

PREFACE

DOMESTIC VIOLENCE: A GLIPSE OF THE BIG PICTURE IN MIAMI-DADE COUNTY

- In 2006, 29,000 incidents of domestic violence were reported in the jurisdiction of the Miami-Dade Police Department.
- During this same period, 7394 Injunctions for Protection were filed, representing roughly 25% of reported incidents and generally “mirroring” the profile of Miami-Dade’s population: 55% of petitioners were Hispanic, 32% were African American, and 10% were White Non-Hispanic.¹
- More than 12,000 calls were made to local domestic violence Hotlines.²
- Children, the most vulnerable victims of domestic violence, comprised half of the residents in local domestic violence centers.
- 1,097 women and children victims of domestic violence were given emergency residential services in 2006.
- Victims of domestic violence improved their sense of well being over the course of their stay at the centers, and expressed a high level of satisfaction with the services.

¹ Domestic Violence Intake Unit statistical data, 2006.

² Miami-Dade County Department of Human Services (DHS), monthly domestic violence service reports.

INTRODUCTION

As domestic violence shelters evolved from small community based facilities that relied upon volunteer staff funded by private donations to larger, more complex organizations that receive federal, state, and county funding, efforts have begun in recent years to assess the services of these organizations to clients (Riger, Bennett, Wasco, Schewe, Frohmann, Camacho, & Campbell, 2002). Consistent with its mission that includes “*generally monitoring and evaluating the provision of services to domestic violence victims,*” the Domestic Violence Oversight Board (DVOB) funded this three year evaluation of domestic violence centers in Miami-Dade County. The principal objectives of the evaluation were to describe and analyze interventions provided by the centers, determine the outcomes and benefits of services for clients, and compare differences in organizational processes between the centers.

In the first year the major evaluation activities involved completing the overall evaluation design and assessing the evaluation capacity of each center as well as the existing management information systems. The results of these activities were described in the Year 1 Evaluation Report, 2005. The Year 2 report presented the baseline measures for evaluating client and service outcomes, comparative service data between Miami-Dade County and the State of Florida, and findings from the ongoing examination of local service delivery modalities.

This Year 3 report presents an overall description of the core services and clients in Miami-Dade's domestic violence centers, and an analysis of the extent to which these services are helpful to domestic violence victims. The report is based upon data collected from May, 2004 to June, 2006.³ Following this introduction, Section 1 provides a brief description of the certified domestic violence centers in Miami-Dade County, identifies the services provided by the centers, presents the comparative use of services in Miami-Dade and the State of Florida, and discusses the major issues and recommendations for each service category. Data regarding the extent to which clients have benefited from domestic violence services are presented in Section 2. Service delivery modalities are described in Section 3, and Section 4 analyzes the similarities and differences between the public-government operated centers and the community-based model. The report concludes with observations and comments in Section 5.

³ A detailed description of the evaluation methodology, instruments, and data analysis procedures is presented in Appendix A.

DOMESTIC VIOLENCE CENTERS IN MIAMI-DADE COUNTY: A PROCESS AND OUTCOME EVALUATION OF SERVICES AND CLIENT OUTCOMES

SECTION 1 DOMESTIC VIOLENCE CENTERS AND SERVICES

Formal efforts to establish an emergency shelter and other services for victims of domestic violence in Miami-Dade County began in 1974 and as a result, the 63 bed North Dade Victim's Center (Safe Space North)⁴ opened in 1977. The South Dade Victim's Center (Safe Space South)⁵ was established in 1988 and has 24 beds. A third center, *The Lodge*, was recently established in 2004 and has 40 beds. The *North* and *South* Centers are county facilities staffed by county employees. *The Lodge* is the first facility constructed by the DVOB and the first center operated by a community based nonprofit organization. Each of these centers is certified by the Florida Department of Children and Families (DCF) and monitored for compliance by the Florida Coalition Against Domestic Violence (FCADV).

