crisis intervention/ counseling modality. • Trained crisis responders/ counselors. • Physical space for the program. • Equipment (phones/ computers). Information on local services and programs for proper referrals. Method of making public aware of the issues and agency services (via advertising or community outreach programs). Client notification of available services by systems.	Counselors provide tools to empower clients over the phone or in person by: • Planning for safety. • Normalizing and validating feelings. • Identifying available options. • Identifying individual rights. • Assisting with emotional stabilization and coping skills. • Assessing needs. • Educating on the impacts of trauma and what to possibly expect in the near future. • Exploring personal safety skills. • Involving clients in the decision-making process on how they will use the resources offered. Staff members refer clients to other needed services internally and externally.	Number of hotline calls. Number of clients. Number of hours spent providing crisis intervention or supportive counseling services. Number of client referrals (to and from). Number of clients who utilized more than one service at the agency.	* 1. Percentage of clients reporting satisfaction with the agency services. *(Subscale: General Satisfaction on ESQ-LF)* 2. Increased sense of safety. *(Item 13 on ESQ-LF)* 3. Creation of a safety plan. *(Item 11 on ESQ-LF)* 4. Identification of support systems. *(Item 9 on ESQ-LF)* 5. Knowledge of the effects of crisis and trauma. *(Item 10 on ESQ-LF)* 6. Increased coping and empowerment. *(Subscale on ESQ-LF)* 7. Increased knowledge of victim compensation process. *(Subscale on ESQ-LF)*	1. Decrease in risk-taking behaviors. *(Scale on ACQ)* 2. Decrease in avoidant/numbing symptoms. *(Subscale on ACQ)* 3. Decrease in hyper-arousal symptoms. *(Subscale on ACQ)* 4. Decrease in intrusive recollections. *(Subscale on ACQ)* 6. Increase in sexual functioning. *(Scale on ACQ)*	Enhanced client capacity to address own needs. Enhanced client well-being. Reduction of risks for future victimization (identification of vulnerabilities). Experience success in overcoming the trauma of victimization.

LOGIC MODEL notes:

- An individual item cannot be removed from the tool and asked independently from its scale or subscale; to maintain validity and reliability, all items in a scale or subscale must be asked. However, outcomes can be reported for individual items (questions).
- ACQ and ESQ-LF refer to the VSPE tools.
- The outcomes noted above are examples and are not an all-inclusive list.

* "Percentage of clients reporting satisfaction with agency services" may be considered an output or an outcome depending on the definition of an outcome from the source requesting the data.
** Long-term outcomes are not covered by these tools or this manual.

What are the components of a logic model? (Kellogg 2004, p. 2.)

1. What is needed to make this program a reality?

Inputs are specific resources that are needed to operate a program such as staff, volunteers, time, money, supplies, equipment, technology, training, etc.

2. What can be done or provided if these resources are available?

Activities are what a program does with the resources. They are the services, processes, techniques, events and actions of the planned program. Some activities provided by a victim service agency may be the provision of emotional support, identification of individual victim rights, education on available resources, or accompaniment to medical or legal proceedings.

3. What will be the quantifiable result if these activities are accomplished?

Outputs are the direct results of program activities. They are usually described in terms of the size and/or scope of the services and products delivered or produced by the program. The outputs for a victim service program might be the number of hotline calls, number of clients served, number of crisis counseling hours provided, or number of accompaniments to legal proceedings. These are measurements for process evaluation.

4. What impact will the client experience as a result of the services?

Outcomes are specific benefits received by the clients as a result of services. The benefits for clients most often identified by staff members working in the victim service field are changes in client attitudes, behaviors, knowledge, skills, or level of functioning.

Outcomes can be short-term, intermediate-term and/or long-term. The difference between each level is usually the length of time it takes to achieve the outcome or the complexity of each outcome. This will be determined by an agency as it establishes the intended impact of its services. Generally speaking, short-term refers to benefits that may result from a briefer intervention, and experienced within the first year of service or less; intermediate-term outcomes may be accomplished with a more sustained intervention, and would more likely occur within two to four years of service. Long-term outcomes, in the field of victim services, are difficult to measure. Since many clients do not stay in contact with the agency providing services for an extended number of years, the data to track long-term outcomes is difficult to gather. The safety considerations in contacting clients post-service and the resources required (time and money) often make evaluating long-term outcomes prohibitive. You may be able to track the long-term outcomes if your agency has contacts with social researchers interested in the long-term effects of victimization. You would need to explore the ethical, practical and safety considerations before undertaking such a project.

For concepts that can be measured with the VSPE tools, examples of short-term outcomes for victim services may be an increased sense of safety, the development of a safety plan, increased knowledge of options, or increased coping and empowerment. Examples of intermediate-term outcomes are a decrease in risk-taking behaviors or decreased post traumatic stress symptoms. (These examples are also referenced on the sample logic model on page 3-2.)

We used the following terminology to discuss the development of our tools:

Tools/Questionnaires: Broad terms used to describe the documents we developed (instruments, surveys, etc).

Scale: The grouping of items on a questionnaire that address a specific outcome. You may state an outcome based on a scale. A scale may also be referred to as an **indicator** (information that **indicates** a particular outcome).

Subscale: A grouping of items within the larger scale that address a specific outcome. You may state an outcome based on a subscale. A subscale may also be referred to as an **indicator** (information that **indicates** a particular outcome).

Item: Each question or statement within a subscale or scale. You may state an outcome based on an item. An item may also be referred to as an **indicator** (information that **indicates** a particular outcome).

The next section provides additional information about scales, subscales and items.

THE TOOLS

After we had clearly defined outcomes, we developed tools/questionnaires to measure them. This is where we saw the biggest void when we started the project in 1996. Historically, tools/questionnaires have been developed within the mental health and social work fields that could be used to measure individual issues clients experience post victimization (e.g., anxiety or depression), but an inclusive tool that addressed the full range of issues could not be found. To further complicate matters, most were developed as instruments to assess a client's symptomatology or diagnosis, not as something to be used to evaluate the effectiveness of services. There was a paucity of tools/questionnaires that were comprehensive enough to address a broader range of issues or designed for evaluation of victim services. Therefore, we set out to design tools/questionnaires that would evaluate the impact of services on the range of problems commonly experienced by victims of crime.

We recognized that we would need more than one tool to accommodate the different types of services offered by agencies and the different methods of providing those services. Therefore, we developed two tools/questionnaires (see Appendix I for copies of these tools):

- **The Adult Client Questionnaire (ACQ)**, to evaluate the effectiveness of the agency's services in helping clients with the issues that result from victimization.

- **The Empowerment and Satisfaction Questionnaire (ESQ),** to evaluate a client's satisfaction with the services, and the impact of services on a client's life.

Adult Client Questionnaire (ACQ)

As noted above, the ACQ measures the impact an agency's services have on clients. This tool is designed for self-reporting and is geared to adult clients. The questionnaire is to be answered before the beginning of services (pre-service) and at periods of time during (subsequent-service) and at the end of services (post-service) to measure the degree of change a client experiences in the issues that result from victimization.

By asking about the behavioral, emotional and physical factors in a client's life each time the questionnaire is administered, a client's current life experience will be conveyed through her/his responses. Comparing the responses from the pre-service questionnaire (questionnaire administered prior to services) and subsequent questionnaire (questionnaires administered at an interim point and/or at completion of services) provides a measurement of the degree of change occurring in a client's life during the course of service.

The ACQ is comprised of 25 questions, or items, which are organized in four separate scales. The scales are: Risk Taking Behavior, which consists of four items that measure if the client is involved in risk taking behaviors; Eating Behaviors, which consists of two items that measure the client's eating habits; Sexual Functioning, which consists of two items related to a client's perception of difficulties with sexual functioning; and Post Traumatic Stress Symptoms, which is a 17 item self-report measure of symptoms of post traumatic stress (PCL-C; Weathers et al, 1993). Within this post traumatic stress scale, there are three subscales: intrusive recollections, avoidant/numbing symptoms, and hyper-arousal symptoms.

In reference to these scales and corresponding items, clients rate how much they were "bothered by that problem in the past month." Items are rated on a 5-point scale ranging from 1 ("not at all") to 5 ("extremely").

We developed other versions of the client questionnaire to be used for teens, children, and for caregivers to complete for children too young to complete their own questionnaire. Because of a lack of data, we were not able to complete the reliability and validity testing on these tools, and so have not included them in this manual. There are other tools available in the literature on post-traumatic stress for assessing the impact of trauma for these populations that may be adapted for the purpose of service evaluation. They are described in the appendix of this manual (Appendix VI).

Empowerment and Satisfaction Questionnaire (ESQ)

As references in the section above, Adult Client Questionnaire (ACQ) was designed to evaluate outcomes for clients who have ongoing, regular contact with an agency. Recognizing that this model does not encompass all the clients who come to our agencies for services (e.g., clients in a court setting) and that it does not assess a client's satisfaction with our services, we developed the Empowerment and Satisfaction Questionnaire (ESQ), Long Form (LF) and Short Form (SF). You may use the questionnaire in the long form or short form, depending on the services your agency offers.

The ESQ is to be administered at the completion of services, and is designed for self-reporting. Both versions of the ESQ combine client satisfaction questions with questions that ask about the client's perception of the impact the agency's services have had on helping to resolve issues in the client's life resulting from the victimization. Because the questionnaire is completed at the end of services, the section that addresses the impact of services is done as a retrospective view – asking the client to report on her/his perception of that impact. All clients over the age of 14 years old can complete this questionnaire. Further, caregivers are encouraged to complete the questionnaire in relationship to their loved one's experience if the client cannot complete it (e.g., young children, individuals with cognitive disabilities).

The ESQ-LF is a 25 question (or item) questionnaire that combines two instruments, a modified version of the Mental Health Statistics Improvement Program survey (2000) and the original service questionnaire we created. The ESQ-LF is one scale (Empowerment and Satisfaction) with six subscales (for example, increased coping and sense of empowerment, general satisfaction with services, knowledge of Victim Compensation). In addition, the long form includes two items required of domestic violence agencies by the Pennsylvania Coalition Against Domestic Violence (items 11 and 18). If your agency does not provide services to victims of

domestic violence and you are using the long form of the ESQ, you may choose to eliminate these items.

The ESQ-SF is a 9 item self-report form based on the ESQ-LF. This tool only measures clients' general empowerment and satisfaction with services. This is a one-dimensional (no subscales) questionnaire.

