



EVALUATION REPORT: YEAR I
Prepared for the Miami-Dade
Domestic Violence Oversight Board

by the Thurston Group
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Preface	i
<hr/>	
Introduction	1
<hr/>	
Section 1: The Evaluation Process: Year 1	6
<hr/>	
Section 2: Re-Tooling the Evaluation Design	24
<hr/>	
Section 3: Strategic Planning	32
<hr/>	
Section 4: Summary Comments	34
<hr/>	
References	36
<hr/>	
Attachments 1 - 8	37
<hr/>	

PREPARED BY
THE THURSTON GROUP

*Maxine Thurston-Fischer,
PhD, MSW
Principal Investigator*

*Paul St. Rosemant, MA
Research Associate*

PREFACE

In 2004, The Thurston Group officially began evaluation and technical assistance services for the Domestic Violence Oversight Board (DVOB). The services, prescribed in a NOFA issued on behalf of the DVOB by the Alliance for Human Services, require two types of activities over a three year period: evaluation and technical assistance.

The major tasks for Year 1 were to: (1) further develop the approach and outcomes for the process evaluation; (2) identify outcomes for clients and methods for collecting these data; (3) assess the technical assistance needs of the domestic violence centers; and (4) assist the DVOB in strategic planning. In addition, we began the process evaluation by taking a cursory look at service models, safety planning for clients, and follow-up services. The results of the Year 1 evaluation and related activities are presented in this report.

Following the introduction, the report begins with a discussion of the process evaluation and includes a look at the organizational context of local DV centers, client profiles, service statistics, safety planning, and follow-up services. The management information systems currently used in the centers and the technical assistance needs of these organizations are summarized.

Much of our work with the staff of the DVOB and centers has involved soliciting input, review, and critique of the proposed client outcome evaluation as well as identifying program services outcomes. The resulting process and outcome evaluation designs are presented in Section 2 of the report.

Our work plan for Year 1 also included the facilitation of a strategic planning retreat for the DVOB. Section 3 addresses this activity and the report concludes with summary comments.

INTRODUCTION

Domestic violence has been increasingly visible on the U.S. social, political and policy landscape since the late 1960's. Historians and researchers indicate that efforts to stem the tide of violence towards women within the home have advocacy roots within the Feminist Movement (Riger, Bennett, Wasco, Schewe, Frohmann, Camacho, Campbell, 2002). Through the milieu of social debate, protest and lobbying, efforts increasingly developed to enact legislation and reform institutional response to domestic violence (DV) by government agencies, the Courts, law enforcement and the healthcare system. Advocates who formed the collective voice of what came to be called the Battered Women's Movement established local domestic violence shelters modeled after those developed in England (Riger, et al, 2002).

In Miami-Dade County, formal efforts to establish a domestic violence shelter began in 1974 and as a result the first public DV shelter, The North Dade Victim's Center, opened in 1977 (Internal County Document, Advocates for Victims Program, Brief History). A second satellite facility, The South Dade Victim's Center was established in 1988. A third facility, The Lodge, was recently established in 2004, and is the first operated by a private non-profit organization.

As DV shelters (from here referred to as DV centers) have evolved from small community based facilities that relied upon private donations to larger, more complex organizations that now receive federal, state and county funding, efforts have begun to assess the services of such facilities. Data were compiled from The Department of Children and Family Annual DV Reports and Data Tables to examine DV trends over the past five years for both the state of Florida and Miami-Dade County. (For a summary of the data see Attachment 1).

The data indicate that 14% of reported instances of domestic violence statewide occur in Miami-Dade County.¹

The certified DV centers in Miami-Dade serve a client population that is both ethnically and linguistically diverse in comparison to the profile of clients statewide. Similar diversity is reflected in emergency shelter clients at The Lodge during its first ten months of operation. DV centers in Miami-Dade are used significantly less by Caucasians while statewide, almost half of shelter clients are Caucasians.

¹ Source: The Florida Statistical Analysis Center: FDLE. Crime in Florida. Florida Uniform Crime Report. 1999, 2000, 2001, 2002, 2003 and 2004

TABLE 1: ETHNICITY OF EMERGENCY SHELTER CLIENTS IN MIAMI-DADE AND FLORIDA

Ethnicity	% Miami-Dade	%Florida
African-American	48%	29%
Caucasian	08%	48%
Hispanic	40%	18%
Other	4%	5%

A slightly higher ratio of children (54%) receives emergency shelter in the Miami-Dade DV centers than in those statewide (50%). A significantly greater number of domestic violence situations are brought to the attention of Miami-Dade centers by telephone than elsewhere. Within the county, 84% of safety plans are conducted via telephone compared to only 51% elsewhere in the state.

With a client population that is predominantly Hispanic, African American and Haitian, local DV centers are challenged to provide services that are culturally responsive and accessible in English, Spanish, and Creole. For example, the North Dade Victim’s Center identifies the need for having a 24-hour Creole Hotline service to better respond to Haitian American victims.

Interview data from local DV staff suggests that most clients who seek services experience high rates of poverty, which may contribute to other social stressors such as substance abuse and barriers around housing, immigration, and childcare. Indeed, the literature suggests that “intimate violence

is more prevalent and more severe in disadvantaged neighborhoods” (US Department of Justice, 2004), and that poorer clients face institutional barriers around affordable housing, health care and childcare, as well as instances of economic bias, racism and sexism. It is suggested that other issues impacting a DV survivor’s life cannot be isolated from the violence and considered to be of lesser importance (Krennek, 2000).

This suggests that DV centers operating within the county have to be strategic with the support that they provide given the limited resources and, in some instances, the limited staff capacity available to them. A collaborative evaluation process offers an organized approach for identifying strengths and areas for improvement in the current system.

THE EVALUATION

The Domestic Violence Oversight Board (DVOB) has funded this three year evaluation to describe and analyze interventions provided by DV centers, determine the outcome and impact of services for clients, and compare differences in organizational processes between the DV centers. The evaluation process and products are intended to inform and support DVOB efforts to execute its vision that “Miami-Dade County develops a system of services for victims of domestic violence that is: (1) guided by a set of [service standards], (2) coordinated to maximize resources, (3) responsive to the needs of victims and families, and (4) effective in improving the outcomes for the victims and their families” (DVOB and The Alliance for Human Services, DV Funding NOFA, 2003).

This annual report documents evaluation activities conducted during the 2004-2005 funding year. In keeping with best evaluation practice reflected in research literature over the past ten years, our evaluation design intends to: (a) compile data which documents program implementation, service outcomes, and service impacts for clients, (b) examine the context in which each DV center operates, and (c) build stakeholder capacity (i.e. DVOB, DV Center staff, and other community members) to use evaluation processes and products to inform decision making intended to create or reform policy, and improve the operational and service delivery capacity of the DV center network

(Fetterman,1996; Chelmsky, Shadish, Sanders, 1997; W.K. Kellogg Foundation 1998; Levin, 1999; Riger, et al, 2002).

