Effectiveness of Hotline, Advocacy, Counseling, and Shelter Services for Victims of Domestic Violence

A Statewide Evaluation

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The authors report the results of an evaluation of services provided by 54 Illinois domestic violence agencies. In collaboration with the University of Illinois at Chicago evaluation team, domestic violence advocates identified services to be evaluated, specified desired outcomes of those services, and participated in developing measures of those outcomes in both English and Spanish. Within the limitations of the study, outcomes were positive in all four program areas: hotline, counseling, advocacy, and shelter. The authors then discuss implications for evaluation of domestic violence programs that maintain victim safety as a guiding principle.

Keywords: *domestic violence; evaluation; women; treatment*

Programs for victims of domestic violence are an integral part of community approaches to prevention of violence. Evaluation of these programs, however, is both recent and limited in scope. As in many social service programs in which resources for evaluation are limited, providing direct services takes priority over evaluating the efficacy of those services. However, trends such

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as evidence-based practice, competition for social service dollars, and professionalization have moved the evaluation of domestic violence programs to a higher priority. Further evidence of this trend includes the stipulation of formal evaluation of the programs funded by the federal Violence Against Women Act of 1994. Expectations for evaluation extend beyond major federal initiatives, as local centers and shelters are increasingly required by funders to demonstrate the effectiveness of their efforts (Campbell & Martin, 2001).

Requirements for evaluation have not been uniformly well received by violence-against-women social service agencies. Some agencies resist evaluation for ideological and other reasons. Grassroots efforts and volunteer labor created most violence against women programs (Campbell, Baker, & Mazurek, 1998; Riger, 1994; Schechter, 1982). These community-based organizations often had shared decision making, limited hierarchies, and a mission-driven approach to service linked to feminist principles. As the demand for services provided by these agencies increased, many domestic violence agencies turned to government and private funding sources for survival and to expand their programs. The acceptance of private and public funds often bound these agencies to the rules and regulations of their funders, including documentation and evaluation. Domestic violence agency staff may perceive top-down, funder-enforced evaluations as an intrusive, unhelpful presence that does not improve services but rather detracts scarce time and resources from service delivery. Mandated program evaluations that are not attentive to these challenges will not likely gain the support of agency staff; most important, they may compromise the safety of the participants.

Client safety is one of several concerns in conducting evaluation. Safety may be compromised when, for example, evaluation data are subpoenaed by attorneys for batterers in criminal or civil cases. Although domestic violence agencies may be protected by state law from releasing information about their clients, evaluators and researchers without adequate human subjects protection could be subpoenaed to provide information about individual women. Because information about substance abuse and emotional problems may be of particular interest to a batterer's attorney, this information should not be gathered unless adequate human subjects protection is in place. There is also a danger that research and evaluation conducted without adequate resources may expend the time and attention of staff, which in turn may reduce the safety of the women with whom they work.

Although it is possible to design and implement scientifically rigorous program evaluations that address the specific needs of survivors of abuse, such efforts may require more resources than small local organizations can realistically afford. Program evaluation may require scientific and adminis-

trative resources beyond the reach of individual domestic violence programs. Many funders who require program evaluation do not always provide the resources needed to conduct such efforts. Therefore, it is not uncommon for service agencies to face mandated evaluation with very little support. In response to this dilemma, the Domestic Abuse Project developed a comprehensive resource guide for evaluation of domestic violence services that can be used by small, local shelters (Edleson & Frick, 1997). Since then, other researchers and advocates have developed similar evaluation protocols (e.g., Sullivan, 1998). The current evaluation extends these models by applying measures developed for individual agencies to a statewide cluster of agencies.

Domestic Violence Services

In addition to a variety of preventive and educational services directed at the community at large, domestic violence agencies typically provide some combination of the following services to victims of domestic violence: (a) crisis hotline, (b) counseling, (c) advocacy, and (d) emergency shelter. Crisis hotlines and advocacy are staffed by volunteers, paraprofessionals, and professionals who have received intensive training in crisis intervention and the legal procedures for acquiring an order of protection. Most agencies operate a telephone crisis hotline 24 hours a day, 7 days a week. Abused women, their families, friends, and significant others can speak to advocates about abusive experiences and/or get information and resources to address specific issues such as housing or child care. Licensed professionals and other staff may provide counseling services for women and children. Staff may provide peer counseling, which is not viewed as therapy. Many domestic violence agencies also provide community- and school-based prevention and outreach services as well as batterer intervention programs.