Agencies may choose to tailor the ESQ to match the type of service being evaluated, including only those subscales that relate to the service. For example, you might choose to include the scale that addresses the clients' perceptions of the support and advocacy they received through the legal system if you were using this tool for clients receiving legal advocacy services; but might not include perception of support and advocacy through the medical system.

Along with either the ESQ-LF or ESQ-SF, we recommend the use of the Short Post-Traumatic Stress Disorder Rating Interview (SPRINT; Connor & Davidson, 2001). This 9-item modified measure (based on an original 8-item self-report measure) assesses the core symptoms of PTSD (intrusion, avoidance, numbing, arousal), somatic malaise, stress vulnerability, and role and social functional impairment. Symptoms are rated on a five point scale from 1 ("not at all") to 5 ("very much"). We added item 33 to capture the feelings of shame and guilt that victims often report. Using this 9-item measure would add a second scale for the ESQ-LF or ESQ-SF. The final two items ask clients to rate the improvement they have experienced since receiving services at the agency. The ESQ-LF and ESQ-SF tools we included in the appendix to this manual both contain the SPRINT measure.

Scales and Subscales in the ACQ and ESQ

We have included a full listing of the scales and subscales with related questions/items for each of the tools in the appendix section of this manual. In addition, the outcome examples in the sample logic model in this chapter include a reference to the scale, subscale or item from each of the tools.

You may report outcomes based on a full scale (e.g., ESQ-LF), a subscale (e.g., Increased Support or Knowledge Through the Legal System) or the response to an individual item. However , we caution and note that most outcomes are best measured by using full scales and/or subscales and not single items/questions. For example, post traumatic stress is made up of a collection of symptoms and behaviors. It would not make sense for you to use one question from the scale to describe the client's level of symptoms (as one question does not capture the variance of symptoms that may be occurring in the client's life). This holds true for client satisfaction, capacity of safety planning, types of risk behaviors, empowerment and so forth.

Reliability and Validity of the ACQ and ESQ

As mentioned before, we have been able to establish initial reliability and validity for both the **Adult Client Questionnaire** (**ACQ**) and the **Empowerment and Satisfaction Questionnaire** (**ESQ**), by analysis of data acquired through field testing.

ADAPTING THE TOOLS

The integrity (reliability and validity) of the questionnaires requires that all items/questions remain in each scale or subscale. However, the overall questionnaire may be shortened if an agency determines that a portion of the content is not relevant to its clients or services. This is done by removing and/or eliminating the scale/subscale, not just individual items/questions. Further, if an agency wishes to add questions to the questionnaire,

this is appropriate and acceptable. However, the new questions would need to be tested on how they add or detract from the questionnaire's reliability and validity. This could be a time-intensive undertaking and would require the skills of someone familiar with the steps of this process. Therefore, we suggest that if the agency wishes to add questions, it is best to use an open-ended question that allows for the client to descriptively or qualitatively answer the question. If you do add an "untested" question with a numbered response bank, the scores from that question cannot be included in the scores from the other items on the questionnaire.

SCORING THE TOOLS

What do you do with this information you've gathered? First, data must be entered into a computer system to analyze what the clients reported. That involves "scoring" the questionnaires, or putting a numeric value to the response (this makes the data quantitative, rather than qualitative, and easier to report in meaningful ways).

Adult Client Questionnaire (ACQ)

The ACQ responses are scored on a "1" to "5" Likert scale. The Likert scale is a psychometric response bank measuring either a positive or negative response to a statement. In the ACQ, we ask respondents to specify the severity of symptoms in their life. The questionnaire was designed based on standard practice for the lower number in the response bank to represent less symptoms and the higher number to represent more symptoms (1 = "Not at all" to 5 = "Extremely"). This response numbering is consistent throughout the tools, in order to avoid confusion.

The ACQ address issues in a client's life (e.g., emotional or behavioral). By comparing the questionnaire responses prior to service to the questionnaire responses after services have been received, you will be able to gauge change in the client's life. The change you will be looking for is a decreased overall score, which means that the client has seen positive changes because of a reduction in symptoms related to the trauma of victimization.

Empowerment and Satisfaction Questionnaire (ESQ)

The ESQ responses are also based on a "1" to "5" Likert scale. For Sections A, B, C, D, and E of the questionnaire, the responses are scored from "1" (strongly disagree) to "5" (strongly agree). The scoring corresponds with the number for the response and "5" is the highest desired score for all of these items.

In Section F, symptoms are rated on a five point scale from 1 ("not at all") to 5 ("very much") in the first nine items (items 27 through 35). The items ask about the level that a client's life is affected by the issues related to victimization. For these items, the desired score is 1, indicating fewer negative reactions to the victimization. If the responses are scored only at the end of services, these items will be an indicator of the impact of victimization for the client following services. If this section is used as a pre/post questionnaire for clients, you will be able to measure the change in overall score from the first administration of the tool to the second administration.

Item 36 asks clients to report how much better they feel since beginning services. This requires a response that is on a 0 to 100 % grid line, from 100% (As well as I could be) to 0% (No Change). The score from this item will stand alone and cannot be included with the items being measured by the 5 point scale.

The final item (37) returns to being scored on a 5 point scale, but has a different response bank than the other items in this section: it ranges from "Very Much" (a score of 1) to "Worse" (a score of 5). This item asks the client to rate how the symptoms described in items 27 to 35 in Section F have improved since the beginning of services. The desired response for this item is "Very Much" (a score of 1). Although this is a 5 point scale as

used in the Sections A through E, since the response bank is not the same, the score from this item will also stand alone. The score on this item should not be summed or averaged with the other scales or subscales. There are also qualitative questions infused throughout the ESQ. You may choose to leave these in or delete them. We found many clients completed these questions with comments that are both motivating to staff ("thank you","you are wonderful","keep up the great work","you were my angel", etc.) and helpful in identifying specific areas of improvement ("I was never told about victim compensation"). In addition to sharing comments with staff or volunteers as general affirmation of their work, or with the board or funders to reflect the success of the agency's services, these responses are also important for outcome reporting. To analyze the open-ended questions for rich and descriptive information, you would look for themes or trends among those responses. For example, in our analysis of the qualitative responses from the questionnaires we received during field testing, we identified transportation and lack of adequate parking as a trend in the responses. Therefore, a theme from the client responses is "issues with accessibility to services." We could report this to our funders as an area of concern, or use it in advocating with policy makers for changes in the community. Remember, the voices of our clients are stronger than our voices. Through their collective voices, we can advocate for change that will benefit victims of crime.

DEMOGRAPHICS

You may choose to include the collection of demographics with the ACQ or ESQ to: 1) provide information for process evaluation, 2) provide more information from which to analyze the outcomes (e.g., are certain racial or age groups more satisfied than others or are certain age or socioeconomic groups more likely to receive information about victim compensation than others?). Most of this demographic information is already collected during the intake process at victim service agencies. While it may seem redundant to collect this information again, remember that the ESQ and in some cases the ACQ are likely to be filled out anonymously and so may not be linked to existing client demographic information. Additionally, it does not take much time for a client to complete this section and it can be used to ensure that the population responding to evaluations is representative of your entire client population. By analyzing demographic information, you may find that only a certain age, gender, disability, sexual orientation, socioeconomic, or racial group provides you with feedback.

THE DESIGN:
ANALYZING AND REPORTING RESULTS

CHAPTER 4

- Analysis of the Data
- Reports
- Software

It is through the analysis of data and reporting capabilities that an agency is able to obtain the following benefits described in Chapter 2: outcome data for funding sources, guidance in program planning, affirmation of the effectiveness of services or additional information available to the community. In your logic model, or goals and objectives, you will have identified desired outcomes for the impact of your services. Analyzing data from the ESQ and the ACQ will provide you with information that tells you whether your services are having the impact you expect – and that your clients need. The reports will provide you with the data that will demonstrate how you are achieving your desired outcomes.

ANALYSIS OF THE DATA

Once information is available, you will begin your analysis. To obtain basic information about the impact of your services, the analysis does not need to be especially complex or difficult.

At the very least, you can track mean scores and/or changes in mean scores. For example, the responses for all scales on the ACQ are from 1 to 5; the desired response is a 1, indicating a reduction in the type of issues or symptoms individuals experience following victimization. You may choose to look at a specific scale, and track the percentage of clients who have shown a positive change (i.e., responses moving towards "1".) To do this, you would identify the client group you'll be tracking outcomes for, determine the number of clients in this group who have experienced a positive change (their responses are moving towards "1"), and calculate the percentage of clients who have experienced positive change. This type of analysis, and the reports that could result from it, are described in more detail in the section on Reports.

You can also choose to go deeper with more analysis to determine statistical significance. For consistency, it will help to identify one person on staff who will handle the data analysis and report writing. If you intend to do a more in-depth analysis of the data, you may want to link with an outside resource (e.g., through a local university) to support that effort.

Considerations about the data in the ACQ and ESQ:

1. Because the ACQ is comprised of four individual scales, you will never be analyzing the data from all four scales together as an aggregate score. The data from each scale can be analyzed and reported on individually. You can analyze the number of clients who have shown a positive change in all four scales, and report on that percentage. However, you cannot average all 25 items together.

2. The ESQ is comprised of two individual scales: the Empowerment and Satisfaction scale (with 6 subscales), and the Short Post-Traumatic Stress Disorder Rating Interview (SPRINT; Connor & Davidson, 2001). This tool was designed to be used primarily as a post-service tool. Therefore, for items 1 through 26, and items 36 and 37, you are not looking for change in the clients' responses over time, but will be comparing their post-service responses to the desired score (for items 1 through 26, the desired score is "5"; for items 36 and 37, the desired score is "1"). The responses in the Empowerment and Satisfaction scale (items 1 through 26), and items 36 and 37 in the Post Traumatic Stress Symptomatology scale can be analyzed in terms of percentage (e.g., the percentage of clients who reported satisfaction with the agency's services), or by the mean – average – score for the group of questionnaires being analyzed (the average aggregate score for items 1 through 25 for a specific group of client questionnaires). You will always keep the analysis for items 1 through 26 separate from the analysis for items 36 and 37 since they are in different scales.

   For items 27 through 35, from questionnaires that are administered post-service, you will have data on the post traumatic stress symptoms that your clients are experiencing. This will not show any change – so will not be determining an impact of services. However, these items are important for the context of item 37 ("Overall, how much have the above symptoms improved since starting services?"); and the data may also be used to articulate the impact of victimization. In addition, you may choose to use items 27 through 35 in a pre/subsequent questionnaire format. If you do so, you would analyze the data for these items in the same manner you do the information from the ACQ.