During this first year, we began the process of describing and analyzing service processes and further identified the focus and plan for examining service outcomes. We assessed the overall evaluation capacity of each DV center and we modeled our efforts after a similar study conducted in Illinois (Riger, et al, 2002).

Evaluation activities included:

- **Strategically working with various policy makers, researchers, and services providers within the DV service network to identify appropriate process and service outcomes;**
- **Conducting workshops, presentation and/or meetings with the DVOB and DV center staff to introduce them to the evaluation, and involve them in the planning process;**
- **Documenting the safety planning and client follow up process within each DV center;**
- **Assessing the Management Information Systems (MIS) operating within the three facilities;**
- **Identifying appropriate measurement tools which could be used to assess client service outcomes.**

YEAR-ONE EVALUATION: GOALS AND OUTCOMES

Research suggests that evaluations assessing domestic violence services often operate in politically charged environments, are generally top-down efforts requested by the funder, and require considerable collaboration between stakeholder groups. Further challenges to an evaluative process involve unique issues related to safeguarding client confidentiality, safety, and shelter operations (Fetterman et al., 1996; W. K. Kellogg Foundation, 1998; Levin, 1999; Zweid & Burt, 2002; Riger, et al, 2002; and Sullivan and Cain, 2004). Accordingly, year-one evaluation activities sought to:

- 1. Involve the DVOB, its staff, and service providers in the evaluation design process.**
- 2. Establish a common language to discuss the evaluation process, intended use, and products.**
- 3. Identify agency resources² that could support evaluation efforts.**
- 4. Identify what DV center staff would like to learn as a result of participating in the evaluation.**
- 5. Identify and define the various roles within the evaluation process.**
- 6. Establish a collaborative methodological framework to guide Year 2 and 3 evaluation activities.**

The above activities were important because they sought to elicit stakeholder buy-in and investment in the evaluation process. Research suggests that when this occurs it improves the quantity and quality of the data that is collected and increases stakeholder capacity to use evaluation data because it is more meaningful (Fetterman, 1996; Riger, et al, 2002; and Sullivan & Cain, 2004). Within the context of our collaborative design, evaluative outcomes accomplished during the first year include:

- Identifying appropriate process and service outcomes.**
- Developing a comprehensive understanding of the data that is currently collected by each site.**
- Documenting and reporting on Safety Planning and Follow-up services currently provided by each DV center.**
- Facilitating workshops with each DV center to introduce the evaluation, review process and service outcomes, clarify evaluative roles, and brainstorm approaches to collect data.**
- Beginning the process of identifying needs for technical assistance and developing a technical assistance plan for the DV Centers.**

²Resources refer to: (1) staff ability to support data collection efforts, (2) approaches and/or systems that already exist to compile and examine data, and (3) structured activities within the DV centers through which evaluative meetings could be conducted with the staff.

EVALUATION TERMINOLOGY

Given the variety of nomenclature used to describe the staff of DV Centers, as well as evaluation processes (see Attachment 2), the following terms will be used to standardize terminology within the context of the evaluation report.

- *Service Provider*: refers to Advocates, Social Workers and Social Work Aides that provide direct service to the DV clients.
- *Site Administrators*: refer to the administrative team that oversees staffing and service delivery within the DV centers.
- *DV clients*: refer to survivors of DV, and their family, who receive services within the DV center.
- *Process Outcomes*: Measures used to assess program implementation.
- *Service Outcomes*: Measures used to assess client services and their impact on the lives of clients.
- *Stakeholders*: Community members who have a vested interest in, or are accountable for, the implementation of DV services.

EVALUATION METHODS AND APPROACH

Our approach seeks to establish a framework for the evaluation around the tenets of collaboration. The evaluation uses a mixed methods design that will include qualitative data throughout the process and quantitative data in years 2 and 3.

This year one report is based upon data collected through a series of informational interviews, surveys, meetings and workshops that were conducted with the DV center staffs, and supplemented with program documents. All three DV centers are involved in the evaluation. More than a hundred (136) evaluative activities were conducted during the 2004-2005 funding year and are documented in contact notes and reports, and entered into our electronic data system (see Attachment 3). Confidentiality is maintained with respect to data given by individuals, and all data are maintained at the administrative offices of The Thurston Group.

SECTION I

THE EVALUATION PROCESS: YEAR 1

The purpose of the process evaluation is to describe and analyze how domestic violence centers deliver services, and the extent to which these processes meet or exceed minimum performance standards of the DVOB, accrediting bodies, and promising practices identified in the literature. In addition, the organizational contexts in which services are provided are considered, and in Year 2 we will

develop criteria for analytically describing the organizational settings.

In Year 1, however, preliminary overviews were done with respect to the organizational context of the centers, their services, and management information systems (MIS). In addition, independent reports were completed relative to safety planning, follow-up services, and technical assistance.

ORGANIZATIONAL CONTEXT OF DOMESTIC VIOLENCE CENTERS IN MIAMI-DADE

THE DOMESTIC VIOLENCE CENTERS AND THEIR MISSION

The mission statements of The Lodge, The North Dade Victim's Center, and The South Dade Victim's Center stress a common theme of safety, refuge, and support for survivors of DV and are consistent with the historical role of such facilities (Riger, et al, 2002). A review of program literature, as well as interview data suggests that each of the centers attempt to support survivors of DV in a manner that empowers, increases self-esteem, and builds self-sufficiency. However, only the private facility (The Lodge) includes "social change" as an organizational mandate within its mission statement.

While advocating for social change that will benefit DV survivors has been an important historical role of DV centers, a recent study which examined the DV service network in Miami-Dade County suggests that DV centers run by the county government have an "inherent conflict" in relation to advocating for systemic change. This conflict is brought about because the staffs of public centers are employed by the very entity that may be in need of reform (Advocate Program Inc., 2003).

This divergence in role highlights a unique characteristic of the DV center network within the county. While national and statewide DV centers are predominantly operated by non-governmental organizations (NGOs), Miami-Dade County's DV Center network is comprised of both county government and privately run facilities. This unique quality allows DV stakeholders within the county an opportunity to examine the support and obstacles in delivering services in both private and government DV centers. Few evaluative studies have examined this organizational dichotomy in local domestic violence service systems.

SERVICES AND MODELS OF DELIVERY

The categories of services provided by the DV centers are designed to meet the criteria for certification. As a result, each of the three centers provides a similar complement of services to survivors of DV. However, as shown in Table 1, there are some differences. For example, The Lodge is the only center offering legal services and on-site medical care. Transitional housing is uniquely available at the South Dade Victim's Center.