Shelters are a critical feature of services for battered women. They offer safe refuge for women and their children, providing time for women to think about their options and to begin to rebuild their lives with social, legal, and medical assistance if needed. General evaluations of shelter services suggest that these services are helpful to battered women. Shelter and advocacy for battered women may be more helpful than traditional counseling services (Bowker & Maurer, 1986; Donato & Bowker, 1984). Berk, Newton, and Berk (1986) found that a shelter stay can reduce the frequency and intensity of new violence, but these effects depend on whether the woman had already started to make changes in her life before entering shelter. Sedlak (1988) found that after 2 weeks of living at a shelter, women were less depressed and more hopeful. Although shelter services are clearly important to battered women, much of the evaluation research has focused on advocacy programs.

Battered women's advocates accompany and support women as they navigate the legal, medical, and social systems seeking protection from future abuse. Advocates provide a link between women seeking assistance and institutional agents (e.g., police, attorneys, medical personnel, public housing agents, etc.) who may not be sympathetic. They also facilitate victim participation in the criminal justice process (Hart, 1993). Working with advocates, battered women learn about the criminal justice system within a supportive context. Women who receive advocacy services are more likely to seek and follow through with legal remedies (Weisz, 1999; Weisz, Tolman, & Bennett, 1998) and report greater success in obtaining resources and support than women who did not receive advocacy (Sullivan, Campbell, Angelique, Eby, & Davidson, 1994; Sullivan, Tan, Basta, Rumptz, & Davidson, 1992).

Sullivan and Bybee's (1999) recent research reports the importance of an advocacy program for battered women's safety and quality of life. For 2 years at 6-month intervals, they followed women who received 10 weeks of intensive advocacy services. The advocates worked with women to identify their unmet needs and to help them access community resources. Over the 2-year follow-up period, 24% of women who worked with advocates experienced no physical abuse by the original assailant or a new partner, compared to 10% of women who had not received advocacy services. Women who participated in the advocacy program also made positive changes to their lives. At follow-up, they had obtained more of the resources they sought, had fewer depressive symptoms, and were more effective at acquiring social support than those in the control group.

As noted earlier, battered women's agencies have also expanded their services to include counseling. Counseling services provide women and their children with an opportunity to address the impact of violence on their lives. Counseling services are usually offered individually as well as in support group settings. The structure and content of counseling services varies from agency to agency (e.g., feminist and social services models of care, cognitive restructuring therapy, assertive communication, problem solving, body awareness, vocational counseling, education about women's issues, gender socialization, self-esteem building, concrete plan development, trauma therapy, and grief-resolution-oriented counseling). However, a common thread across most domestic violence counseling programs is the exploration of battering from the perspective of power, control, and gender inequality.

A few studies have evaluated the efficacy of counseling for battered women. These studies examined supportive, psychoeducational shelter- and community-based individual and group counseling. Overall, the findings suggest that psychoeducational, supportive counseling for battered women may be an effective approach for improving self-esteem, affect (anxiety,

depression, and hostility), assertiveness, social support, locus of control, coping abilities, and self-efficacy (Cox & Stoltenberg, 1991; Mancoske, Standifer, & Cauley, 1994; Tutty, 1996; Tutty, Bidgood, & Rothery, 1993).

The Current Study

As part of a statewide adoption of evidence-based practice, in May 1998 the Illinois Department of Human Services (IDHS) initiated an evaluation of all 87 state-funded domestic violence and sexual assault agencies in Illinois. Unlike previous published evaluations of domestic violence services, this project evaluated multiple services (e.g., hotline, counseling, advocacy, and shelter) across 54 Illinois programs serving victims of domestic violence. By evaluating across agencies and services, the funders who initiated this project hoped to demonstrate the overall impact of domestic violence services in Illinois. This report briefly summarizes the process of that evaluation and reports the aggregated statewide outcomes. For a detailed discussion of the rationale and process of this evaluation, see Riger et al. (2002).