3. In either tool, you may report on the scores for an individual item as an indicator for an identified outcome (e.g., from the ESQ, the identification of a support system might be singled out for analysis and reporting based on a request from a funding source). This is particularly useful when you want to highlight strengths or areas of concern that clients report about single concepts or ideas. However, in order to preserve the integrity of the tools, you may not ask just that question of clients. The item is a valid and reliable indicator of that outcome only if it is asked with all the items in the scale or subscale.

   The software that you choose to use to support the outcome data and analysis will determine the types of reports you will produce. The software should have the capacity to record a "missing value" on items for which the client did not respond. Otherwise, the score would be calculated as "0" in the data analysis. You should review the tools/questionnaires before entering the data, to identify items that need to be coded for "missing value," and to determine the number of items that have been skipped in each scale or subscale; a scale or subscale in which too many items were skipped (more than 1/3) should be excluded.

REPORTS

Depending on an agency's software capabilities, a report may be in the form of numbers, a bar graph, a pie chart, or a line graph. These visual reports, however, must always be accompanied by a narrative description of the results and analysis. Based on the type of information collected outcome data can be sorted by demographic or data variables. For example, an agency may find that its services are more effective for a specific age group.

Reporting on Mean Scores:

A short-term outcome on our sample logic model is "increased coping and sense of empowerment." By looking at the mean of the aggregated scores for the items in that subscale on the ESQ-LF, you will be able to report on your clients' responses (from "strongly agree" to "strongly disagree").

Reporting on Changes in Mean Scores:

An intermediate-term outcome on our sample logic model is "reduction in post traumatic stress symptoms." There is a scale on the ACQ that includes a grouping of items for that outcome (see Appendix II for the listing of scales and their items for the questionnaire). By looking at the mean score for this scale for pre-service questionnaires for a group of clients, and then the mean score for these same clients on their subsequent-service or post-service questionnaires, you will be able to calculate the degree of change for this group of clients. We must note here, however, that until more data is collected from a large group of victim service providers, a benchmark for statistical significance of the change will not be established. You can, however, report this number without claiming statistical significance.

Reporting the Percentage of Clients Showing an Improvement in Response to the Victimization:

Using the outcome noted above, "reduction in post traumatic stress symptoms," you can also track the number of people who showed improvement in this area and report this as a percentage, comparing it to the entire group of clients completing the questionnaire. For example, you might establish the following projected outcome:

> PROJECTED OUTCOME: For the 200 clients receiving services in the counseling program, 75% of them will show a reduction in post traumatic stress symptoms.
>
> To track this outcome, you will review the data for these 200 clients, tracking how many of them showed an improvement from pre-service questionnaire to subsequent questionnaire in post traumatic stress symptoms. When you complete that review, you will have an actual outcome statement:
>
> ACTUAL OUTCOME: For the 200 clients receiving services in the counseling program, 78% of them showed a positive change. Therefore, the agency slightly exceeded its goal.

You can use the data to:

- Identify change, as an aggregate, for all clients receiving a particular service or all clients within an entire program, which indicates if that service, or your entire program, has achieved the expected outcome.

- Identify effective and ineffective counseling techniques. If during the course of measuring outcomes, you institute a new counseling technique and notice a change in a specific scale or subscale, this could provide valuable information about the effectiveness of this new technique.

SOFTWARE

Software has been developed for the outcomes project using a software package (R/Client) designed for client information management. The software may be used in conjunction with the other features of the R/Client package providing a "seamless" application from client registration through entry of service information to outcome data. It may also be used as a stand-alone package, using only the outcome module. A manual has been developed by the software developer to support this R/Client software.

You may choose to use the software that has been designed specifically to support this project, or you may choose to use other software.

If you are using another data management package, creating a spreadsheet in Microsoft® Excel or using other software (such as SPSS or SAS), there must be a way to calculate the amount and direction of change in the scores for each item, from pre-service to subsequent questionnaires. The individual scores should then be able to be calculated by subscales (the items grouped together) and as a total.

PLANNING AND IMPLEMENTATION

CHAPTER 5

- Securing Buy-in
- Addressing Consent, Confidentiality and Bias
- Selecting the Services to Evaluate and the Tool to Use
- Deciding What Demographic Information to Collect
- Allocating Staff Resources
- Developing a System for Implementation
- Conducting Training for Staff, Volunteers and Board

To launch a successful outcome measurement project requires a significant amount of time planning for the project and preparing key stakeholders for their role in implementation. There are many things to consider prior to implementation. Initial careful consideration of all aspects of the project and its impact on the organization will lead to an increased ability to achieve the best results.

SECURING BUY-IN

…from external stakeholders (clients, funding sources, the community, etc)
Before deciding to adopt this model for measuring the impact of services, agency leaders should identify expectations external stakeholders might have about the way outcomes will be measured and shared. Leaders in the agency (the Executive Director, managers) will present this approach to stakeholders, discuss expectations, and describe the final model that will be used.

For example, the local United Way may have adopted a specific plan to be used by member agencies in addressing the effectiveness and impact of their services. If this were the case, agency leaders would review the VSPE evaluation model with the United Way staff to determine if it is acceptable. Since this model provides concrete data about the impact of services, as does the United Way model, its acceptance is likely.

. . . from internal stakeholders (staff members, board members, volunteers)
After the decision is made to adopt this model to measure the outcomes relating to the services that are provided to clients, agency leaders must determine who is crucial to the success of the concept internally. Key participants could include members of the Board of Directors, the management team, direct service staff, volunteers, and the administrative team who will provide support to the project. Areas of concern should be identified and addressed and additional information provided as necessary. Agency leaders should be prepared and able to document and discuss the benefits of adopting outcome measurements.

If all key participants are informed and have the opportunity to ask questions, it will ease the process of adopting and implementing an outcome evaluation method. Reviewing the documented benefits will also be helpful when facing the inevitable challenges of implementing an outcome model. Some examples of benefits and concerns are noted below for your reference.

Potential benefits for internal stakeholders

Counselors *Staff and Volunteer*	Validation of their work Opportunity to identify areas for skill enhancement
Board of Directors	Objective and concrete basis for measuring the impact of services offered Better information for response to community questions about the effectiveness of services
Management team	Valuable information for program planning and resource allocation
Overall	Validation of the agency's work Enhanced funding opportunities

Concern about impact on clients

Will procedures be too intrusive on clients' time when they are in crisis and need to deal with their specific issues?	Through field-testing, we found that clients were not adversely affected, since it takes less than 15 minutes for each administration of either the ACQ or ESQ questionnaire.
Will this process raise client anxiety?	Since this is a voluntary activity for clients, they may decline to participate at any time or may opt not to complete the full ACQ or ESQ.
Will this process take time away from service provision to clients?	The process has been designed to fit within the regular flow of an agency's services and to occur outside of counseling time normally spent with clients.

ADDRESSING CONSENT, CONFIDENTIALITY AND BIAS

Consent, Confidentiality and Bias require serious consideration (see the last section of Chapter 2 for additional information on these topics). We address these topics again in this chapter since you will be taking these issues into consideration as you plan for implementation.

Consent: In the VSPE model, participation is voluntary. Each client is asked to sign a consent form, explaining the tool and the client's rights related to the tool, before participating. An agency should never base the provision of services on a client's willingness to complete the questionnaire. (See Appendix III for a sample Consent Form.)

Confidentiality: In the VSPE model, provisions have been made to address confidentiality concerns. Questionnaires are tracked through the use of client numbers, rather than names, on all forms. This allows each individual agency to decide whether or not the questionnaire information will be linked to client identity and record at any time. Linking outcomes data to the client file provides enhanced information in the analysis of overall outcome results (demographics already collected, length of service, type of service, etc). However, linking outcomes data to the client file also links more data to that client. You should consider this, and your agency's policy on client files/records and the type of information stored in a client's file, as part of your decision-making regarding client identity and outcome information.

The questionnaires are designed as management tools for program planning and development by analyzing overall scores from a group of clients receiving a particular service. Each agency must consider the implications in linking outcome data to a client file, and establish protocol to support that decision. Agencies may choose one of the following options for data entry/management:

Outcome Information Only:

The outcome data may be kept entirely separate from any other information related to the client, with no additional demographic information entered. The agency will be able to track outcomes, but will not be able to link this data to demographics or service data. This may be done on the computer software created to support this project (R/Client), or in any database an agency chooses to use for this purpose.

Outcome information with Demographic Information:

The outcome data may be kept separate from client identity and file (which includes the record of services received and demographics from intake), with the extra step taken of gathering specific client demographic information at the time the questionnaire is administered. The agency will be able to track outcomes, and link them to demographics but not service or identifying client data. This may be done on the computer software created to support this project (R/Client), or in any database an agency chooses to use for this purpose.

Outcome Information Linked To Client Data:

The outcome data may be entered into the database that tracks all other client information, linked directly to that data and the client. The agency will be able to track outcomes, and link them to demographics collected at intake and service data (e.g., length of service, type of service). This may be done on the computer software created to support this project (R/Client), or in any database an agency chooses to use for this purpose.

See the section on "Deciding what Demographic Information to Collect" for additional guidelines.

Bias: Developing procedures to address the possibility of bias is important. Ideally counselors should not administer the questionnaire to their clients. If clients believe that their counselors will be reviewing their responses, they may answer differently by giving favorable impressions or responding in the way they believe their counselors expect them to respond.

SELECTING THE SERVICES TO EVALUATE AND THE TOOL TO USE

Not all services will be appropriate for the pre-service and subsequent service questionnaire (ACQ) design. Agency leaders should consider:

- The amount of time that the client is in personal contact with the agency and the number of contacts the client is likely to have with the agency. Brief or short-term interactions may not provide enough time between intervals to complete both a pre-service and post-service questionnaire. The ESQ might be a better option with brief or short-term client interactions.

- The state of crisis existing for a client in relationship to a particular service. Some services have contact based on an immediate crisis when it would not be appropriate to administer a questionnaire (for example, medical advocacy).

After deciding which services to evaluate with the ACQ, agency leaders will need to determine at what point to administer subsequent questionnaires. (See Appendix IV for a list of service definitions used in the development of this project.) Clients who are receiving services to be evaluated will receive the pre-service questionnaire (ACQ) at the time of the first service.

DECIDING WHAT DEMOGRAPHIC INFORMATION TO COLLECT

For the ACQ, you may choose to collect demographic information specific to this evaluation process. If so, include a demographic information collection form with the first administration of the ACQ. (See Appendix III for a sample.)