TABLE 2: DV CENTER SERVICES

DV Center	Emergency Shelter	Counseling	Case Management	Information/Referrals	Emergency Food	Advocacy/Support	Transportation	Financial Assistance	Children/Youth Services	Health Screening/Physical	Legal Services	Support Groups	Community Outreach	24 Hour Hotline	Community Education	Long Term Transitional
The Lodge	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	
The North Dade Victim's Center/South	•	•	•	•	•	•	•	•	•	•		•	•	•	•	•

The program literature for each center suggests that while services are similar there may be philosophical and/or organizational frameworks through which these services are provided which may influence client experience. For example, services at both the North and South Dade Victim's Center seem to operate from a more traditional case management and organizational paradigm common in other government agencies. The literature suggests that such paradigms may be centralized, hierarchical, policy driven, stress professional certification, and have less flexibility to readily adapt to changes within the community it serves.

The Lodge's service delivery model on the other hand seems to incorporate a more feminist organizational paradigm which stresses

collaborative leadership and the ability to advocate for policy change. However, because The Lodge and many other private providers receive public funds, organizationally they may share similar structural characteristics found in the public DV centers such as a hierarchical organization system, professional standards for staffing, and strong policies around fiscal accountability (Riger, et al, 2002).

Whatever the organizational design preference, little is known in the research literature about how such structures and ideological frameworks impact service delivery. Over time this process evaluation may identify indicators to facilitate our further understanding of this phenomenon.

SERVICE CAPACITY

The North Dade Victim's Center has 63 beds and the largest capacity for emergency shelter. The Lodge has 40 beds, and the South Dade Victim's Center has 24. While neither of the public facilities offers medical services³, The Lodge does have an on-site Medical clinic.

Both public shelters are able to provide long-term transitional housing through the Inn Transition Project established in 1989 by the Advocates for Victims Program, in collaboration with the Junior League of Miami.

Within the public DV centers, emergency shelter services are offered from six to eight weeks for survivors of DV and their dependants, while at the private facility this same service is offered for up to 12 weeks. Temporary extensions of shelter may be allowed, but are generally discouraged.

“While national and statewide DV centers are predominantly operated by non-governmental organizations (NGOs), Miami-Dade County’s DV Center network is comprised of both county government and privately run facilities.”

³North Dade’s medical services were discontinued November 1, 2004 due to fiscal restructuring within Jackson Hospital.

CLIENT PROFILES, SERVICE STATISTICS AND STAFFING

CLIENT DEMOGRAPHIC DATA⁴

Emergency shelter clients are mostly young women and their young children and are African American or Hispanic (Table 3). More than one half of the children in emergency shelter are under the age of five, and almost half the women are less than 30 years of age. Few domestic violence victims who are Caucasian or over the age of 44 have used emergency shelter services. However, shelter clients at The Lodge have been more ethnically diverse.

TABLE 3: EMERGENCY SHELTER CLIENT CHARACTERISTICS: 2004

<i>Race/Ethnicity</i>			
<i>Ages</i>	<i>North %</i>	<i>South %</i>	<i>The Lodge %</i>
Caucasian	7	0	14
African American	55	30	38
Hispanic	36	60	43
Other	2	10	4
0 -23 mos	14	11	13
2 -4 yrs	15	17	14
5- 12 yrs	19	23	24
13-17 yrs	5	9	4
18-29 yrs	20	22	20
30-44	21	16	21
45-59	4	2	4
60 and over	2	0	0

⁴Source Advocates for Victims Program, Annual Report of Service, FY 01-02,02-03 and 04-04.

SERVICE STATISTICS

Each of the DV centers in Miami-Dade County provides a range of basic services. Data shows an increase in both requests and use of DV services by survivors of domestic violence. Calls to the DV Hotline and information and referrals have increased as well as the use of emergency shelter. For example, in 2002 the North and South DV centers housed 597 women and children in emergency shelter. In 2004 the number served in these centers was 1039, a 43% increase. In addition, during its first months of operation in 2004, The Lodge provided shelter to 290 women and children. Hotline calls to the North and South DV centers increased 67% from 3841 to 6408 during the same time period.

In 2004, 590 women and 739 children were sheltered in the three DV centers (Table 3). The North and South centers provided 31,426 emergency shelter days averaging a stay of 24 days for each woman and child.⁵ More than 10,000 telephone inquiries were made to the centers, either to the hotline (6,719) or for information and referrals (4,023).

TABLE 4: UNITS OF DV SERVICES BY CENTER: 2004

<i>Sample Service Units</i>	<i>North</i>	<i>South</i>	<i>The Lodge (10 mos)</i>	<i>Totals</i>
Unduplicated women sheltered	358	100	132	590
Unduplicated children sheltered	419	162	158	739
Total shelter days provided	25,405	6,021	NA	31,426
Average days of emergency shelter per person	33	23	NA	56
Total hotline calls	5,398	1,010	311	6,719
Total information and referral calls	2,226	1,357	440	4,023

North Dade Victim's Center

African Americans (55%) and Hispanics (36%) are the primary users of shelter services at the North Dade Victim's Center. Over the past three years The North Dade Victim's Center provided emergency shelter to 2,039 clients, almost equally divided between women (48%) and children under the age of 18 (49%). **There has been a steady increase in the number of clients seeking shelter services. The number of women and children sheltered increased by 46% between 2002 (532) and 2004 (779).**

⁵ Information not included in service reports of The Lodge.

Outreach services have increased by 97%. The number of outreach clients was 399 in 2002 and 786 in 2004. Sixty-two percent (62%) of these clients were women and 38% were children. African Americans and Hispanics account for most outreach clients at the north DV center.

With regard to the 24-hour hotline service, the rate of calls received increased by 62% during this three year period. Calls for information and referral increased by 108%.

South Dade Victim's Center

The South Dade Victim's Center has experienced a significant increase in service requests during the past three years. The center provided emergency shelter to 488 clients between 2002 and 2004. **The number of women and children sheltered increased by 300% between 2002 (65) and 2004 (262).** Forty percent (40%) of those sheltered were women and 60% were children under the age of 18. Hispanics (58%) and African Americans (30%) account for most of the shelter population.

An increased demand for outreach services is also evident at the South Center. **Outreach services have increased by 333%.** The number of outreach clients was 30 in 2002 and 137 in 2004. Thirty-two percent (32%) of these clients were women and 68% were children. African Americans (45%) and Hispanics (47%) accounted for most outreach clients in 2004.

With regard to the 24-hour hotline service, the rate of calls received increased by 100% during this three-year period from 506 in 2002 to 1010 in 2004. Calls for information and referral totaled 617 in 2002 and 1357 in 2004, representing a 120% increase.