SERVICES IN DOMESTIC VIOLENCE CENTERS

Certified domestic violence centers are expected to provide eight core services:

1. Hotline Services. A 24 hour, 7 days a week crisis hotline that community members may access for domestic violence services, referrals, or advice.
2. Information and Referral. Information exchange and recommendations regarding the services and community resources available for victims of domestic violence including their children.
3. Emergency Shelter. Temporary housing for victims of domestic violence and their dependents.

⁴ Referred to hereafter as the North Center.

⁵ Referred to hereafter as the South Center.

4. Counseling. Individual and group sessions where information is provided about the dynamics of domestic violence; Assessment of risks, case management, support, and information is made available to residential and non-residential clients.
5. Case Management. Development of a service plan, including a safety plan, and a process for coordinating services and following up on client's progress.
6. Child Assessments and Services. Evaluation of basic needs of children including screening for abuse and risk assessment; Age appropriate counseling and other services to help children process domestic violence experiences, adjust to the transition of living in a residential center, and support their education and social needs.
7. Community Education. Presentations to the public of information on the incidence, dynamics, and prevention of domestic violence.
8. Professional Training. Activities offered to law enforcement personnel and other professionals who have contact with victims of domestic violence as part of their work.

In addition, all three centers offer non-residential services that include case management, counseling, and other support services.⁶ Each of these service categories is discussed in the sections following, including client profiles and service outputs.

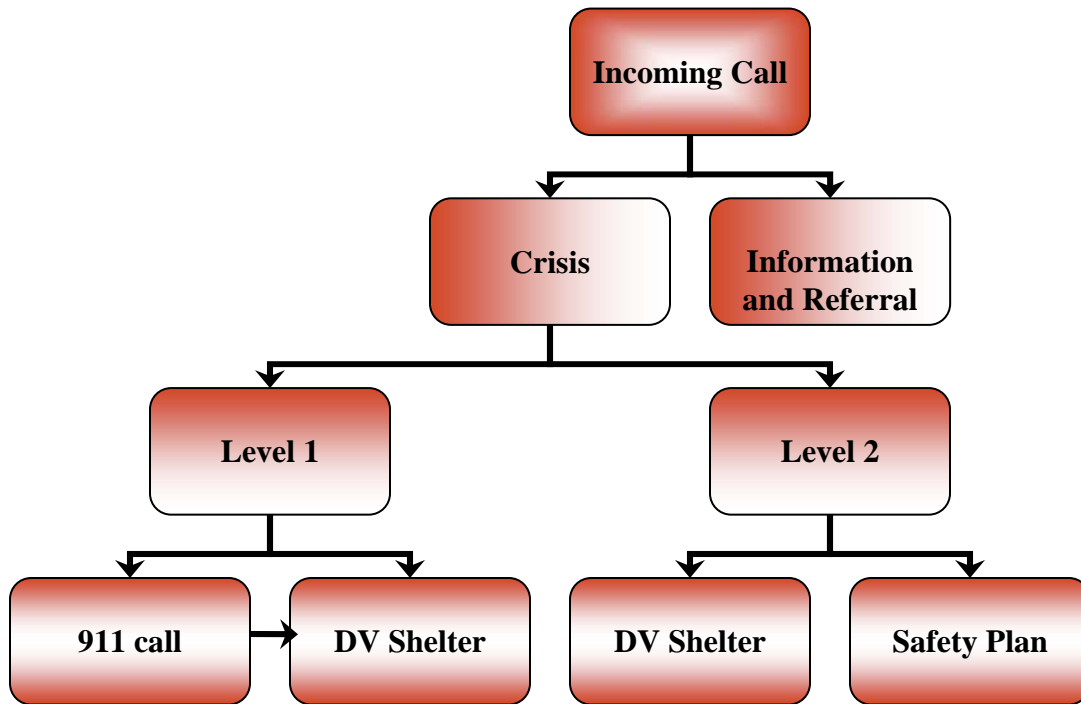
Hotline Services

For many victims of domestic violence, the gateway to help begins with a call to a domestic violence hotline. A statewide toll-free 800 number operates 24 hours a day, seven days a week. Callers are provided immediate assistance in the form of a connection to the nearest certified domestic violence center, or information and referrals to other appropriate services. Assistance is available in English, Spanish, and Creole. The process evaluation

⁶ The South Center has access, but does not operate several units of transitional housing that may be available to clients for a limited period of time.

objectives were to assess who is likely to call the hotline, major reasons for calls, and the volume of calls.