For the ACQ, outcome data may also be integrated with existing client demographic information obtained from the initial client intake form. This will be possible only if the client's identity is linked to the questionnaire.

Since the ESQ is to be completed anonymously, you would not be able to link that to existing client demographic data. Therefore, you will have to collect demographic information at the time you administer the ESQ.

ALLOCATING STAFF RESOURCES

Outcome project manager	• This person will manage the project and should have a hands-on knowledge of service provision.
	• General responsibilities will include:
	  • Development and implementation oversight of all procedures related to the outcomes project.
	  • Coordination of data management.
	  • Analysis of data and interpretation of results.
	  • Involvement in the development of reports.
	  • Analysis of reports.
	  • Involvement in program planning and related activities.

Counselor or direct service provider	• Though the process should have a limited impact on this person's daily work, the counselor or direct service provider will need to be familiar with the process. In addition, the counselor will need to allocate time for:
	  • Tracking for administering subsequent questionnaire(s). This will be done by using a log form (see Appendix III for a sample form).
	  • Periodically reviewing the aggregated data and processing the implications.
	  • Participating in program planning adjustments based on the outcome information.
	• Note: If administrative or support staff will not be administering the questionnaires, counselors may have to support each other in this function. (For example, Counselor "A" would administer questionnaires to clients of Counselor "B", and vice versa). This would require an additional time commitment from direct service staff.

Administrative or support staff	• As previously noted, counselors should not administer questionnaires to their own clients. A practical alternative is to have the questionnaires administered by administrative or support staff. • The administrative staff person will need time in her or his schedule for brief interactions with clients coming in for appointments.
Data management person	• This person is responsible for data entry of all questionnaires (ACQ and ESQ), and will generate reports needed for analysis and program planning. Ideally, to maintain the integrity of collected data, this person will not be administering questionnaires to clients or have access to information that will tie client identity to the questionnaire form.

DEVELOPING A SYSTEM FOR IMPLEMENTATION

At this point,

- buy-in from internal and external stakeholders has been secured,
- decisions have been made on what services will be evaluated and what demographic information will be collected,
- the impact on clients has been considered, including confidentiality and consent,
- software to track data has been chosen, and
- a plan has been developed for allocation of staff resources.

Now it is time to develop a system for implementation. The following questions must be answered as part of the implementation process.

What data management system is best suited to the agency's needs?

We addressed the options for data management in the previous chapter. Your agency should make a decision about managing the data in the software option you have selected before beginning to collect data for the outcome analysis.

What numbering system will be used for the questionnaires and demographic sheets?

- If a packaged software program is used and outcome information is to be linked to client files and existing demographics, the software program's numbering system may be used.

- If outcome information is not to be linked to a client's file, a system must be established to link a client's outcome information to demographic information. This may be accomplished through a numbering system or some other type of coding.

  Note: To protect confidentiality, client names should not be included on the pre-service and subsequent service questionnaires, nor on the demographic sheets. If they are to be used in tracking the administration of surveys, they should be noted only on the cover sheet for the questionnaires. Coversheets should be stored separately from the identifying materials in a locked or secure filing system.

Using a logbook

A logbook is a helpful tool to track distribution of subsequent questionnaires and to record unusual circumstances that might have an impact on data. (A few examples are noted below and are also referenced in more detail in Appendix III.) A logbook may include columns to:

- Track the assignment of numbers to client identity.
- Track attempts to administer questionnaires.
- Note the way the questionnaire is administered (for example, through the mail or in-person).
- Note other unusual circumstances, such as:
  - ✓ An individual who declines to participate.
  - ✓ An individual who is unable to complete the questionnaire due to a state of crisis or other issues. Care should be taken, as you would with any sensitive client information, when noting the circumstance.

When will the questionnaires be administered?

For the ACQ, pre-service questionnaires are administered to all clients receiving selected services prior to their first appointment or in-person contact. Subsequent questionnaires may be administered at some intermediate point in the counseling relationship, or may be done only at the end of service. This will be determined by the type of information to be gathered. For example, an agency may have a long-term counseling program. It is reasonable for the agency to decide to use two to three time intervals to measure outcomes from this type of service.

An effective technique for administering questionnaires is to ask new clients to arrive 15 minutes early for their first appointment, and to receive the ACQ, consent form, demographics form (if demographic information from the client intake is not going to be linked to the outcomes) and instructions from an administrative or support staff person. The staff person making the appointment can explain that the client will be completing a short questionnaire to assist the agency in evaluating the effectiveness of its services.

At subsequent administrations of the ACQ, the administrative or support staff person would then be responsible to meet the client immediately following the designated session to administer the questionnaire. The ESQ is also given following the last session.

Establish a communication mechanism to facilitate the flow of information between the counselor and the administrative or support staff person who will be administering the questionnaires. This includes but is not limited to the timing of questionnaire administration, and any issues specific to clients.

Who will administer the questionnaires?

The agency will need to make final decisions about which staff people will be involved in administering questionnaires. See the "Allocating Staff Resources" section earlier in this chapter.

How will you make and store blank copies of questionnaires and forms?

A supply of questionnaires and forms need to be accessible to any staff who will be administering these documents. The supply should be adequate to cover anticipated needs. Be sure to establish who is responsible for maintaining the supply of questionnaires and forms.

Since timing is important to this process, not having a questionnaire available could mean missing an opportunity to collect valuable data.

Where and how will clients complete the questionnaires?

Ideally, the client will complete the questionnaire in a quiet space other than the counseling space. If the waiting area is crowded or noisy, a client may find it difficult to concentrate on the questionnaire. Therefore, it is important to ensure that a client haves the most optimal space possible in which to complete the questionnaire.

Agencies should use a variety of means in being prepared to meet the diverse needs of clients, including adaptations for reading ability, language, injuries and disabilities (e.g., questionnaires in Braille, large print, electronic format, etc). If a staff person will be reading the questionnaire to a client, that person should make arrangements to do this in a private setting.

Who will keep track of clients who will be completing questionnaires?

The client's counselor will likely be the person to keep track of which clients are due to receive questionnaires. The counselor will review client schedules the day before, and inform the person who administers the questionnaires which appointments will require the administration of questionnaires. This allows the person administering the questionnaires to prepare and anticipate when she or he will be needed throughout the day. This process can also be done through some software programs.

How will completed questionnaires be passed to the data management person?

Develop a system for paper flow, including a locked, confidential location for storing the completed questionnaires until they can be transferred to the data management person. All questionnaires should be given to the data management person for data entry as soon as possible after their completion. Further, the agency should identify an area for the forms to be stored after the data is entered and compiled. Data entry managers generally establish a regular schedule for data entry of completed questionnaires.

As with any client information, completed questionnaires should be treated as confidential agency materials.

CONDUCTING TRAINING FOR STAFF, VOLUNTEERS AND BOARD

Training should be provided, at a minimum, to those individuals who have responsibility for any steps in the system. Ongoing training may also be necessary to monitor the process, address any concerns, and fine-tune the system. We have found better results when we involve all staff members in assessing the outcomes of our agency services. Staff members may gain a sense of pride for being involved in the process of improving services to clients.

Implications of outcomes information

Regular, scheduled staff meetings can be used as a forum to discuss the project and its implications. At the meetings, staff can discuss the information that has been gathered and what it means for the organization.

Discussions will provide staff members with ample information to answer their questions about the value of the process and the impact on service planning. This will make the process meaningful to staff members by sharing the valuable insights that can be gained from measuring outcome information. In addition, agency leaders can solicit ideas from staff about additional reports to generate or new ways to analyze data. As with any process, keeping staff members informed will reduce concerns about unknown impacts and increase commitment to the project.

THE FUTURE OF THE PROJECT

As with any project, the future must always be considered. The broader implications of having a standard, statistically significant, statewide collection system for data that can show the impact victim service professionals have on the well-being of the population being served are astounding. This project has provided the field with new tools to evaluate the impact of services, thus providing important data about the most effective use of resources. The ability to then share data with funders and the general community about the impact of services will help ensure that financial resources remain for victims to receive the vital services they need and to which they are entitled.

However, the work clearly is not completed, and will be an evolving process. The victim services field has historically provided, and will continue to offer, a plethora of services to a multitude of victims. Yet gaps in services exist, and the ability to measure the impact of services on specific populations remains unfinished. Work is still to be done on the expansion of this specific methodology to evaluate services for teens and children. In addition, these tools must be tested with specific populations, and assessed for use with other types of services as new programs become available. The original collaborative group began this project with the intention of assessing the effectiveness of services and developing a more effective way of demonstrating to funding sources and the public the purpose and impact of providing services to victims of crime. This project has been in process for eleven years, and will continue into the future, evolving as data is analyzed, expanding as opportunities for further testing become available.

APPENDICES

I. Tools/Questionnaires

   A. Adult Client Questionnaire (ACQ)

   B. Empowerment and Satisfaction Questionnaire-Long Form (ESQ-LF)

   C. Empowerment and Satisfaction Questionnaire-Short Form (ESQ-SF)

II. Scales and Subscales, including the list of items for each scale and subscale

   A. Adult Client Questionnaire (ACQ)

   B. Empowerment and Satisfaction Questionnaire-Long Form (ESQ-LF)

   C. Empowerment and Satisfaction Questionnaire-Short Form (ESQ-SF)

III. Sample Forms:

   A. Cover Sheet for the ACQ

   B. Consent Form

   C. Log for Tracking

   D. Demographic Form

IV. Service Definitions (PCAR)

V. Testing for Reliability and Validity: General Information

Vi. Tools From Other Sources Available to Evaluate Services for Children And Teens

VII. Developing the Methodology for the Original Evaluation Project

VIII. Reference/Citation list

APPENDIX I

A. Adult Client Questionnaire (ACQ)

ADULT CLIENT QUESTIONNAIRE (ACQ)

Experiencing or remembering a hurtful or violent event often impacts how people feel or behave. **Please circle the answer that best describes how much you have been bothered by that problem in the past month. Provide one response and one response only on the scale provided.**

(This information will not be used for counseling purposes; if you have immediate needs, please talk to your counselor.)