The Lodge

During the first ten months of operations in 2004, The Lodge provided emergency shelter to 290 survivors of DV (Table 3). Forty-six percent of those sheltered were women and 54% were children under the age of 18 (Table 4).

The Lodge sheltered the most ethnically diverse group of clients. African Americans accounted for 43%, Hispanics 38%, and Caucasians, 14% of those who received emergency shelter services.

The Lodge received 331 hotline calls during its initial 10 month period of operations. In addition, 440 calls requesting information and referrals were made to the center.

COMMENTS

The data presented for all three DV centers indicate that services are provided to an ethnically and linguistically diverse client population. Children account for a large proportion of emergency shelter clients and often present unique service challenges such as school attendance and child care. We can infer from the literature and interview data that clients primarily come from low-income environments.

While Service Provider comments suggests that clients present themselves to the DV centers with a variety of issues that must be addressed (i.e. lack of adequate employment to support themselves and their family, inadequate housing, substance abuse issues, challenges around immigration, etc.) it is unclear how these items impact the service delivery capacity and types of services within the respective Centers. The process evaluation in Year 2 will attempt to identify these interrelationships.

STAFFING PATTERNS AND ISSUES

The North Dade Victim's Center has approximately 17 service providers (advocates, social workers, social worker aides), and 3 site administrators. The South Dade Victim's Center has approximately 8 service providers and 2 site administrators, and The Lodge has

approximately 13 service providers and 2 site administrators.⁶

Recruiting and retaining appropriate staff is a challenge for the DV centers. Four themes emerged relative to staffing issues: (1) having adequate staff capacity to respond to the language diversity within its client population, (2) having an appropriate number of staff members to cover all of the shifts within the centers, (3) training, supporting, and transitioning staff members that are involuntarily transferred or are new to the DV centers, and (4) retaining appropriate staff.

The North Dade Victim's Center

Interview data indicates that while the DV center has an adequate number of staff, they do not have enough Spanish speaking Master's level caseworkers (known as Social Worker 1s). Currently there are two Spanish speaking Social Worker 1s, however an additional caseworker fluent in Spanish is desired.

Covering shift changes is an issue. While County officials are credited with developing an understanding of the scheduling changes that exists with a 24-hour DV facility, their responses do not suggest a working understanding of how fragile and interdependent the shift schedules are within the center. Interview respondents cite instances

⁶ Data for The North and South Dade Victim's Center were compiled from interview data, while data for The Lodge was compiled from program documentation. Numbers are approximate to account for staff turnover, which may have occurred after the interview data was compiled, and/or program literature published.

where staff members want to customize their work schedule to accommodate personal needs and/or preferences, which may be taken up the County administrative chain of command when the shelter's schedule cannot accommodate such requests. County personnel may approve such requests due to contractual, union, or policy agreements. Thus, county protocols, staff policies, and layers of bureaucracy have the potential to detrimentally impact center operations and services.

Involuntary transfers (referred to as "bumping" by County employees), often create personnel issues. Respondent data suggests that there are challenges in training, supporting and transitioning such employees within the centers. In many instances, involuntary reassignments are viewed as a demotion, or in some cases results in the loss of salary. Affected staff members often communicate anger, frustration and betrayal in the process.

Staff members who find themselves in this position many times have to transition from more traditional 9:00 AM – 5:00 PM work settings to a 24 hour facility where service providers may have to work evening and night shifts. This process also creates management challenges when it comes to transitioning new staff members into the existing work culture. Existing staff members, who view new arrivals as angry and resistant to working in the center, have to be coached and reminded to be supportive of their new colleagues. Overall, interview data suggests that having reluctant

service providers within the DV center may impact service delivery, because they are sometimes unwilling to do what is necessary to deliver the best service possible to clients.

The South Dade Victim's Center

The South Dade Victim's Centers' primary staffing challenge is having adequate personnel to manage all shifts. During the period covered by this report, the DV center is understaffed, and two part-time Social Work Aide positions are unfilled due to a hiring freeze. As a result, only one staff member works the weekend shifts and some night shifts.

The shelter model requires that at least two Service Providers work each shift. Given the staff shortage, both Site Administrators must be on call 24 hours per day, 7 days per week. In addition, when staff members call in sick or have a family emergency, the Site Administrators have to struggle to find appropriate replacement staff to cover the shift.

Interview data suggests that while County officials are aware of the challenge, the recommendation of having Master's level Social Workers provide some night and/or weekend coverage would potentially compromise the quality and efficacy of case management services. These social workers would not always be available weekdays during the hours of 9:00 AM to 5:00 PM when clients need the most support obtaining essential services (such as housing, TANF, healthcare, and/or support navigating the Court system).

Another staffing challenge is the ability to hire candidates who have experience and are knowledgeable about DV services. Because the center is a county facility, staffing guidelines of Miami-Dade county must be followed. Accordingly DV center positions are offered to county employees first, who can be “bumped” into an open position from another case management program. Respondents suggest that the County has a generalist bent to social work assignments that result in the reassignment of case managers who have little to no DV experience. This process presents similar management and service challenges faced by The North Dade Victim’s Center and previously described.

The Lodge

Staff retention has been the most difficult personnel challenge faced by The Lodge. During its first year of operation, The Lodge has experienced staff turnover in almost all of its administrative and service provider positions. Indeed, the emergency shelter has had three managers in this first year.

While new non-profit service agencies often experience some degree of staff instability during their formative years, it is unclear how service delivery and client experience have been impacted within The Lodge. Year 2 data collection efforts will continue to examine this issue and describe the “lessons learned” in staffing a new community-based residential facility.

“Four themes emerged relative to staffing issues: (1) having adequate staff capacity to respond to the language diversity within its client population, (2) having an appropriate number of staff members to cover all of the shifts within the centers, (3) training, supporting, and transitioning staff members that are involuntarily transferred or are new to the DV centers, and (4) retaining appropriate staff.”

SAFETY PLANNING

To collect data regarding the safety planning process, we conducted a series of interviews and sites observations with the site administrators and service providers at all three DV centers from May to November 2004. In addition, client records were reviewed, as well as the state re-certification report for the North and South Dade Victim's Center. Data was then analyzed, compiled and presented in a preliminary observation report November 2004 (See Attachment Item 2). Report findings were reviewed with all three centers whose staff provided additional feedback that was used to further clarify, enhance, and appropriately revise the findings.

STANDARDS FOR SAFETY PLANNING SERVICES

Minimum standards for safety planning are set by the State of Florida and compliance is required for a domestic violence shelter to be certified. Florida statute requires that (1) all staff and volunteers answering calls to the 24-hour hotline be trained in safety planning, and (2) shelter residents housed 72 hours or more, and outreach clients who receive three or more counseling sessions, have a case management plan. The case management plan must include a safety plan for the adult client and for each child who is capable of carrying out a safety plan. While state certification standards require that 97% of DV center clients have safety plans developed,

DVOB requires new shelter facilities such as The Lodge, to have a safety plan for all clients.