Diagram 1: Routing of Hotline Calls



Calls to domestic violence hotlines are assessed and classified into two categories based upon information provided by the caller: (1) crisis and (2) information and referral (Diagram 1). Crisis calls are made by, or on behalf of, a victim needing immediate services as a result of domestic violence. Crisis calls have two levels of seriousness. Level 1 calls involve situations in which a victim is currently in a life threatening circumstance. These calls result in an immediate call to 911 either by the victim, or by the center with the victim's permission. Level 2 calls are most commonly received, and involve highly unsafe and volatile situations where domestic violence may be imminent. In these circumstances, an assessment of the victim's immediate safety is made during the call. The victim is offered, or may request, emergency shelter or elect an alternative such as going to the home of a relative or friend.

A second category of calls to domestic violence hotlines involve requests for information or referrals. Requests for these services are made by victims of domestic violence, family members of victims, service providers, or members of the general public.

To better understand how domestic violence hotline services are used in Miami-Dade County, 2,693 callers who were not in crisis responded to a survey between April, 2005 and June, 2006.⁷ Each call received at a domestic violence hotline is documented with the time of the call, primary reason for the call, and role of the caller.

Hotline Services in Context: Miami-Dade County and Florida

In the State of Florida and in Miami-Dade County, **calls to domestic violence Hotlines have steadily increased over the past three years** (Table 1). In 2005-06, more than a million calls were reported statewide, and 12,868 were reported in Miami-Dade.

**Table 1
Florida and Miami-Dade County Domestic Violence Hotline Calls
2004 – 2006**

	Florida			Miami-Dade		
	04-05	05-06	Rate of Change	04-05	05-06	Rate of Change
Crisis calls	135,338	136,663	1%	5,894	6,291	7%
Information and referral calls	887,783	982,489	11%	5,513	6577	19%
Total # of Hotline calls	1,023,121	1,119,152	9%	11,407	12,868	13%

Source: DCF Domestic Violence Reports, FY 2004 – 2005 and 2005-2006
Source: 2004-2005 DVOB Service Reports submitted by The Lodge

⁷ Appendix A contains further information about how these data were collected.

County (DCF, 2006). The increase in call volume has been highest for information and referrals. These calls increased in Florida by 11% and in Miami-Dade by 19% over the past two years (2004-05 and 2005-06). The volume of crisis calls during this period increased modestly in the state (1%), however **in Miami-Dade crisis calls increased by 7%.**

Hotline Services: Center Level Profiles and Discussion

As the first certified domestic violence center in Miami-Dade County, local calls to the 800 hotline are routed to the *North Center* and callers are referred to the nearest domestic violence service provider as needed. In addition, Creole speaking callers from anywhere in the State of Florida are routed through the *North Center* where interpreters are available to speak to the caller. Hotline calls can be made directly to both the *South Center* and *The Lodge* and are routed to social workers or other trained staff in the centers.⁸

In 2005-06, the *North Center* reported 7,336 hotline calls, a volume somewhat lower than the previous year (9,063). However, calls increased significantly at the *South Center*, mostly for information and referrals. Although *The Lodge* was not required to formally report calls to the Florida Coalition Against Domestic Violence in 2005-06, they provided Hotline data to The Thurston Group as did each of the other centers as part of this evaluation from April 2006 to June 2007. Hotline information revealed the following:⁹

- The largest number of crisis calls was made to the *North Center's* hotline. **Twenty-six per cent (26%) of callers to the *North Center* were in crisis, and 11% of those were in Level 1 crisis, defined as an “emergency life-threatening situation.”** In contrast, crisis calls were 3% of the total at the *South Center* and 13% at *The Lodge*.
- **The victim was the person most likely to call the hotline.** At the *North Center*, 83% of callers identified themselves as the abuse victim; 87% of callers to *The Lodge* were victims as were 70% of callers to the *South Center*.