		Not at all	A little bit	Moder-ately	Quite a bit	Extrem-ely
1.	Repeated, disturbing memories, thoughts, or images of the victimization?	**1**	**2**	**3**	**4**	**5**
2.	Repeated, disturbing dreams of the victimization?	**1**	**2**	**3**	**4**	**5**
3.	Suddenly acting or feeling as if the victimization were happening again (as if you were reliving it)?	**1**	**2**	**3**	**4**	**5**
4.	Feeling very upset when something reminded you of the victimization?	**1**	**2**	**3**	**4**	**5**
5.	Having physical reactions (e.g., heart pounding, trouble breathing, sweating) when something reminded you of the victimization?	**1**	**2**	**3**	**4**	**5**
6.	Avoiding thinking about or talking about the victimization or avoiding having feelings related to it?	**1**	**2**	**3**	**4**	**5**
7.	Avoiding activities or situations because they reminded you of the victimization?	**1**	**2**	**3**	**4**	**5**
8.	Trouble remembering important parts of the victimization?	**1**	**2**	**3**	**4**	**5**
9.	Loss of interest in activities that you used to enjoy?	**1**	**2**	**3**	**4**	**5**
10.	Feeling distant or cut off from other people?	**1**	**2**	**3**	**4**	**5**
11.	Feeling emotionally numb or being unable to have loving feelings for those close to you?	**1**	**2**	**3**	**4**	**5**
12.	Feeling as if your future will somehow be cut short?	**1**	**2**	**3**	**4**	**5**
13.	Trouble falling or staying asleep?	**1**	**2**	**3**	**4**	**5**
14.	Feeling irritable or having angry outbursts?	**1**	**2**	**3**	**4**	**5**
15.	Having difficulty concentrating?	**1**	**2**	**3**	**4**	**5**

		Not at all	A little bit	Moder-ately	Quite a bit	Extrem-ely
16.	Being "super-alert" or watchful or on guard?	**1**	**2**	**3**	**4**	**5**
17.	Feeling jumpy or easily startled?	**1**	**2**	**3**	**4**	**5**
18.	Using alcohol or drugs not prescribed to you to deal with your feelings?	**1**	**2**	**3**	**4**	**5**
19.	Doing risky things?	**1**	**2**	**3**	**4**	**5**
20.	Doing things to physically harm yourself?	**1**	**2**	**3**	**4**	**5**
21.	Drinking or using drugs too much?	**1**	**2**	**3**	**4**	**5**
22.	Eating too much?	**1**	**2**	**3**	**4**	**5**
23.	Having no interest in sexual activity?	**1**	**2**	**3**	**4**	**5**
24.	Having difficulty becoming sexually aroused?	**1**	**2**	**3**	**4**	**5**
25.	Not eating enough?	**1**	**2**	**3**	**4**	**5**

Weathers, F., Litz, B., Herman, D., Huska, J., & Keane, T. (October 1993). The PTSD Checklist (PCL): Reliability, Validity, and Diagnostic Utility. Paper presented at the Annual Convention of the International Society for Traumatic Stress Studies, San Antonio, TX.

APPENDIX I

B. Empowerment and Satisfaction Questionnaire-Long Form (ESQ-LF)

EMPOWERMENT AND SATISFACTION QUESTIONNAIRE (ESQ-LF)

As a client of our agency, you received services in response to a traumatic event(s). In order to provide the best possible services, we would like to know how much our agency helped you to deal with that particular trauma. Please read the following statements about the services and other aspects of the agency and circle if you strongly agree, somewhat agree, are neutral (don't feel strongly one way or the other), somewhat disagree or strongly disagree with the statements.

Section A:

		Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly Agree
1.	Staff respected my background (e.g. gender, race, culture, ethnicity, sexual orientation, disability, lifestyle, etc.).	**1**	**2**	**3**	**4**	**5**
2.	Services were available at times that were good for me.	**1**	**2**	**3**	**4**	**5**
3.	I was asked to participate in deciding what services I would receive.	**1**	**2**	**3**	**4**	**5**
4.	I feel the staff heard me.	**1**	**2**	**3**	**4**	**5**
5.	I got the kind of service I wanted.	**1**	**2**	**3**	**4**	**5**
6.	Staff helped me believe that I could change and improve my life.	**1**	**2**	**3**	**4**	**5**
7.	The services I received helped me deal more effectively with my problems.	**1**	**2**	**3**	**4**	**5**
8.	Because of the services I received, I learned skills to help me better manage my life.	**1**	**2**	**3**	**4**	**5**
9.	The services I received helped me identify a support system.	**1**	**2**	**3**	**4**	**5**
10.	The services I received helped me become aware of how crisis and trauma affect my life.	**1**	**2**	**3**	**4**	**5**
11.	The services I received helped me plan for my safety.	**1**	**2**	**3**	**4**	**5**
12.	The staff informed me about Victims Rights.	**1**	**2**	**3**	**4**	**5**
13.	The services I received helped me cope with my fear for my safety.	**1**	**2**	**3**	**4**	**5**

Section A (continued):

		Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly Agree
14.	Because of the services I received, I know more about the options and choices available to me overall.	**1**	**2**	**3**	**4**	**5**
15.	I would return to this agency if I needed victim services in the future.	**1**	**2**	**3**	**4**	**5**
16.	I would recommend this agency to a friend in need of victim services.	**1**	**2**	**3**	**4**	**5**
17.	In an overall, general sense, I am satisfied with the services I received.	**1**	**2**	**3**	**4**	**5**
18.	Because of the services I received, I know about community resources that are available to me.	**1**	**2**	**3**	**4**	**5**
	Is there anything else you would like to say? _____ _____					

Section B: If you visited our facility, please answer the following questions. If you never visited our facility, skip to Section C.

		Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly Agree
19.	I was able to get around the building easily.	**1**	**2**	**3**	**4**	**5**
20.	The facilities were comfortable for me.	**1**	**2**	**3**	**4**	**5**
	Is there anything else you would like to say? _____ _____					

Section C: If someone from our agency met you at an emergency medical facility, please answer the following questions about the services we provided. If not, please skip to Section D.

		Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly Agree
21.	I felt supported through the medical system by staff from the agency.	**1**	**2**	**3**	**4**	**5**
22.	Because of the services I received, I now know more about the medical system.	**1**	**2**	**3**	**4**	**5**
	Is there anything else you would like to say? _____ _____					

Section D: If someone from our agency accompanied you through the legal process, please answer the following questions about the services we provided. If not, please skip to Section E.

		Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly Agree
23.	I felt supported through the legal system by staff from the agency.	**1**	**2**	**3**	**4**	**5**
24.	Because of the services I received, I now know more about the legal system.	**1**	**2**	**3**	**4**	**5**
	Is there anything else you would like to say? _____ _____					

Section E: If you had any of the following out-of-pocket (not covered by any type of insurance) financial losses as a direct result of the victimization, please answer the following questions. If you did not have any of these out-of-pocket financial losses, please skip to Section F.

- Medical expenses
- Home healthcare
- Counseling fees
- Loss of earnings
- Loss of support
- Funeral expenses
- Crime scene cleanup fees
- Relocation expenses
- Transportation expenses
- Child care
- Replacement of medical devices
- Replacement services (of normal daily household chores – cooking, lawn care, cleaning, etc.)

		Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly Agree
25.	The agency made me aware of the Pennsylvania Victim Compensation Program.	**1**	**2**	**3**	**4**	**5**
26.	The information provided by the agency helped me understand the victim compensation process.	**1**	**2**	**3**	**4**	**5**
	Is there anything else you would like to say? _____ _____					

Section E: Please consider the following reactions which sometimes occur after a traumatic event. This section is concerned with your personal reactions to the traumatic event which happened to you. Please circle one answer for each question.

	In the past week	Not at All	A Little Bit	Moderately	Quite a Lot	Very Much
27.	How much have you been bothered by unwanted memories, nightmares or reminders of the event?	**1**	**2**	**3**	**4**	**5**
28.	How much effort have you made to avoid thinking or talking about the event, or doing things which remind you of what happened?	**1**	**2**	**3**	**4**	**5**

	In the past week	Not at All	A Little Bit	Moderately	Quite a Lot	Very Much
29.	To what extent have you lost enjoyment for things, felt sad or depressed, kept your distance from people, or found it difficult to experience feelings?	**1**	**2**	**3**	**4**	**5**
30.	How much have you been bothered by poor sleep, poor concentration, jumpiness, irritability or feeling watchful around you?	**1**	**2**	**3**	**4**	**5**
31.	How much have you been bothered by pain, aches or tiredness?	**1**	**2**	**3**	**4**	**5**
32.	How much would you get angry or upset when stressful events or setbacks happened to you?	**1**	**2**	**3**	**4**	**5**
33.	How much have you been blaming yourself or feeling guilty for what happened to you?	**1**	**2**	**3**	**4**	**5**
34.	How much have the above symptoms interfered with your ability to work or carry out daily activities?	**1**	**2**	**3**	**4**	**5**
35.	How much have the above symptoms interfered with your relationships with family or friends?	**1**	**2**	**3**	**4**	**5**
36.	How much better do you feel since beginning services? (as a percentage) 100% 50% 0% As well as I could be No change					
37.	Overall, how much have the above symptoms improved since starting services? (circle one) Very Much 1 Much 2 Minimally 3 No Change 4 Worse 5					
	What did you find helpful about our services? _____ _____ _____					
	What did you find not helpful about our services? Please include any suggestions you have for improvement. _____ _____ _____					

CLIENT DEMOGRAPHICS

TYPE OF VICTIMIZATION
(Check All That Apply to Your Current Situation)

- ☐ Domestic Violence
- ☐ Sexual Assault
- ☐ Child Abuse (Sexual)
- ☐ DUI Victim
- ☐ Caregiver of Victim/Survivor
- ☐ Physical Assault
- ☐ Child Abuse (Physical)
- ☐ Robbery
- ☐ Homicide Survivor

How long did you receive services from our agency?

- ☐ 0-3 months
- ☐ 3-6 months
- ☐ 6-12 months
- ☐ 1-2 years
- ☐ 2-4 years
- ☐ more than 4 years

TYPE OF SERVICE RECEIVED
(Check all that apply)

- ☐ Crisis counseling
- ☐ Victim compensation
- ☐ Legal advocacy
- ☐ Shelter
- ☐ Group counseling
- ☐ Individual therapy
- ☐ Medical advocacy

Have You Had Prior Victimizations?