FINDINGS/OBSERVATIONS

Each of the three DV centers appears to meet the standard criteria established by the state and DVOB. While safety planning is an ongoing process for DV center clients, the data suggests that this process occurs at three critical points during a DV survivors contact with a center; (1) when the client contacts the 24-hour hotline and communicates that (s)he is a victim of abuse, (2) when a client presents herself/himself for emergency shelter or outreach services, and (3) when a client's case is closed. At each of the previously mentioned service points DV survivors create and/or revise their safety plan with a Service Provider. Safety plans are then archived for future reference if a caller decides not to pursue additional services, or are maintained in a client's case file/chart when a case is opened.

SERVICE BARRIERS

Interview data with the staff of the North and South Dade Victim's Centers identify at least three barriers to engaging and sustaining effective safety planning with clients. (1) Safety planning is often not a priority for clients,

particularly victims in residential services;
(2) DV survivors often have a misplaced sense of security from the abuser and minimize the necessity for safety planning and; (3) the client may reveal essential elements of the safety plan after leaving the center. Additional discussion on these issues can be found in Attachment 4: *Preliminary Evaluation Observation: Safety Planning Services in Domestic Violence Shelters*, November 2004.⁷ In the upcoming evaluation period, we hope to further explore the matter of safety planning to include the victim's perspective.

Additional discussion on these issues can be found in Attachment 4: Preliminary Evaluation Observation: Safety Planning Services in Domestic Violence Shelters, November 2004.

⁷ It should be noted that data from staff members of The Lodge did not yield findings regarding service barriers. Thus, the service barriers presented in this section were identified at the North and South Dade Victim's Centers.

FOLLOW-UP SERVICES

Follow up contacts are an integral part of the services continuum for victims of domestic violence. The standards set by the DVOB for new shelters in the 2003 Notification of Funding Availability for applicants require follow-up services for all clients.

To collect data regarding the current follow-up process, a series of interviews and sites observations were conducted with the site administrators and service providers at all three DV centers from May to November in 2004. In addition, client records were reviewed as well as the state re-certification report for the North and South Dade Victim's Center. Data was then analyzed, compiled and presented in a preliminary observation report in November 2004 (See attachment Item 3). Report findings were reviewed with all three centers whose staff provided additional feedback that was used to further clarify the report findings and observations.

FINDINGS/OBSERVATIONS

The frequency of contacts and the range of follow-up services provided vary based upon (a) client needs and availability, (b) programmatic resources, and (c) staff priorities. Once shelter or outreach services end, the service providers are typically tasked with conducting follow-up contacts. These periodic

inquiries, usually by telephone, give the staff an opportunity to assess the DV survivors' current situation and determine if further services are needed. Each contact is noted, whether initiated by the clients or by the staff, and are maintained in the client file/chart. (For additional discussion on the follow-up process see Attachment 5: *Preliminary Evaluation Observation: Client Follow-up Services in Domestic Violence Shelters*, November 2004).

SERVICE BARRIERS

Conversational and interview data with DV staff members suggests the following barriers affect the follow up process:

- *Accessibility of Victims:* Staff report modest success in contacting victims once they leave the shelter. In many instances, victims do not wish to be contacted. Other common reasons include (1) disconnected or changed telephone numbers, (2) victim moves to an unspecified location, and (3) the victim has returned to the abuser and may be fearful to contact the staff.
- *Limited Services:* The shelters have limited resources to meet the most common needs of victims such as affordable housing, childcare and adequate employment. Clients in need of these services may see little value in maintaining contact with the shelter.

ITEM FOR CONSIDERATION

- *Review priority and timing of follow-up. Services seem to be conducted under the assumption that the victim can always contact the shelter if there is a need for services. It is possible that some victims, particularly those with more limited socioeconomic resources, may benefit from more immediate and regular attempts at follow up contacts. This is corroborated by the literature, which suggests that DV survivors that have low incomes and “are likely to move frequently and have erratic phone services” (Sullivan, 2004).*

MANAGEMENT INFORMATION SYSTEMS

Information concerning the Management Information Systems (MIS) in place at the three DV centers was collected in a series of interviews conducted in March and April of 2005 and observations of the manual and electronic data systems in each center. Staff members interviewed included site administrators, service providers, and data entry specialists. Interview protocols and questions were developed to guide the interview process, (see Attachment 6) and interviewees were provided an opportunity to review the data upon its completion for both accuracy and to provide additional feedback. The data collected from this process allowed the evaluation team to identify the types of data currently collected by each center and to identify areas where technical support and/or training may be required.

Overall, the current data compiled by each center includes demographic information regarding the clients as well as the type and frequency of services provided. However, the capacity of the MIS and electronic database systems differs significantly between the public and private DV centers. Furthermore, there is not a common format for reporting client and service data. As a result, categories of data cannot be readily compared across the centers.

The North and South Dade Victims' Centers

The hardware and software currently used in the county DV centers is antiquated and limited in usefulness. The system, based on a DOS framework, is incompatible with almost any other computers in the county or elsewhere. Indeed, only one or two people are capable of providing technical support or maintenance to the system when needed.

Primarily used for reporting purposes, the centers' electronic database system allows the staff to monitor services and referrals, develop reports, track the number, frequency and types of calls that are placed on the hotline, maintain census data, and produce very limited reports. Additionally, the staff has the ability to track the number of emergency shelter stays by an individual client, which aides in assessing the lethality of violence.⁸

In addition to external reporting, the database is used to inform staff performance evaluations which occur annually. Site administrators indicate that they are able to monitor the frequency that a service provider meets with a client, the services and referrals that are provided to clients, the

⁸ Staff comments suggest a correlation between the severity of injury and possible death with the frequency of emergency shelter stays

number of annual service minutes provided by service providers, and whether or not a service provider complies with state and local performance measures. Access to the database is restricted to the site administrators and data entry specialists. Service providers however, are able to review a client's history of shelter services with the specific DV center.

Efforts are underway to develop an upgraded web-based database system for both public DV centers, however it is unclear when this system will be brought online. The current database systems are maintained separately within each center and are not networked to allow shared information between the north and south centers. The current system cannot be altered to accommodate emerging service delivery or client outcome data.