⁸ Given the existing 800 Hotline at the North Center, The Lodge was granted an exemption from the requirement of having a Hotline.

⁹ Hotline surveys by center: North (n=956); South (n=1312); The Lodge (n=425).

- Repeat callers accounted for 27% of hotline contacts at the *North Center*, 20% at the *South Center*, and 30% at *The Lodge*; the reasons for repeat calls are not systematically documented or classified.
- **Callers to the hotlines are often unclear about its function and frequently request services outside the purview of the domestic violence centers.** For example, a large proportion of callers who are not in a crisis situation requested housing; (47% at the *North Center*; 42% at the *South Center*; 67% at *The Lodge*). The main reason for half of the calls to the *South Center*'s hotline was for information or referrals to a wide range of services including housing, health care, employment, job training, and assistance with immigration issues.
- **Callers expressed a high level of satisfaction with the hotline services.** When asked, if they were satisfied with the amount of help they received, 98% of the callers to the *North Center* responded "yes," as did 91% at the *South Center*, and 96% at *The Lodge*.

Hotline Services: Issues and Recommendations

Issue. A significant volume of calls to the Hotline involve requests for information and referral to a range of community services.

Recommendation. *Requests for information and referral services should be more fully documented to determine if many of these calls could be suitably handled by Switchboard of Miami or another appropriate agency.*

Emergency Shelter and Residential Services

The core service of domestic violence centers is to provide emergency shelter and safety for victims, and provide the support they need to avoid further abuse and improve their lives. In Miami-Dade County, 127 emergency shelter beds are available for domestic violence victims in the three certified centers. Half (50%) of the beds (63) are at the *North Center*, 19% (24) at the *South Center*, and 31% (40) at *The Lodge*.

In addition to shelter, certified centers offer a core of residential support services to victims and their children. These include information and referral, individual counseling,

group counseling/support groups, case management and advocacy, children’s services, and health services.

Residential Services in Context: Miami-Dade County and Florida

In Miami-Dade County, 1,097 adults and children were sheltered as a result of domestic violence during 2005-06, although the *South Center* operated with fewer than half of its 24 bed capacity during this period¹⁰ (Table 2). While slightly fewer victims received emergency shelter services due to diminished bed capacity at the *South Center*, victims remained in the shelters for significantly longer periods of time. **Total shelter days for victims almost doubled, reflecting the 22% increase in the number of adults in emergency shelter longer than 72 hours.** As shown in Graph 1, in contrast to

	Florida			Miami-Dade		
	04-05	05-06	Rate of Change	04-05	05-06	Rate of Change
Total shelter days	340,580	375,250	10%	46,745	82,847	77%
Adults receiving shelter services	7,049	7,326	4%	555	541	-3%
Children receiving shelter services	6,728	6,802	1%	606	556	-8%
Adults remaining longer than 72 hours	5,163	5,405	5%	403	492	22%

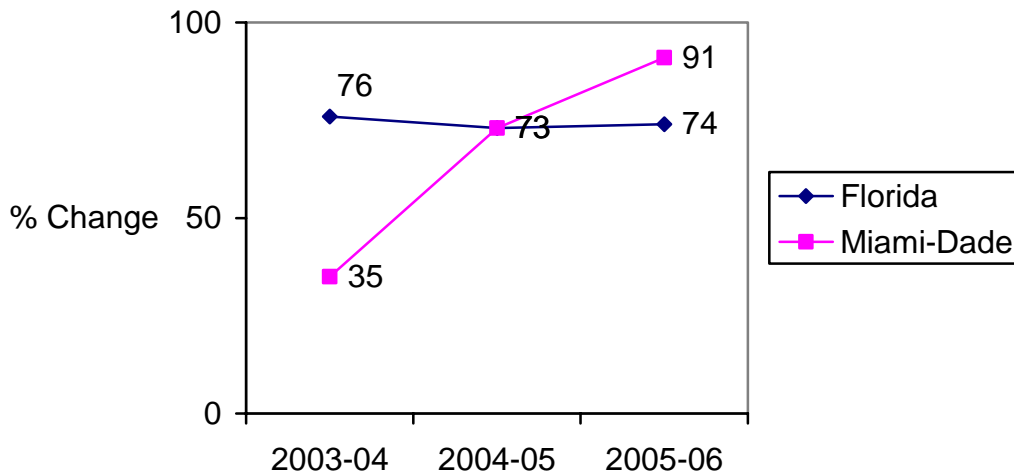
Source: DCF Domestic Violence Reports, FY 2004 – 2005 and 2005-2006