METHOD

Evaluation Procedure

The primary goal of the evaluation was to collect standardized, outcome-based evaluation data to complement process evaluation data that have been, and continue to be, collected by IDHS and its funded agencies. This project unfolded in two phases. The first phase included the development of evaluation objectives, measurement tools, data collection procedures, workshops for program staff, a training manual for evaluating domestic violence programs, and repeated field tests of the evaluation measures. In the second phase, we distributed measures throughout the state and trained agencies to collect data using the evaluation measures and to use the evaluation findings within their own organizations. We collected and analyzed one fiscal year's data. Although the evaluation design and measurement tools were standardized across the state, service delivery was not standardized, making this project an example of cluster evaluation. Cluster evaluation is an approach to evaluating multiple programs with similar goals but different activities that allowed us to combine goal-based evaluation, standard outcomes, and participatory methods in one evaluation approach (Worthen, Sanders, & Fitzpatrick, 1997).

We first surveyed program staff and representatives from various Illinois domestic violence programs about which services to evaluate. Subsequently, we invited program staff to join a workgroup to discuss which of the many services they offered should be included in the evaluation efforts and to identify the desired impacts of each service. Based on all information collected from surveys and focus groups, we developed measurable performance objectives for the services common to most programs working with victims of domestic violence: (a) hotline; (b) brief advocacy, usually legal; (c) long-term advocacy; (d) counseling; and (e) shelter.

After drafting outcome measures for each program, we again asked agencies to review our work. We sent each agency a draft of the interview guides and surveys and met with service providers in groups around the state to discuss the tools we developed. Agency staff were vocal and offered thoughtful suggestions about new items, wording changes, and the logistics of the data collection plan. We then revised the measures accordingly, repeating this process several times. We are confident that this process improved the validity of the measures.

The service providers who brought their expertise regarding their clients' backgrounds to bear on the evaluation measures greatly informed the content and wording of the items. One example of this process was provider concern about the inclusion of measures of posttraumatic stress, depression, and other indicators of adverse effects of domestic violence. It may seem logical that effective programs should reduce the adverse effects of domestic violence. Our team initially argued to advocates that such measures did not stigmatize the victims of violence any more than they would stigmatize the victims of a tornado. Service providers offered convincing feedback, however, that shifted the focus of the counseling evaluation from psychological responses (e.g., depression and anxiety) to whether counseling was helping women make healthy decisions, rebuild and regain control of their lives, and increase their self-efficacy. The core of their argument was a concern that information about social and psychological dysfunction, if it fell into the wrong hands, could be used against a woman in divorce or custody proceedings. Moreover, such information would contribute to what many advocates believe is a social stigma toward battered women suggesting that they are dysfunctional and to blame for the abuse.

Staff at each of the 54 IDHS-funded domestic violence programs incorporated the evaluation data collection procedures into their service delivery procedures. Shelter staff administered their measures once during the first 2 weeks of the client stay. Hotline and advocacy staff administered the evaluation questions at the conclusion of the service. Staff administered the counseling measures before and after services. Counseling clients who had used

the hotline also completed the before-counseling measure questions about using that service. Once completed, questionnaires were put in sealed envelopes and mailed to the evaluation team by designated agency staff.

Sample

Women receiving advocacy, shelter, hotline, or counseling services at 1 of 54 state-funded domestic violence programs in Illinois were eligible to participate in the evaluation. Characteristics of participants are listed in Table 1. Participants in this evaluation were ethnically diverse. There were no significant differences between English-speaking and Spanish-speaking participants on any outcome measures of advocacy, shelter, or counseling outcomes. A brief description of counseling clients is in Table 2. According to Illinois census data, White (64.4% vs. 73.5%) and Hispanic (5.4% vs. 12.0%) participants are underrepresented and African American participants are overrepresented in our sample (25.7% vs. 15.1%). Participants are also younger (median age = 33.0 vs. 34.7 years) and obviously more female (98.7% vs. 51.0%) than the state population. These differences are consistent with reports of most domestic violence programs.