BARRIERS TO THE SYSTEM: NORTH AND SOUTH DADE CENTERS

- *The DOD operating system is antiquated, inflexible, and marginally useful.*
- *The database system does not allow the staff to develop customized reports which may fall outside of the scope of current report parameters set up in the system.*
- *The data collected in the satisfaction survey cannot be aggregated.*
- *The database system does not allow the staff to isolate and sort data by client language, which makes it difficult to compile data for The Creole Hotline, which is operated by the North DV center.*

The Lodge

The Lodge has appropriate computer hardware and a customized, yet flexible MIS software package. However, at the time of this report, the electronic database system is still under development. Interview data suggests that this system will allow the center to compile census and demographic data, maintain data on shelter services, and compile performance review data.

While the database system currently in use within the public DV centers is primarily used for reporting purposes, The Lodge's database system will allow Service Providers to maintain and update client charts electronically. In addition, they will be able to maintain both the Shift Change Reports and the Monthly Register on the database system.

The server for the database system is located on-site, and staff computers will be networked to access the database once it is brought online. The current database system is only accessible on one computer, which is maintained by the Site Administrator and the Data Entry Specialist.

RECOMMENDATIONS

- ***The existing hardware and software in the county DV centers should be replaced; networking capability should be established between the centers***
- ***The MIS software at The Lodge should be fully operationalized as soon as possible***
- ***Technical assistance can be provided to the public DV centers for compiling Satisfaction Survey Data***

TECHNICAL ASSISTANCE PLANNING

As a result of our initial conversations with DV staff members, the following topics emerged as possible areas for additional technical assistance:

- Enhancing collaboration across DV centers.
- Developing strategies for enhancing outreach, community education, and professional training.
- Improving the long-term effect of case management services.
- Developing strategies to access community services that assist clients in the area of budgeting and money management.
- Building staff capacity to collect evaluation data and analyze data to enhance services.

We will collaborate with ACTT, to review and update the needs assessment of each DV center to determine additional training and technical support needs. Efforts are currently underway to develop a technical assistance plan for each DV center for the coming year. Technical assistance plans will guide training efforts in data collection and analysis, as well as identify strategies and resources that will build upon the professional capacity of DV center staff.

SECTION 2

RE-TOOLING THE EVALUATION DESIGN

PROCESS OUTCOMES

One objective of the process evaluation is to describe and analyze how domestic violence centers deliver services according to the expected standards. Efforts to identify appropriate process outcomes began in 2003. Outcome indicators were reviewed by various stakeholder groups via meetings and administrative focus groups, and have been revised and updated on an ongoing basis.

In keeping with the best evaluation practice cited in the literature, process evaluation data will document program implementation efforts within the DV centers, and provide a context for examining service outcome data, i.e. what is the story that helps us understand or explain outcomes (W.K. Kellogg Foundation, 1998). The process evaluation design incorporates the minimum performance standards as outlined in the NOFA and summarized in Table 5.

The process evaluation will describe and analyze how the DV centers implement services in core performance and service areas:

- Emergency and residential
- Outreach and non-residential
- Information and referral
- Counseling
- Crisis hotlines
- Children's services
- Case management and advocacy
- Community education
- Medical
- Staff development

Data will come primarily from observations of services, interviews and conversations with staff and clients, and program files and other documents.

TABLE 5 – PROCESS OUTCOMES

(As revised 6-05 with DV center staff input)

Process Evaluation Question: *To what extent do the domestic violence centers implement services according to expectations and standards in the field and outlined in the DVOB NOFA for service delivery?*

Service Component (Specified in NOFA)	Process Evaluation Questions (Examples)	Source and Method of Collecting Data
DV CENTER SERVICES	<ul style="list-style-type: none"> • What types of services, including volunteer services, are provided by each Center? • What are the major service needs for clients? • What are the practices, policies, and procedures used to ensure that clients receive needed services? What are the barriers to, and facilitators of attaining this objective? What strategies are most successful? • What are the supports and obstacles to service participation? What strategies are used to improve services to clients? How are clients involved in the process? 	<p>Periodic review of staff documentation in case files, observations and survey/ interview.</p>
INFORMATION AND REFERRAL	<ul style="list-style-type: none"> • What are the practices, policies, and procedures used to assess the information and referral needs of clients? • What are the major needs of clients for information and referrals? • What procedures and strategies are used to develop and maintain referral resources? • How are clients connected with resources outside of the Center (e.g. Relocation funds, TANF, etc.)? How are services coordinated with other agencies (e.g. Office of Atty. General, legal services, etc.)? • How are client assessments for danger conducted? What are the barriers to, and facilitators of conducting these assessments? • What are the procedures for documenting the success of client referrals? • What are the gaps in referral resources for clients? 	<p>Periodic review of staff documentation in case files, observations and survey/ interview.</p>

Service Component (Specified in NOFA)	Process Evaluation Questions (Examples)	Source and Method of Collecting Data
24-HR. HOTLINES/ CRISIS LINES	<ul style="list-style-type: none"> • What is the volume and pattern of hotline calls (e.g. Time of day, role of caller, requests, etc.)? • How are inquiries documented? • What changes, if any, would enhance hotline services? • What are the referral sources? 	Periodic review of program records, staff documentation, surveys and interviews.
CHILD SUPPORT SERVICES	<ul style="list-style-type: none"> • How are services to children developed and implemented? How are parents involved in the process? • What types of services are provided to children? What are the gaps, if any, in needed services? • How is the assessment presented to a child and the parent? How are outcomes of the child assessment used? • How are outreach services provided to children who witness domestic violence? How are children in need of these services identified? 	Periodic review of program records, staff documentation and interviews
CASE MANAGEMENT/ ADVOCACY	<ul style="list-style-type: none"> • What are the strategies for engaging clients in developing and implementing case management plans? • What are the barriers and supports to implementing the plans? How are these issues addressed? 	Periodic review of staff documentation in case files and client survey/interview.
COMMUNITY EDUCATION	<ul style="list-style-type: none"> • What are the practices, policies, and procedures used to educate the public about domestic violence? • How is participant feedback regarding community education efforts documented? 	Periodic review of program records, staff documentation and interviews.

Service Component (Specified in NOFA)	Process Evaluation Questions (Examples)	Source and Method of Collecting Data
STAFFING AND TRAINING	<ul style="list-style-type: none"> • What are the staffing patterns (i.e. job title, function, etc.)? • What are the qualifications and skills of the staff? • What strategies are used for recruiting and (re)training appropriate staff? • How are the services provided by DV staff members monitored and assessed? • How is the level of staff satisfaction with respect to their jobs documented? How is staff input sought and utilized? • What strategies are used to improve staff training and skills? • What barriers/challenges exist around staffing? What strategies are used to overcome staffing barriers/challenges? 	<p>Periodic review of personnel files, interviews, and review of staff documentation.</p>
MEDICAL CARE	<ul style="list-style-type: none"> • What are the policies and procedures for identifying the medical needs of clients? • How are clients linked with needed medical resources? 	<p>Periodic review of staff documentation.</p>
CLIENT SATISFACTION	<ul style="list-style-type: none"> • How does the center document clients' level of satisfaction with the services received? • What do clients perceive as most satisfactory about their experience with services offered by the Center? • How is client feedback used by the Center to modify or change services? 	<p>Periodic review of staff documentation and interviews.</p>

CLIENT OUTCOMES

The proposed design of the outcome evaluation is intended to determine the extent to which services and interventions result in changes of attitudes, knowledge, behavior, and/or skills among recipients. This aspect of the evaluation design will assess changes reported by consumers as a result of receiving services from the DV center. While a comparison group design is not feasible for this effort, to the extent possible baseline measures will be taken at the start of services and will be compared to measures taken after services have ended. The revised design and major outcomes for consumers in each of the service areas outlined in the NOFA is summarized in Table 6.