Source: 2004-2005 and 2005-2006 DVOB Service Reports submitted by The Lodge

¹⁰ The South Center sustained significant damages from hurricanes in 2005. The center was temporarily relocated to InTransition where 12 emergency shelter beds were available for victims of domestic violence.

statewide trends, the percentage of adults in emergency shelter longer than 72 hours has increased substantially in Miami-Dade County in each year reported.

Graph 1. Florida and Miami-Dade County: Percent of adults in shelter longer than 72 hours



When shelter beds are occupied, the potential exists that fewer victims may be served. We looked at trends in the average lengths of stay¹¹ in the shelters. **We found that in Miami-Dade County the average length of stay in domestic violence shelters has increased threefold since 2003-04 while remaining fairly the same statewide.** In 2003-04 and 2004-05, the average length of stay in Florida’s shelters was 25 days, and increased to 27 days in 2005-06. In Miami-Dade however, the average length of stay was 33 days in 2003-04, 40 days in 2004-05, and almost doubled to 76 days in 2005-06.

In Miami-Dade County, it has become increasingly difficult to find appropriate and affordable housing for victims when they are otherwise prepared to leave the shelter. Staff members cited several instances where they believed that women had either

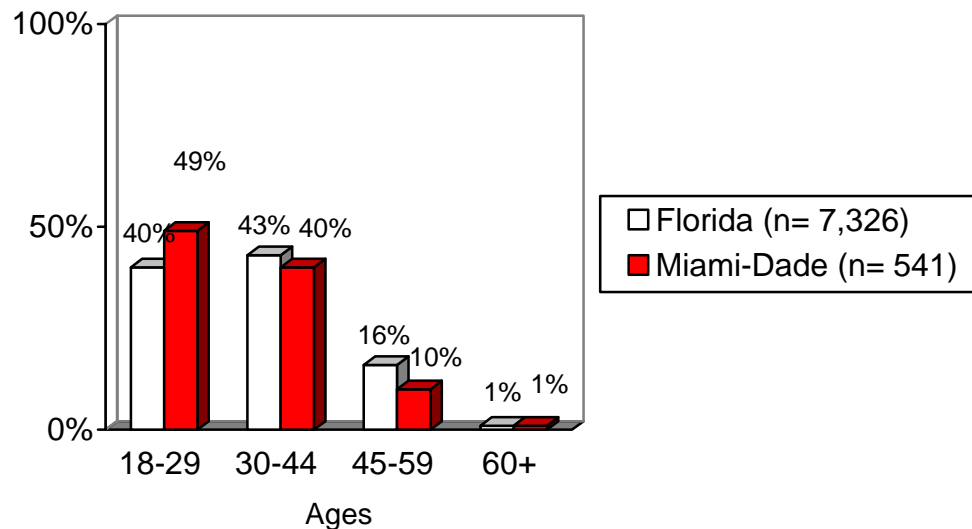
¹¹ The computation of average length of stay was made by dividing total shelter days by the sum of the total shelter days for adults and children. The resulting ASOL represents concurrent stays for a family group, not for an individual, (eg. a family of four staying for 10 days has an ALOS of 40 days).

stayed longer than necessary at the shelter or returned to the abuser because they had no other housing options.

In Miami-Dade County and the State of Florida, 99% of domestic violence emergency shelter residents are women and their children.¹² Children are a higher proportion of residential clients in local domestic violence shelters (51%) than in the state as a whole (48%).