Outcome Measures

After reviewing the literature and established measurement tools for our objectives, we determined that existing measures were too long, used complicated language, or were otherwise too cumbersome for use in this project. Therefore, we created new outcome measures borrowing from published measures, our experience in the field, consultation with researchers and evaluators both locally and nationally, and consultation with domestic violence advocates and service providers. Published measures that were partially adapted into the evaluation tools included the Empowerment Scale (Rogers, Chamberlin, Ellison, & Crean, 1997), the Rosenberg Self-Esteem Scale (Rosenberg, Schooler, & Schoenbach, 1989), the Personal Problem-Solving Inventory (Heppner & Peterson, 1982), and items taken from a manual by the Pennsylvania Coalition Against Sexual Assault (Sullivan, 1998). All measures used in this project and a manual are available at http://www.uic.edu/depts/psch/idhs/DVmanual.htm.

Increased knowledge and feeling supported are key outcomes across all programs. In addition to information and support, some programs had additional outcomes: improved decision making (counseling and advocacy); self-efficacy, goal setting, coping, whether the client has a safety plan, and the extent to which client views “the personal as political” (counseling); and

TABLE 1: Participant Characteristics

	Shelter	*Counseling (Matched)*	*Brief Advocacy*	*Extended Advocacy*	*Hotline*[a]
n	1,174	638	5,858	1,421	192
Race (%)					
African American	41.4	26.7	27.0	23.9	21.9
White	42.2	64.4	60.8	65.9	69.3
Latino	9.0	4.2	10.1	4.6	3.1
Percentage Spanish[b]	2.9	1.1	3.6	0.8	0.0
Percentage female	99.3	98.9	95.6	99.3	99.0
Age (mean)	32.0	33.6	33.0[c]	32.7	33.9

a. Outcome data were collected on 6,496 hotline calls, but the only identifier collected at the hotline event was language in which the tool was administered (5.0% of hotline evaluations were in Spanish). The data in this table are taken from 192 individuals seeking counseling who report using the crisis line, administered at the time of the counseling intake.
b. The language in which the evaluation tool was administered was Spanish.
c. Age estimated by service provider.

TABLE 2: Characteristics of Counseling Services and Clients

n (pre)	5,260
n (post)	1,440
n (matched)	638
Race/ethnicity (%)	
African American	25.7
Latino/Hispanic	5.4
Asian/Pacific Islander	0.6
Native American	1.0
White	64.4
Other	1.1
Bi-/multiracial	1.7
Percentage questionnaire administered in English	97.4
Percentage female	98.7
Age (mean)	33.8
Percentage survivor of	
Childhood sexual assault	45
Childhood physical abuse	48
Adult sexual assault	13
Services modalities (%)	
Individual counseling	90
Group	41
Family	12
Mean number of counseling sessions	2.2

feeling safe (shelter). At the suggestion of advocates, we also added process indicators of comfort (shelter) and staff respect (shelter). Staff respect indicated the extent staff are seen as respecting racial/ethnic identity, cultural customs, religious/cultural beliefs, and sexual orientation (both counseling and shelter programs).

Items were placed on a 4- or 5-point metric indicating amount, frequency, or agreement. Examples of items are in Table 3.[1] To simplify analysis, summary indices were created for counseling, hotline, and shelter by adding responses to sets of items. Internal consistency of these summary indices were evaluated using Cronbach's alpha. The counseling index, hotline index, and shelter index all have at least marginal reliability ($\alpha \geq .70$).

Analysis

Because there was no appropriate comparison group, the primary method of analysis for advocacy, hotline, and shelter services is the proportion of participants who endorsed key outcome statements. For counseling, we are able to use related group *t* tests to compare before and after service; a standard alpha of .05 indicates statistical difference between before and after scores.

RESULTS

Outcomes for all five service areas evaluated are in Table 4. The outcomes in Table 4 are cross-sectional measures for hotline, advocacy, and shelter participants and the after-service measures for counseling. Also included in Table 4 are characteristics of the measure: number of items, Cronbach's alpha for measures with more than one item, range, mean, and standard deviation.