As specified in Table 6, several approaches will be used to assess client outcomes. To the extent feasible, pre- and post- measures will be given to document outcomes. These data will be supplemented with post-only surveys and formalized interview reports.

Special meetings were convened with the staff at each DV center. For a review and discussion of the evaluation plan (see Attachment 7 for the presentation materials). We also sought staff input on the process of collecting data and incorporated this feedback in our revised plan and approach. The proposed outcome indicators were reviewed and discussed in focused meetings with administrative and program staff. We have

revised and updated the outcome evaluation plan in accordance with the feedback provided.

TABLE 6 – CLIENT OUTCOMES

(As revised 6-05 with DV center staff input)

General Client Outcome/Impact Evaluation Question: *To what extent do clients benefit from domestic violence center’s services?*

Service Component (Specified in NOFA)	Impact/Outcomes Desired for Consumers	Principal Indicator(s)	Source of Data	Method of Collecting Data
SHELTER/ RESIDENTIAL SERVICES	DV survivors who use residential services perceive themselves (and their children) to be physically and emotionally safe while in the shelter.	Positive responses/scores on survey items.	Shelter evaluation survey, Safety Plan.	After 72 hrs in the shelter, Post counseling survey, during the safety planning process and/or interview.
	DV survivors have increased awareness of their options at the end of their stay at the DV residential facility.	Ability of clients to identify options.	Client survey.	Documented at follow-up contacts, (2 months).
	DV Center residents gain the knowledge to create safety plans for reducing risk of future abuse.	95% of the women in shelter for more than 72 hrs will have a safety and security plan before leaving the Center.	Program records.	Post-services survey, exit interview, interview or focus group.
	Residents gain increased knowledge about domestic violence and its effects.	Ability of clients to identify new and improved areas of knowledge about domestic violence.	Client survey and/or focus groups.	Pre- and Post- Survey administered before/after counseling services, Post-services survey, interview or focus group.

Service Component (Specified in NOFA)	Impact/Outcomes Desired for Consumers	Principal Indicator(s)	Source of Data	Method of Collecting Data
24-HR. HOTLINES/ CRISIS LINES	<p>Callers in crisis receive needed information, crisis support and/or services.</p> <p>Callers requesting information about services and options for survivors of domestic violence receive that information.</p> <p>Callers requesting information about programs for batterers receive that information.</p> <p>Callers requesting assistance in finding a safe place to go receive such assistance.</p>	Positive responses/scores on survey items.	Crisis Line Assessment survey; client survey.	Pre-counseling client survey; Crisis hotline interviews, Survey administered during the intake process (crisis callers).
INFORMATION AND REFERRAL	Residents at the DV centers gain increased linkages with community resources and support services appropriate to meeting their needs.	Positive responses/scores on survey items.	Client survey and The Client Satisfaction Survey.	Post-services (exit interview).
CASE MANAGEMENT/ ADVOCACY	<p>Residents at the DV centers gain increased linkages with community resources and support services appropriate to meeting their needs.</p> <p>Clients gain knowledge of their rights as a victim and the remedies that accompany these rights.</p>	Positive responses/scores on survey items.	Program records; client survey, and The Client Satisfaction Survey.	Post-services (exit interview); follow-up contacts (2 months).

Service Component (Specified in NOFA)	Impact/Outcomes Desired for Consumers	Principal Indicator(s)	Source of Data	Method of Collecting Data
INDIVIDUAL COUNSELING	Residential and outreach clients who receive group and/or individual counseling gain: <ul style="list-style-type: none"> • Increased self-esteem/empowerment • Decreased sense of social isolation • Increased knowledge about DV and how it impacts their life 	Scores on questionnaire.	Client questionnaire.	Questionnaire given before and after counseling sessions, Survey administered midway in the service delivery process and the exit interview for clients receiving individual counseling.
CHILD SUPPORT SERVICES	Mothers increase their knowledge about the impact of violence on their children. Children develop an awareness of domestic violence. Children understand the safety plan and its purpose.	Positive responses/scores on mother's survey re children items. Positive responses/scores on children's survey.	Mother's survey re their children. Children's Survey.	Pre survey data (family assessment process)/post survey data (Exit Interview).

SECTION 3

STRATEGIC PLANNING

DVOB PLANNING RETREAT

In collaboration with the DVOB staff and members, we facilitated a strategic planning process for the Board that included a retreat in April 2005. An online survey of Board members and key stakeholders helped to inform and guide the agenda for the retreat (see Attachment 8). The survey and interview data suggested that the Board needed clarity and guidance in the areas of community collaboration, establishing clear and attainable goals and objectives, executing its policy-making role, and developing standards for measuring its accomplishments.

The retreat was facilitated by Dr. Denice Rothman Hinden of Managance Inc., a consultant partner of The Thurston Group. The agenda was designed to provide committee members with an opportunity to: (1) Develop a resume of DVOB member talent, (2) agree on the ingredients for effective DVOB leadership, (3) agree on a 3-year strategic direction for the DVOB and (4) prioritize specific action items for 2005-2007.