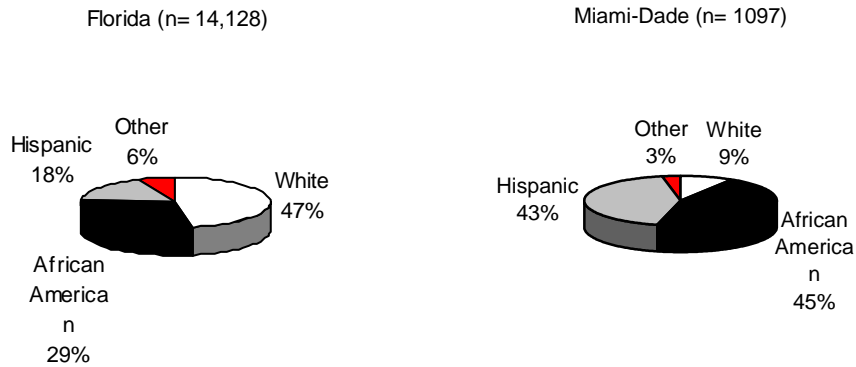
Typically, the women in Miami-Dade’s emergency shelters are between the ages of 18 and 29 (Graph 2) most of whom are African American (Graph 3). In contrast, elsewhere in Florida the typical woman in shelter is between the ages of 30-44 and Caucasian. The ethnic profile of residential clients in Miami-Dade County and in Florida has remained unchanged over the past two years.

Graph 2. Florida and Miami-Dade County: Adults in shelter by age



¹² DCF Domestic Violence Report, FY 2005-06.

Graph 3. Florida and Miami-Dade County: Adults in shelter by ethnicity



The age distribution of adult residential clients statewide has remained the same since 2003-04. However, in Miami-Dade adults and children in domestic violence centers were younger in 2005-06 than in the previous year. In 2004-05, 41% of adults in Miami-Dade shelters were between the ages of 18-29, however 49% were these ages in 2005-06. Twenty-seven percent (27%) of children in local shelters were ages 2-4 in 2004-05. The proportion of children these ages increased to 33% in 2005-06.¹³

Residential Services: Center Level Profiles

At the *North Center* during 2005-06, 330 adults and their children (n=321) received residential services (Table 4). While the number of clients receiving residential services declined slightly for adults (3%) and children (1%) when compared to the previous year, their average length of stay at the shelter was longer than in previous years. The total number of shelter days provided at the *North Center* in 2005-06 was 30,498, a 12% increase over the number of days provided in 2004-05 (27,208). **Victims remained at the *North Center* an average of 47 days in 2005-06 compared to 41 days in 2004-05.** The average length of stay for clients at the *North Center* is still below the acceptable 60 day threshold established by the *North* and *South* centers.

While their numbers are relatively few, the *North Center* has served increased numbers of men during the past two years. Male victims of domestic violence are usually

¹³ DCF Domestic Violence Reports, FY 2003-2006.

Table 4
Miami-Dade DV Centers
Units of Residential Services by Center 2004–2006

	North Center			South Center			The Lodge		
	04-05	05-06	Rate of Change	04-05	05-06	Rate of Change	04-05	05-06	Rate of Change
Total shelter days	27,208	30,498	12%	6,512	3,794	-42%	12,760	48,555	281%
Number of adults receiving shelter services	340	330	-3%	76	59	-22%	142	152	7%
Number of Children receiving shelter services	325	321	-1%	108	72	-33%	178	163	-8%