Counseling is the only program for which pre- and postservice data are available, and it is useful to examine the counseling program in more detail. Counseling usually consisted of individual sessions (provided to 90% of participants), but nearly half of the participants (41%) also had group counseling. Family counseling (12% of participants) in the context of domestic violence programs usually means mother and children. Consistent with other studies, many of the participants were victims of childhood sexual assault (30%) and/or childhood physical abuse (37%).

The eight items of the counseling index that are asked both before and after services, when summed, form a reliable scale, the Counseling Outcomes Index (COI; $\alpha = .87$). The COI after-service score ($M = 31.08$, $SD =$

TABLE 3: Outcome Measures, Number of Items, Item Anchors, Sample Items, and Number of Index Items

Index	*Item Anchors*	*Items*	*Sample Item*
Support	1 = never, 5 = always	2	I have someone I can turn to for helpful advice about a problem.
Self-efficacy	1 = never, 5 = always	3	I trust my ability to solve difficult problems.
Coping skill	1 = never, 5 = always	3	I have ways to help myself when I feel troubled.
Goal setting	1 = never, 5 = always	3	I was an active participant in setting goals with my counselor(s).
Information	1 = never, 5 = always	3	Counseling has given me new ways of looking at abuse.
Nonjudgment	1 = strongly disagree, 5 = strongly agree	3	My counselor(s) listened respectfully and took me seriously.
Safety plan	1 = strongly disagree, 5 = strongly agree	1	My counselor(s) helped me develop a safety plan.
Personal is political	1 = strongly disagree, 5 = strongly agree	1	My counselor(s) explained that domestic violence is not only a personal problem but also a social problem.
Respect	1 = strongly disagree, 5 = strongly agree	4	Staff respected my racial/ethnic identity.

5.96) was significantly greater than the COI before-service score ($M = 29.51$, $SD = 6.19$) using the related groups t test ($t = 8.16$, $df = 548$, $p < .001$). The after-service COI was correlated with after-services measures of information ($r = .40$) and goal setting ($r = .50$) but not with age, administration language (Spanish or English), use of crisis hotline, type of counseling received (individual, family, or group), number of sessions, race, or time elapsed since the abuse episode. The before-after effect size for the COI is modest (.25).

There were no statistically significant differences between hotline outcomes drawn from telephone interviews and hotline outcomes drawn from counseling interviews. The Hotline Index is the sum of two questions about information and support, each on a 0 to 4 scale. Spanish-speaking respondents ($M = 7.64$, $SD = 1.14$, $n = 308$) had slightly better outcomes ($t = 9.54$, $df = 403.9$, $p < .001$) on the Hotline Index than English-speaking respondents ($M = 7.18$, $SD = 1.16$, $n = 4{,}426$), a difference that corresponds to a moderate effect size (.40).

TABLE 4: Outcome Measures by Program: Number of Items, Cronbach's Alpha, Range, Mean, and Standard Deviation

	n	*Items*	*Alpha*	*Range*	*Mean*	SD
Counseling[a]						
Social support	1,475	2	.86	2-10	8.1	1.9
Self-efficacy	1,461	3	.86	3-15	10.9	2.5
Coping skills	1,394	3	.72	3-15	11.9	2.4
Goal-setting	1,395	3	.79	3-15	12.7	2.4
Information	1,407	3	.82	3-15	13.2	2.2
Counseling index (post)	1,374	8	.84	8-40	31.0	5.6
Hotline						
Information	4,734	1	—	1-4	3.5	0.7
Support	4,734	1	—	1-4	3.6	0.6
Hotline Index	4,734	2	.70	2-8	7.2	1.1
Brief advocacy						
Information	5,267	1	—	1-4	3.8	0.6
Support	5,267	1	—	1-4	3.9	0.4
Decision making	5,267	1	—	1-4	3.7	0.6
Brief advocacy index	5,267	3	.65	3-12	11.3	1.2
Brief advocacy information	4,035	5	.83	5-20	18.6	2.3
Extended advocacy						
Information	1,370	1	—	1-4	3.4	1.0
Support	1,370	1	—	1-4	3.8	0.5
Decision making	1,370	1	—	1-4	3.6	0.6
Shelter						
Safety	1,751	2	.69	2-8	7.6	0.9
Comfort[b]	1,643	5	.81	5-20	16.6	3.0
Respect[b]	1,672	4	.96	4-20	17.8	3.3
Shelter Index[b]	1,559	11	.83	11-48	41.9	5.6