- ☐ Yes
- ☐ No Type: _____

DATE OF BIRTH: _____

GENDER:

- ☐ M
- ☐ F
- ☐ Other

DISABILITY:

- ☐ Mental/Emotional
- ☐ Physical
- ☐ Other

PRIMARY INCOME SOURCE

- ☐ Employment
- ☐ Pension/Retirement
- ☐ Support
- ☐ Social Security
- ☐ Unemployment
- ☐ Public Assistance
- ☐ Other

ETHNIC ORIGIN

- ☐ Black/African-American
- ☐ White
- ☐ Hispanic/Latino(a)
- ☐ Asian or Pacific Islander
- ☐ American Indian/Alaska Native
- ☐ Bi-racial
- ☐ Other: _____
- ☐ Unknown

MARITAL/RELATION (if adult)

- ☐ Married
- ☐ Living with Partner
- ☐ Separated
- ☐ Relationship, Not Living with Partner
- ☐ Other: _____
- ☐ Divorced
- ☐ Single
- ☐ Widow/Widower

EDUCATION

- ☐ No GED or High School
- ☐ High School
- ☐ College Degree
- ☐ Graduate Degree
- ☐ Unknown
- ☐ GED
- ☐ Some College
- ☐ Some Graduate
- ☐ Post Graduate

HOUSEHOLD INCOME

- ☐ Less than $5,000
- ☐ $5,000-$9,999
- ☐ $10,000-$14,999
- ☐ $15,000-$19,999
- ☐ $20,000-$24,999
- ☐ $25,000-$29,999
- ☐ $30,000-$49,999
- ☐ over $50,000
- ☐ Unknown

Mental Health Statistics Improvement Program (2000). Mental Health Statistics Improvement Program Survey. Retrieved online [http://www.mhsip.org/surveylink.htm] Oct 16, 2007.
Connor, K., & Davidson, J. (2001). SPRINT: A brief global assessment of post-traumatic stress disorder. International Clinical Psychopharmacology, 16, 279-284.

APPENDIX I

C. Empowerment and Satisfaction Questionnaire-Short Form (ESQ-SF)

EMPOWERMENT AND SATISFACTION QUESTIONNAIRE (ESQ-SF)

As a client of our agency, you received services in response to a traumatic event(s). In order to provide the best possible services, we would like to know how much our agency helped you to deal with that particular trauma. Please read the following statements about the services and other aspects of the agency and circle if you strongly agree, somewhat agree, are neutral (don't feel strongly one way or the other), somewhat disagree or strongly disagree with the statements.

Section A:

		Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly Agree
1.	Staff respected my background (e.g. gender, race, culture, ethnicity, sexual orientation, disability, lifestyle, etc.).	**1**	**2**	**3**	**4**	**5**
2.	Services were available at times that were good for me.	**1**	**2**	**3**	**4**	**5**
3.	I was asked to participate in deciding what services I would receive.	**1**	**2**	**3**	**4**	**5**
4.	I feel the staff heard me.	**1**	**2**	**3**	**4**	**5**
5.	I got the kind of service I wanted.	**1**	**2**	**3**	**4**	**5**
6.	The services I received helped me deal more effectively with my problems.	**1**	**2**	**3**	**4**	**5**
7.	I would return to this agency if I needed victim services in the future.	**1**	**2**	**3**	**4**	**5**
8.	I would recommend this agency to a friend in need of victim services.	**1**	**2**	**3**	**4**	**5**
9.	In an overall, general sense, I am satisfied with the services I received.	**1**	**2**	**3**	**4**	**5**
	Is there anything else you would like to say?					

Section B: Please consider the following reactions which sometimes occur after a traumatic event. This section is concerned with your personal reactions to the traumatic event which happened to you. Please circle one answer for each question.

	In the past week	Not at All	A Little Bit	Moderately	Quite a Lot	Very Much
10.	How much have you been bothered by unwanted memories, nightmares or reminders of the event?	**1**	**2**	**3**	**4**	**5**
11.	How much effort have you made to avoid thinking or talking about the event, or doing things which remind you of what happened?	**1**	**2**	**3**	**4**	**5**
12.	To what extent have you lost enjoyment for things, felt sad or depressed, kept your distance from people, or found it difficult to experience feelings?	**1**	**2**	**3**	**4**	**5**
13.	How much have you been bothered by poor sleep, poor concentration, jumpiness, irritability or feeling watchful around you?	**1**	**2**	**3**	**4**	**5**
14.	How much have you been bothered by pain, aches or tiredness?	**1**	**2**	**3**	**4**	**5**
15.	How much would you get angry or upset when stressful events or setbacks happened to you?	**1**	**2**	**3**	**4**	**5**
16.	How much have you been blaming yourself or feeling guilty for what happened to you?	**1**	**2**	**3**	**4**	**5**
17.	How much have the above symptoms interfered with your ability to work or carry out daily activities?	**1**	**2**	**3**	**4**	**5**
18.	How much have the above symptoms interfered with your relationships with family or friends?	**1**	**2**	**3**	**4**	**5**

19. How much better do you feel since beginning services? (as a percentage)

100% 50% 0%

As well as I could be No change

20. Overall, how much have the above symptoms improved since starting services? (circle one)

Very Much	Much	Minimally	No Change	Worse
1	2	3	4	5

What did you find helpful about our services?

	What did you find not helpful about our services? Please include any suggestions you have for improvement. _____ _____ _____

CLIENT DEMOGRAPHICS

TYPE OF VICTIMIZATION
(Check All That Apply to Your Current Situation)

- ☐ Domestic Violence
- ☐ Sexual Assault
- ☐ Child Abuse (Sexual)
- ☐ DUI Victim
- ☐ Caregiver of Victim/Survivor
- ☐ Physical Assault
- ☐ Child Abuse (Physical)
- ☐ Robbery
- ☐ Homicide Survivor

How long did you receive services from our agency?

- ☐ 0-3 months
- ☐ 3-6 months
- ☐ 6-12 months
- ☐ 1-2 years
- ☐ 2-4 years
- ☐ more than 4 years

TYPE OF SERVICE RECEIVED
(Check all that apply)

- ☐ Crisis counseling
- ☐ Victim compensation
- ☐ Legal advocacy
- ☐ Shelter
- ☐ Group counseling
- ☐ Individual therapy
- ☐ Medical advocacy

Have You Had Prior Victimizations?

- ☐ Yes
- ☐ No Type: _____

DATE OF BIRTH: _____

GENDER:

- ☐ M
- ☐ F
- ☐ Other

DISABILITY:

- ☐ Mental/Emotional
- ☐ Physical
- ☐ Other

PRIMARY INCOME SOURCE

- ☐ Employment
- ☐ Pension/Retirement
- ☐ Support
- ☐ Social Security
- ☐ Unemployment
- ☐ Public Assistance
- ☐ Other

ETHNIC ORIGIN

- ☐ Black/African-American
- ☐ White
- ☐ Hispanic/Latino(a)
- ☐ Asian or Pacific Islander
- ☐ American Indian/Alaska Native
- ☐ Bi-racial
- ☐ Other: _____
- ☐ Unknown

MARITAL/RELATION (if adult)

- ☐ Married
- ☐ Living with Partner
- ☐ Separated
- ☐ Relationship, Not Living with Partner
- ☐ Other: _____
- ☐ Divorced
- ☐ Single
- ☐ Widow/Widower

EDUCATION

- ☐ No GED or High School
- ☐ High School
- ☐ College Degree
- ☐ Graduate Degree
- ☐ Unknown
- ☐ GED
- ☐ Some College
- ☐ Some Graduate
- ☐ Post Graduate

HOUSEHOLD INCOME

- ☐ Less than $5,000
- ☐ $5,000-$9,999
- ☐ $10,000-$14,999
- ☐ $15,000-$19,999
- ☐ $20,000-$24,999
- ☐ $25,000-$29,999
- ☐ $30,000-$49,999
- ☐ over $50,000
- ☐ Unknown

Mental Health Statistics Improvement Program (2000). Mental Health Statistics Improvement Program Survey. Retrieved online [http://www.mhsip.org/surveylink.htm] Oct 16, 2007.
Connor, K., & Davidson, J. (2001). SPRINT: A brief global assessment of post-traumatic stress disorder. International Clinical Psychopharmacology, 16, 279-284.

APPENDIX II

Figure A. Adult Client Questionnaire Scales and Subscales and Related Items

ADULT CLIENT QUESTIONNAIRE (ACQ)		
SCALES/SUBSCALES	**Questions/Items (with item numbers from the questionnaire)**	
SCALE: **Risk Taking Behavior**	**18.** Using alcohol or drugs not prescribed to you to deal with your feelings? **19.** Doing risky things? **20.** Doing things to physically harm yourself? **21.** Drinking or using drugs too much?	
SCALE: **Sexual Functioning**	**23.** Having no interest in sexual activity? **24.** Having difficulty becoming sexually aroused?	
SCALE: **Eating Behaviors**	**22.** Eating too much? **25.** Not eating enough?	
SCALE: Post Traumatic Stress Symptom Checklists (PCL-C) **SUBSCALES:** A. Intrusive recollections B. Avoidant/numbing symptoms C. Hyper-arousal symptoms	**1.** Repeated, disturbing memories, thoughts, or images of a stressful experience? **(Subscale A)** **2.** Repeated, disturbing dreams of a stressful experience? **(Subscale A)** **3.** Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)? **(Subscale A)** **4.** Feeling very upset when something reminded you of a stressful experience? **(Subscale A)** **5.** Having physical reactions (e.g., heart pounding, trouble breathing, sweating) when something reminded you of a stressful experience? **(Subscale A)** **6.** Avoiding thinking about or talking about a stressful experience or avoiding having feelings related to it? **(Subscale B)** **7.** Avoiding activities or situations because they reminded you of a stressful experience? **(Subscale B)**	**8.** Trouble remembering important parts of a stressful experience? **(Subscale B)** **9.** Loss of interest in activities that you used to enjoy? **(Subscale B)** **10.** Feeling distant or cut off from other people? **(Subscale B)** **11.** Feeling emotionally numb or being unable to have loving feelings for those close to you? **(Subscale B)** **12.** Feeling as if your future will somehow be cut short? **(Subscale B)** **13.** Trouble falling or staying asleep? **(Subscale C)** **14.** Feeling irritable or having angry outbursts? **(Subscale C)** **15.** Having difficulty concentrating? **(Subscale C)** **16.** Being "super-alert" or watchful or on guard? **(Subscale C)** **17.** Feeling jumpy or easily startled? **(Subscale C)**

Figure B. Empowerment and Satisfaction-Long Form Scales and Subscales and Related Items