Source: DCF Domestic Violence Reports, FY 2004 – 2005 and 2005 - 2006

Source: 2004-2005 and 2005-2006 DVOB Service Reports submitted by The Lodge

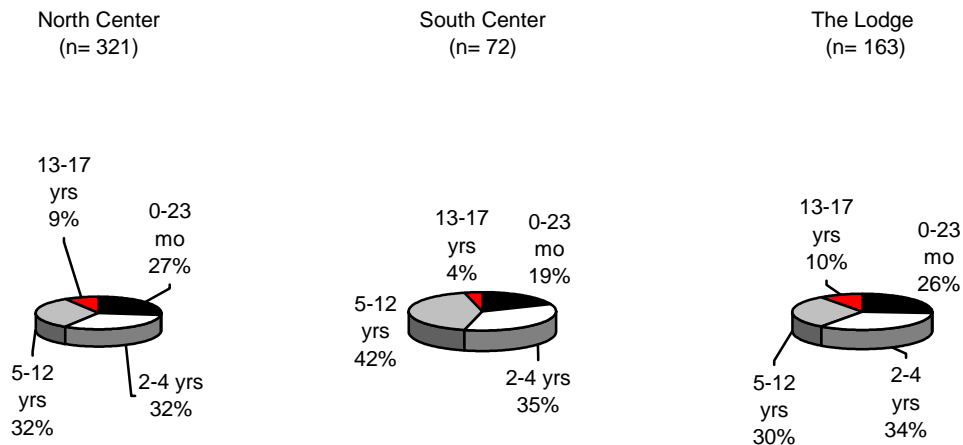
housed in local hotels, however this arrangement is not without problems: Hotels cost more per client; female staff is reluctant to see male clients off-site; and the model for residential services is primarily designed for female rather than male domestic violence victims. Should the number of male clients significantly increase, more specialized services and resources will have to be considered.

The relocation of the *South Center*, (caused by hurricane damage), into a temporary facility significantly altered the center’s capacity to meet client’s needs for residential services. Given the diminished bed capacity of the *South Center* for more than 18 months, between 2004-05 and 2005-06 the number of residential adult clients who received services decreased by 22% and children by 33% (Table 4). Fewer clients resulted in a decrease in the number of shelter days by 42%. Even in temporary facilities however, 59 adults and 72 children received 3,794 shelter days of services. The average stay for clients at the *South Center* was less than a month (29 days) and considerably shorter than in previous years.

The Lodge, in its second full year of operation, provided 48,555 shelter days to 152 adults and 163 children in 2005-06 (Table 4). The number of adult victims sheltered increased by 7% while the number of children sheltered decreased by 8% from 2004-05 to 2005-06. This change indicates that the women in emergency shelter had fewer children in the latter reporting time. **Clients remained in *The Lodge* for a much longer period of time when compared to the previous year. Indeed, 95% of the clients remained in the shelter longer than 72 hours**, compared to the combined rate of 89% in the *North and South Centers*. The average length of stay was 154 days which far exceeded the 90 day acceptable threshold established by *The Lodge*.

Adults and children were equally represented among residential clients (50% each) at the *North Center*; almost a half (48%) were between the ages of 18 and 29 and 43% were ages 30-44. **The *North Center* had fewer residential clients over the age of 45 compared to the other centers.** Children were mostly infants and toddlers ages five or under (59%).

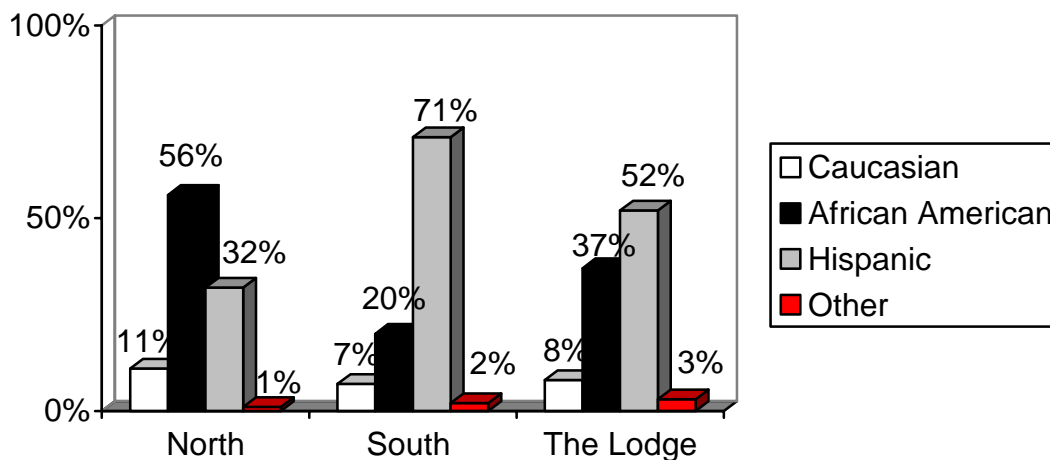
Graph 4. Miami-Dade DV Centers: Children in shelter by age



The South Center had the largest proportion of school aged children 5 to 12 years old (54%) and the smallest proportion of teens (4%). The Lodge had a slightly higher proportion of children under the age of five (60%) than the other centers. One-half of the adult residential clients at the *South Center* and 52% at *The Lodge* were 18-29 years of age.