As a result of the retreat the following action goals were established:

- 1. Shift the DVOB focus to systems change and bring domestic violence issues into the political spotlight.**
- 2. Strengthen the network of DVOB Service Providers through building trust and increasing information sharing and working partnerships.**
- 3. Increase the visibility of the DVOB before the Miami-Dade Board of County Commissioners.**
- 4. Advocate for legislation to protect and increase funding for domestic violence services and position the DVOB to diversify its sources for funding over time.**
- 5. Build capacity of the DVOB membership.**

NEXT STEPS

- **Prepare and present a summary of the strategic plan to the DVOB. The DVOB and staff members will recommend a timeframe and assign responsibility for each element in the action plan.**
- **The Board will review its committee structure to align it with the strategic directions and develop updated charges and work plans that support implementing the strategic plan.**

SUMMARY COMMENTS

The evaluation team has accomplished the Year 1 goals, which included:

- **Establishing collaborative relationships with each of the three DV centers, the DVOB, and other stakeholders groups;**
- **Developing appropriate process and client outcomes;**
- **Identifying promising practices from the literature to inform evaluation methodology, aid in the analysis of data, and guide service delivery enhancements within the DV Centers;**
- **Assessing the Management Information Systems within each DV Center.**
- **Beginning efforts to develop a technical assistance plan, to enhance staff capacity in the areas of evaluation and service delivery;**
- **Facilitating a DVOB planning retreat.**

During the second year we will fully implement the process and outcome evaluation plans outlined in Tables 5 and 6. The Thurston Group will provide technical assistance to each center on all evaluation measures and data collection protocols. In addition, the evaluation team will guide and monitor the adoption and integration of new data collection

forms and instruments. A database for all data items that cannot be captured within the existing database systems within the DV centers will be developed, and all data collection instruments will be field tested, revised (if necessary), and brought online during the fall of 2005. Data collection tools will be completed by clients receiving services at the three centers, which we will collect and analyze.

We at The Thurston Group look forward to continuing this evaluation effort, and would like to thank all participants whose hard work, cooperation, and commitment contributed to the success of this first year.

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ATTACHMENT I:
**STATE AND LOCAL DOMESTIC
VIOLENCE – DATA SUMMARY**

- Over the past five years Miami-Dade County has accounted for 14% of reported cases of domestic violence in the state.
- After a 4% increase in reported cases of DV in Miami-Dade County from 1999 to 2001, instances of domestic violence has decreased by 8% over the last three years. Statewide reported cases of DV decreased by 5% over the past five years.
- Statewide both children and women account for 50% of the DV emergency shelter population respectively. In Miami-Dade County children account for 54% of the emergency shelter population, while women make up the remaining 46%.
- With regard to face-to-face counseling women receive this service at a rate of 64% statewide, while children and men account for 31% and 5% respectively. Within Miami-Dade County children account for 44% of the recipients receiving this service while women account for the remaining 56%.
- Statewide women receive case management services at a rate of 70%, while children and men account for 27% and 2% respectively. In Miami-Dade County the case management service rate for women increases to 75% with children accounting for the remaining 25%.
- Statewide children ages 5–17 account for 66% of child assessments conducted in DV centers, while in Miami-Dade County this same age group accounts for 52% of the assessments. It should be noted that within Miami-Dade County the rate of child assessments conducted for children 0-23 months old and 2-4 years old increased 4% and 5% respectively over the last five years. All other age groups have declined in this service category.
- Statewide 51% of the safety plans are developed via telephone while the remaining 49% are developed via face-to-face contact, within Miami-Dade County the same rates are 89% and 11% respectively.
- With regard to statewide emergency shelter services, Caucasians account for 48% of the shelter population, while African Americans and Hispanics account for 29% and 18% respectively. Within Miami-Dade County 48% of the DV survivors that are receiving similar

services are African American, 40% are Hispanic, and 8% are Caucasian. In relation to age, 53% of the children were ages 5-17 and 85% of the adults were between the ages of 18-44 statewide. While in Miami-Dade County the respective rates for the same age groups were 50% and 90%.

- Regarding outreach services Caucasians account for 64% of the clients receiving this service statewide, the rate of service provision for Hispanics and African Americans are 15% and 18% respectively. Within Miami-Dade county Caucasians only account for 14% of the service population, while Hispanics and African Americans account for 45% and 33%. In relation to age, 79% of the children were ages 5-17 and 83% of the adults were between the ages of 18-44 statewide. While in Miami-Dade County the respective rates for the same age groups were 64% and 87%.
- With regard to community education a total of 37,960 instances of general educational activities and 10,580 professional training activities occurred statewide, while in Miami-Dade County data for the same activities were 351 and 104 respectively. It should be noted that for the county the number of professional training activities decreased by 90% over the last five years.

ATTACHMENT 2: ELEMENTS OF THE EVALUATION METHODOLOGY

- **Participatory Evaluation:** In participatory evaluation, “agencies and evaluators work together to identify program processes and outcomes to be evaluated. The primary purpose of participatory evaluation is to provide agencies with information about program services to enable more informed decision making and problem solving” (Riger, Bennett, Wasco, Schewe, Frohmann, Camacho, Campbell, 2002). Participatory evaluation reflects two beliefs or commitments that are useful for this evaluation. The first is that evaluation should respond to the needs and concerns of the persons or members of the setting beings evaluated. Second, evaluation data has to be meaningful and owned by participants if it is to be useful. (Levin, 1999)
- **Empowerment Evaluation:** This evaluation approach takes collaboration a step further by “using evaluation to foster organizational improvement and self-determination. Empowerment refers to enhancing the skills of the organization to conduct evaluation as well as improving the overall organizational process in a way deemed

appropriate by the participants. Staff members, clients, and community members determine important procedures and outcomes, and conduct the evaluation with input and technical assistance from evaluators who are viewed as partners rather than controllers of evaluation.” (Fetterman 1996)

- **Cluster Evaluation:** A recommended evaluation approach developed by the W.K. Kellogg foundation designed to “evaluate clusters of projects that are either [funded by a common source or address a similar topic or social policy]” (Worthen, Sanders, & Fitzpatrick) (Riger, Bennett, Wasco, Schewe, Frohmann, Camacho, Campbell, 2002). The four key characteristics of a good cluster evaluation include: (1) identifying common threads and themes across a group of projects, (2) seeking to learn not only what happens with respect to a group of projects but also why those things happened, (3) collaborating in a way that allows all players to contribute, and (4) maintaining a confidential relationship between the organizations and the evaluator.” (Riger, Bennett, Wasco, Schewe, Frohmann, Camacho, Campbell, 2002).
- **Outcome Evaluation:** This evaluation approach assesses the short- and long-term result of a project and seeks to

measure the changes brought about by the project in the lives of its clients or the service network. (W.K. Kellogg Foundation, 1998). “The effect of a program for victims should be observable as a change in participants’ knowledge, attitudes, beliefs, well-being, or behavior over time, or a change in system activity over time. In addition the reduction of the effects of injury and trauma, increased coping skills, and added knowledge of available resources are also changes that can potentially be measured.” (Riger, Bennett, Wasco, Schewe, Frohmann, Camacho, Campbell, 2002)

- **Process Evaluation:** This evaluation approach identifies the program components that contribute to resulting program outcomes, both positively and negatively, and provides the information necessary to revise and improve the original design and implementation of program services. Process evaluations address questions concerning a) what type of services are provided, b) how closely these services meet and exceed the system standards, c) who is being served, d) the barriers to services, e) the strategies that are used to improve services and resolve issues, and f) staff training and work assignments. (TTG Program Proposal 2003)