EMPOWERMENT AND SATISFACTION QUESTIONNAIRE-LONG FORM (ESQ-LF)	
Note: THE OVERALL SCALE FOR ITEMS 1 THROUGH 26 IS EMPOWERMENT AND SATISFACTION.	
SCALES/SUBSCALES	**Items/Questions (with item numbers from the questionnaire)**
SUBSCALE: General Satisfaction	**1.** Staff respected my background. **2.** Services were available at times that were good for me. **4.** I feel the staff heard me. **5.** I got the kind of service I wanted. **15.** I would return to this agency if I needed victim services in the future. **16.** I would recommend this agency to a friend in need of victim services. **17.** In an overall, general sense, I am satisfied with the services I received.
SUBSCALE: Increased Coping and Sense of Empowerment	**3.** I was asked to participate in deciding what services I would receive. **6.** Staff helped me believe that I could change and improve my life. **7.** The services I received helped me deal more effectively with my problems. **8.** Because of the services I received, I learned skills to help me better manage my life. **9.** The services I received helped me identify a support system. **10.** The services I received helped me become aware of how crisis and trauma affect my life. **11.** The services I received helped me plan for my safety. **12.** The staff informed me about Victims Rights. **13.** The services I received helped me cope with my fear for my safety. **14.** Because of the services I received, I know more about the options and choices available to me overall. **18.** Because of the services I received, I know about the community resources that are available to me.
SUBSCALE: Satisfaction with Comfort and Convenience of Services	**19.** I was able to get around the building easily. **20.** The facilities were comfortable for me.
SUBSCALE: Increased Support or Knowledge Through the Medical System	**21.** I felt supported through the medical system by staff from the agency. **22.** Because of the services I received, I now know more about the medical system.
SUBSCALE: Increased Support or Knowledge Through the Legal System	**23.** I felt supported through the legal system by staff from the agency. **24.** Because of the services I received, I now know more about the legal system.
SUBSCALE: Victim Compensation Knowledge	**25.** The agency made me aware of the PA Victim Compensation Program. **26.** The information provided by the agency helped me understand the victim compensation process.

SCALE: SPRINT: The Short Post Traumatic Stress Disorder Rating Interview (items 27 to 35 can measure the decrease in symptomatology if used as pre/subsequent)	**27.** How much have you been bothered by unwanted memories, nightmares, or reminders of the event? **28.** How much effort have you made to avoid thinking or talking about the event, or doing things, which remind you of what happened? **29.** To what extent have you lost enjoyment for things, felt sad or depressed, kept your distance from people or found it difficult to experience feelings. **30.** How much have you been bothered by poor sleep, poor concentration, jumpiness, irritability or feeling watchful around you? **31.** How much have you been bothered by pain, aches, or tiredness? **32.** How much would you get angry or upset when stressful events or setbacks happened to you? **33.** How much have you been blaming yourself or feeling guilty for what happened to you? **34.** How much have the above symptoms interfered with you ability to work or carry out daily activities? **35.** How much have the above symptoms interfered with your relationships with family or friends? **36.** How much better do you feel since beginning services? **37.** Overall, how much have the above symptoms improved since starting services?

Figure C. Empowerment and Satisfaction-Short Form Scales and Items

EMPOWERMENT AND SATISFACTION QUESTIONNAIRE-SHORT FORM (ESQ-SF)	
SCALES	**Items/Questions (with item numbers from the questionnaire)**
SCALE: General Satisfaction and Increased Coping and Sense of Empowerment	**1.** Staff respected my background. **2.** Services were available at times that were good for me. **3.** I was asked to participate in deciding what services I would receive. **4.** I feel the staff heard me. **5.** I got the kind of service I wanted. **6.** The services I received helped me deal more effectively with my problems. **7.** I would return to this agency if I needed victim services in the future. **8.** I would recommend this agency to a friend in need of victim services. **9.** In an overall, general sense, I am satisfied with the services I received.
SCALE: SPRINT: The Short Post Traumatic Stress Symptomatology (items 27 to 35 can measure the decrease in symptomatology if used as pre/subsequent)	**10.** How much have you been bothered by unwanted memories, nightmares, or reminders of the event? **11.** How much effort have you made to avoid thinking or talking about the event, or doing things, which remind you of what happened? **12.** To what extent have you lost enjoyment for things, felt sad or depressed, kept your distance from people or found it difficult to experience feelings. **13.** How much have you been bothered by poor sleep, poor concentration, jumpiness, irritability or feeling watchful around you? **14.** How much have you been bothered by pain, aches, or tiredness? **15.** How much would you get angry or upset when stressful events or setbacks happened to you? **16.** How much have you been blaming yourself or feeling guilty for what happened to you? **17.** How much have the above symptoms interfered with you ability to work or carry out daily activities? **18.** How much have the above symptoms interfered with your relationships with family or friends? **19.** How much better do you feel since beginning services? **20.** Overall, how much have the above symptoms improved since starting services?

APPENDIX III

Figure A. Cover Sheet for the ACQ

ADULT CLIENT QUESTIONNAIRE (ACQ)

NOTE to clients: The information on this cover sheet will be completed by agency staff.
Please turn to the next page to begin your part of this survey. Thank you.

Date: _____

Client ID: _____

Pre-test ☐

Subsequent test ☐

Type of victimization: _____

Type of service: _____

Figure B. Consent Form

#_____

CONSENT TO PARTICIPATE IN EVALUATION OF SERVICES

This survey is part of our effort to evaluate the services we provide for our clients. We will use the information from this survey to help our program improve its services. If you agree to participate, you may be asked to complete up to three surveys over a period of time. Each survey takes 10-15 minutes to complete.

Participation in this survey is completely voluntary. Whether or not you participate will not affect your eligibility for services. Your responses to this questionnaire will be held to the same standards of confidentiality as other information kept by this agency.

If you agree to participate in this survey, please read the following statement and sign this form.

I have read this consent form (or this consent form has been read to me), and I agree to participate in this evaluation survey. I understand that my participation is completely voluntary and that I can refuse to answer any question that is asked.

Client: _____ Witness: _____

Date: _____ Date: _____

Figure C. Log for Tracking

LOG TO TRACK VSPE QUESTIONNAIRE ADMINISTRATION					
Survey Number	**Client ID**	**Date of First Survey**	**Date of Second Survey**	**Date of Third Survey**	**Staff Working with Client**

Figure D. Demographic Form

CLIENT DEMOGRAPHICS

Today's Date _____

Survey ID _____

TYPE OF VICTIMIZATION
(check all that describe the victimization you experienced)

- ☐ Sexual
- ☐ Child Abuse (Sexual)
- ☐ Elder Abuse
- ☐ DUI Victim
- ☐ Homicide Survivor
- ☐ Physical Assault
- ☐ Child Abuse (Physical)
- ☐ Robbery
- ☐ Domestic Violence
- ☐ Caregiver of Victim
- ☐ Other Violent Crime

_____

Have you had a prior victimization?

- ☐ Yes
- ☐ No

Type: _____ Date: _____

DATE OF BIRTH: _____

GENDER:

- ☐ M
- ☐ F

ETHNIC ORIGIN:

- ☐ Black/African-American
- ☐ White
- ☐ Hispanic/Latino(a)
- ☐ Asian
- ☐ American Indian/Alaska Native
- ☐ Bi-racial
- ☐ Other: _____
- ☐ Unknown

DISABILITY:

- ☐ Mental/Emotional Type_____
- ☐ Physical Type_____
- ☐ Other:_____

CURRENTLY USING SUBSTANCES *(Drugs or Alcohol)*

- ☐ Yes
- ☐ No

PRIMARY LANGUAGE

- ☐ English
- ☐ Spanish
- ☐ Other:_____

MARITAL/RELATION (if adult client)

- ☐ Married
- ☐ Living with Partner
- ☐ Separated
- ☐ Relationship, Not Living with Partner
- ☐ Other: _____
- ☐ Unknown
- ☐ Divorced
- ☐ Single
- ☐ Widow/Widower

EDUCATION

- ☐ No GED or High School
- ☐ High School
- ☐ College Degree
- ☐ Graduate Degree
- ☐ Unknown
- ☐ GED
- ☐ Some College
- ☐ Some Graduate
- ☐ Post Graduate

EMPLOYMENT STATUS (if adult client)

- ☐ Student/School
- ☐ Employed Full-Time
- ☐ Employed Part-Time
- ☐ Homemaker
- ☐ Self-employed
- ☐ Retired
- ☐ Unemployed
- ☐ Other: _____
- ☐ Unknown

HOUSEHOLD INCOME

- ☐ Less than $5,000
- ☐ $5,000-$9,999
- ☐ $10,000-$14,999
- ☐ $15,000-$19,999
- ☐ $20,000-$24,999
- ☐ $25,000-$29,999
- ☐ $30,000-$49,999
- ☐ over $50,000
- ☐ Unknown

PRIMARY INCOME SOURCE

- ☐ Disability
- ☐ Employment
- ☐ Pension/Retirement
- ☐ Support
- ☐ Social Security
- ☐ Unemployment
- ☐ Public Assistance
- ☐ Other
- ☐ Unknown

APPENDIX IV

SERVICE DEFINITIONS

From the Pennsylvania Coalition Against Rape (PCAR)

CRISIS INTERVENTION: An immediate service to provide information and support to assess the victim's needs related to the violence or abuse. The goal of crisis intervention is an immediate reduction of stressors precipitated by the crisis.

INDIVIDUAL ADVOCACY: Facilitates the victim's negotiation of the different systems encountered as a result of being impacted by violence or abuse.

INFORMATION AND REFERRAL: Assists the victim to identify and gather information about community resources.

CRISIS COUNSELING: Provides information and support and the assessment of victim needs in response to a crisis event or occurrence that is related to the impact of violence and abuse on the individual. The goals of Crisis Counseling are the empowerment of the victim to manage current stressors precipitated by violence or abuse and stabilization of functioning.

SUPPORTIVE COUNSELING: A short term counseling intervention. The goal of supportive counseling is the empowerment of the victim to build coping and personal safety skills.

THERAPY: A process affecting core level changes in attitudes, beliefs, or behavior. This is accomplished through the use of ongoing therapeutic relationship and the application of a theoretical model or framework that may be relational, cognitive and /or behavioral in nature.

Note: PCAR does not fund the provision of therapy.

APPENIDX V

Testing for Reliability and Validity: General Information

There are four main ways to test reliability. The preferred method of testing for reliability depends on the type of methodology and administration procedures. The four ways are:

Interrater reliability – when multiple staff members are conducting the evaluation and are required to rate answers, this test has those staff members administer the test at the same time to the same client and then compare their interpretations/ratings.

Test-retest reliability – administer the survey at two different times and compare to determine if the answers are similar.