a. The mean, range, and standard deviation for counseling are after services.
b. The comfort and respect measures are process indicators, so the Shelter Index—comprised of safety, comfort, and respect—is not, strictly speaking, an outcome measure.

DISCUSSION

This evaluation represents the first statewide evaluation of community-based hotline, shelter, advocacy, and counseling services for battered women. It was the first evaluation to use participatory techniques on a large scale with domestic violence agencies that actively engaged the agencies in the evaluation process from the onset. We believe that this approach to evaluation of domestic violence programs is most likely to achieve the optimal mixture of victim safety, staff cooperation, and useful information.

Overall, results support the effectiveness of domestic violence programs in all five service areas studied. Although acknowledging the limits of this evaluation, we suggest that (a) domestic violence victims gain important information about violence and increase their support during their participation in domestic violence counseling, advocacy, and hotline services; (b) domestic violence victims perceive an improvement in their decision-making ability during their participation in domestic violence counseling and advocacy programs; (c) domestic violence victims increase their self-efficacy and coping skills while participating in domestic violence counseling programs; (d) domestic violence victims feel safe while in shelter; and (e) the effects of domestic violence counseling programs are small but significant. The small effect is not surprising in light of the fact that the mean number of counseling sessions was slightly more than two.

Due to the constraints of a statewide evaluation, the limitations of this study are substantial: Data were self-reported, untested measures were employed, no control groups were used, the data were collected by the service providers, there were substantial portions of data missing at follow-up, there was neither random selection nor random sampling, and outcomes identified individual rather than community effects. Given these limitations, the statements in the previous paragraph remain preliminary. From the most narrow perspective, our evaluation is not an outcome study but an uncontrolled, self-reported description of current functioning, confounded by satisfaction with agency services and numerous unknown other factors. However, the limitations are, in part, offset by the consistency of participant ratings across programs as well as by a perspective that values individual perception of change as an important adjunct to objective indicators. The methods of this evaluation fit the task at hand, and we await other opportunities to employ other methods to enhance our confidence in these results.

One of the concerns in this evaluation was whether administering a questionnaire to hotline callers—even after the resolution of the call—would be safe. Service providers agreed to collect outcome information at the time of the hotline call and to collect the same information at the time of counseling intake from those who reported that they had used the hotline in the past. There was no statistical difference between outcomes collected at the time of the hotline call and outcomes collected at counseling intake so there is no further justification for collecting outcome information during hotline calls.

Implications

Evaluation of domestic violence programs can be improved by refining measurement of outcomes and by the use of comparison groups. Qualitative

and contextual information would greatly enhance our ability to understand outcomes.

This evaluation suggests that funding domestic violence programs produces, within limits, positive results. Results vary across programs, as the services and acuity of need varies across programs. Policy makers and funders can be more assured that dollars are connected with positive outcomes. Staff and consumers can be more assured that their efforts are associated with success. However, this evaluation also reiterates what advocates have said for some time: Domestic violence service providers work with women who are involved with a great deal more than physical assault. Many battered women who seek services also suffer greatly from homelessness and poverty as well as the sequelae of stressors that are associated with such problems. The relatively small effects observed in this evaluation of woman abuse programs are to be expected due to the complexity of the problems studied and the broad variations in service delivery, both between and within domestic violence agencies. It is unlikely that the effects of domestic violence services can be greatly enhanced without a large-scale government and social commitment to issues such as child care, employment, transportation, affordable housing, and social justice.

NOTE

1. All measures used in this evaluation, both domestic violence and sexual assault, along with manuals and frequently asked questions, are available at www.uic.edu/depts/psch/idhs.

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