Parallel-forms reliability – administer the survey with one that is already statistically proven to be reliable and compare the results for similarity.

Internal consistency reliability – assess the scores of each item in the survey with the scores on the rest of the items intended to measure the same content.

If you want to know more about the different types of reliability testing, we suggest you consult a statistics and/or social research text (a citation for one is included in the reference section). For the purpose of testing these tools, we employed test-retest, parallel-forms and internal consistency reliability tests. Interrater reliability was not considered because the forms were developed to be self-report, eliminating the chance of error from different interpretations of answers by different staff members.

There are also different types of validity that must be considered:

Face validity – does the tool appear to measure what it was intended to measure?

Content validity – does the tool cover all possible meanings for each outcome? For example – is a client coping well? To know this, the tool cannot simply ask if the person is crying all the time. Emotions are one part of coping, but so are many other things, for example, physical symptoms, eating habits, or sexual functioning.

Empirical validity – the only type of validity that is not based on judgments, but rather statistical analysis. Do the questions intended to measure a particular concept correlate with other questions that measure the same concept? There are two sub-types of empirical validity:

> *Criterion-related validity* – do the questions about anxiety on the tool we created get results similar to an outside, or external measurement, of the same concept, such as Hamilton's Anxiety Scale?
>
> *Construct validity* (a more complex method of measurement) – do the questions about anxiety and poor coping skills show similar results (i.e. when a client has more anxiety they are also less able to cope) as would be expected?

There are subtypes of both types of empirical validity that we will not cover in this manual.

Testing for Reliability and Validity: VSPE Data

The Adult Client Questionnaire (ACQ) is comprised of 25 items and four separate scales. First, the Risk Taking Behavior Survey (RTBS) consists of 4 questions that measure if the client is involved in risky behaviors. The reliability or internal consistency coefficients of this scale using chronbach's alpha estimate was found to be good (α=.69). The second scale encompasses two questions related to Eating Behaviors (α=.63). The third scale is related to clients' perceptions of difficulties with Sexual Functioning (α=.68). As noted in the manual, initial reliability coefficients appear to be good for all of these scales. The final instrument, the PTSD Checklist (PCL-C) is a 17-item self-report measure of symptoms of PTSD. Clients rate how much they were "bothered by that problem in the past month". This scale has been standardized and shows excellent reliability (α=.94 to α=.97) and validity (Weathers et al., 1993). **It is important to note here that it is possible to compute summary scores for each scale; however, these scales can not be combined to compute an overall score.**

The Empowerment and Satisfaction Questionnaire, Long Form (ESQ-LF) is a 37 item self-report form, designed to be distributed at the end of service. This questionnaire combines three instruments: the modified Mental Health Statistics Improvement Program (MHSIP) survey, the original Service Survey created by the VSPE team, and the Short Post-Traumatic Stress Disorder Rating Interview 9-item modified measure based on the original 8-item self-report measure (SPRINT; Connor & Davidson, 2001). The initial reliability or internal consistency coefficients for the MHSIP and the VSPE Service Survey instruments were found to be excellent (α=.95). We found the VSPE items related to empowerment, advocacy, and satisfaction to show convergent validity with the original 11 MHSIP items. Collectively, these two instruments work together to yield higher reliability coefficients than they do as separate scales. One summary score can be obtained from the combined scales.

The ESQ-SF, is a 9 item self-report form based on the ESQ-LF (using 7 MHSIP items and 2 VSPE Service Survey items). This scale measures only the general empowerment and satisfaction of clients with services. The internal consistency using chronbach's alpha estimate remained similar to the ESQ-LF (α=.94).

The Short Post-Traumatic Stress Disorder Rating Interview (SPRINT) demonstrates excellent reliability and validity when screening for PTSD severity (Connor & Davidson, 2001). We added item 33 to capture the common attribution of victims of shame and guilt. This additional item does not have a negative effect on the overall reliability of the scale. In fact, it appears to have a very slight positive impact by increasing the overall reliability coefficient.

For further information, contact:

Kathryn S. Collins, MSW, Ph.D.
Associate Professor
School of Social Work
525 West Redwood Street
University of Maryland
Baltimore, MD 21201-1777

APPENDIX VI:

TOOLS FROM OTHER SOURCES AVAILABLE TO EVALUATE SERVICES FOR CHILDREN AND TEENS

Youth Satisfaction:

Mental Health Statistics Improvement Program (2000). Mental Health Statistics Improvement Program Survey. [http://www.mhsip.org/surveylink.htm]

Youth Post Traumatic Stress:

- The Child Report of Post-traumatic Symptoms (CROPS), developed by Greenwald and Rubin (1999) is a 24-item self-report for children and adolescents, covering a broad range of Post Traumatic Stress symptoms, with or without an identified trauma, and can be used to measure changes in symptomatology over time. Also available to use with caregivers, is a 32 item Parent Report of Post Traumatic Stress (PROPS) questionnaire, which provides the caretaker's perceptions of the child or adolescent's symptoms and behaviors. Email Ricky Greenwald rg@childtrauma.com to obtain.

  Greenwald, R., & Rubin, A. (1999). Brief assessment of children's post-traumatic symptoms: Development and preliminary validation of parent and child scales. Research on Social Work Practice, 9, 61-75.

- The Child PTSD Symptom Scale (CPSS) (Foa, et al., 2001) is a 26-item self-report measure that assesses PTSD diagnostic criteria and symptom severity in children ages 8 to 18. It includes 2 event items, 17 symptom items, and 7 functional impairment items. Symptom items are rated on a 4-point frequency scale (0 = "not at all" to 3 = "5 or more times a week"). Functional impairment items are scored as 0 = "absent" or 1 = "present". The CPSS yields a total symptom severity scale score (ranging from 0 to 51) and a total severity-of-impairment score (ranging from 0 to 7). Scores can also be calculated for each of the 3 PTSD symptom clusters (i.e., B, C, and D).

  Foa, E. B., Johnson, K. M., Feeny, N. C., Treadwell, K. R. H. (2001). The Child PTSD Symptom Scale: A preliminary examination of its psychometric properties. *Journal of Clinical Child Psychology*, 30, 376–384.

- The UCLA PTSD Index for DSM-IV (UPID) (Pynoos, et al., 1998) is a revision of the CPTS-RI. It is a 48-item semi-structured interview that assesses a child's exposure to 26 types of traumatic events and assesses DSM-IV PTSD diagnostic criteria. It includes 19 items to assess the 17 symptoms of PTSD as well as 2 associated symptoms (guilt and fear of event recurring). This scale can be obtained by email Asteinberg@mednet.ucla.edu.

  Pynoos, R., Rodriguez, N., Steinberg, A., Stuber, M., & Frederick, C. (1998). UCLA PTSD Index for DSM-IV. Rodriguez, N., Steinberg, A., & Pynoos, R. S. (2001). The Child Posttraumatic Stress Reaction Index, Revision 2.

APPENDIX VII

Developing the Methodology: the First Phase of the Project (1997 to 2002)

In developing the outcome measurement methodology the collaborative:

- Obtained public and private funding for the project.
- Identified key stakeholders for inclusion in the project.
- Collected and reviewed a compendium of outcome measurement models and service definitions of mission aligned organizations.
- Conducted twelve statewide focus groups with key stakeholders to solicit input.
- Developed outcome questionnaires that can be used to evaluate the effectiveness of counseling and therapy services provided by an agency.
- Developed a service questionnaire for use with all clients, including an optional section for assessing the effectiveness of advocacy and crisis intervention services.
- Developed the methods and procedures to be used in implementation of the questionnaire.
- Consulted with research experts to verify the efficacy of the methodology.
- Completed three field tests.
- Analyzed data for manageability, accuracy, value of the system as designed, and implications for programs and services.
- Collaborated with Great Lakes Behavioral Research Institute to develop software to manage and analyze outcome data collected.
- Tested the software for accuracy and manageability.
- Completed several statewide trainings, and disseminated information via the Pennsylvania Coalition Against Rape and the Pennsylvania Commission on Crime and Delinquency newsletters.

APPENDIX VIII

REFERENCES/CITATIONS

Attkisson, CC & Greenfield, TK. (1994). "The Victim Satisfaction Questionnaire – 8 and the Service Satisfaction Scale-30". *Psychological testing: Treatment planning and outcome assessment.*

Brewin, C. et al. (2002). "Brief screening instrument for post-traumatic stress disorder." *The British Journal of Psychiatry*. 181: 158-162.

Connor, KM. Davidson, JRT. (2001). "SPRINT: a brief global assessment of post-traumatic stress disorder." *International Clinical Pscyhopharmacology*. Vol 16 No 5: 279-284

Duncan, R., Emmerling, A., McManus, D., Rolison, C., Witwer, G. (2002). Outcome Based Evaluation Tools: A Project of the Pennsylvania Coalition Against Rape.

McNamara. C. (1999). Basic Guide to Outcomes-Based Evaluation for Nonprofit Organizations with Very Limited Resources. Retrieved online from www.managementhelp.org/evaluatn/evaluatn.htm.

Performance Partnership Grant Technical Assistance Coordinating Center. (2004). Pre-Application Technical Assistance Reports for the Access to Recovery Grant Program: A Report on Technical Assistance to Wisconsin. U.S. Department of Health and Human Services; Center for Substance Abuse Treatment.

Rubin, A. Babbie, E. (2001). Research Methods for Social Work, 4th ed. Wadsworth.

W. K. Kellogg Foundation (2004). Logic Model Development Guide. Retrieved online from www.wkkf.org/Pubs/Tools/Evaluation/Pub3669.pdf.

Mental Health Statistics Improvement Program (2000). Mental Health Statistics Improvement Program Survey. Retrieved online from www.mhsip.org/surveylink.htm Oct 16, 2007.

Connor, K. & Davidson, J. (2001). SPRINT: A brief global assessment of post-traumatic stress disorder. International Clinical Psychopharmacology, 16, 279-284.

Weathers, F., Litz, B., Herman, D., Huska, J., & Keane, T. (October 1993). The PTSD Checklist (PCL): Reliability, Validity, and Diagnostic Utility. Paper presented at the Annual Convention of the International Society for Traumatic Stress Studies, San Antonio, TX.

125 N. Enola Drive ✦ Enola, PA 17025
717-728-9740 ✦ 800-692-7445 ✦ FAX 717-728-9781
TTY line 877-585-1091 ✦ www.pcar.org
Toll free 24-hour Information & Referral Line:
888-772-PCAR

LEADERSHIP ❙ ADVOCACY ❙ ACTION