African Americans and Haitian victims of domestic violence comprised 56% of all residential clients at the *North Center*, Hispanics 32%, and White non-Hispanics 11% (Graph 5). Most residential clients were Hispanic at the *South Center* (71%) and *The Lodge* (52%).

Graph 5. Miami-Dade DV Centers: Adults in shelter by ethnicity



Residential Services: Issues and Recommendations

- **Increasing length of stay in shelter.** Total shelter days as well as clients' average lengths of stay almost doubled in the past two years.

Recommendation: Efforts must be continued by the DVOB to increase emergency shelter beds. In addition, the DVOB should actively explore various resources for additional transitional housing as well as permanent affordable housing for victims of domestic violence.

- **Large proportion of children in residential services.** In all of the centers, children are about a half of the residential clients, and a large proportion of them are school age.

Recommendation: The DVOB and other stakeholders should increase collaborative efforts with Dade County Public Schools to facilitate the school retention and adjustment of children exposed to violence in their homes; Accommodations for homework as well as indoor and outdoor recreation areas should be a major consideration in plans for future domestic violence centers.

- **Immigration status of victim.** Fear of reprisals from immigration officials prevents some victims of domestic violence from using residential services.

Recommendation: Targeted efforts to reach immigrants and other under-served sub-groups of domestic violence victims have proven to be successful and should be continued. For example, a special community education and outreach program at the North Center resulted in increasing the number of Haitian victims using shelter services.

- **Negative perceptions of the domestic violence shelter.** A common perception of the domestic violence center identified among many Haitian women was that the shelter was a place for homeless people, substance abusers, or people with other types of “infirmities.” Haitian and White Non-Hispanic shelter clients have sometimes expressed feeling “uncomfortable” because of the dearth of women “like them” in the center.

Recommendation: The domestic violence centers should continue to consciously strive to ensure that the shelter environment is culturally appropriate for all victims with respect to staffing, services, and activities; Presentations to community groups and other public education activities should more clearly describe the shelter environment and client profile.

Non-Residential Services

Domestic violence centers are usually primarily identified as shelters for victims, however these centers provide a range of services to victims and their families outside of the residential setting. Non-residential clients may include victims and family members who have previously been in a shelter as well as those who have not received residential services.

Non-residential services typically include counseling, case management, referrals, direct relief, and advocacy support for adults and children.

Non-residential Services in Context: Miami-Dade County and Florida

Although the total number of adult clients who received non-residential services declined in Miami-Dade and in Florida in 2005-06, the local centers served 2625 clients and 33,149 were served statewide during this period (Table 5). At the same time, in Miami-Dade County, additional resources for non-residential services to children resulted in a significant increase in this area. For example, 389 children received non-residential services in 2004-05 and 1,627 children were served in 2005-06.

In 2005-06, African Americans used non-residential domestic violence services more than ever before in Florida and Miami-Dade County.¹⁴ In Florida, 19% of non-residential clients were African American in 2004-05 and 23% in 2005-06. During this same

	Florida			Miami-Dade		
	04-05	05-06	Rate of Change	04-05	05-06	Rate of Change
Children receiving non-residential services	8,591	5,890	-31%	389	1,627	318%
Adults receiving non-residential services	42,294	27,259	-36%	1,760	998	-43%
Total number of clients receiving non-residential services	50,885	33,149	-35%	2,149	2,625	22%

Source: DCF Domestic Violence Reports, FY, 2004 – 2005 and 2005 - 2006

Source: 2004-2005 and 2005-2006 DVOB Service Reports submitted by The Lodge

¹⁴ These data do not include The Lodge. During the period covered, this center did not report non-residential clients by age or ethnicity.

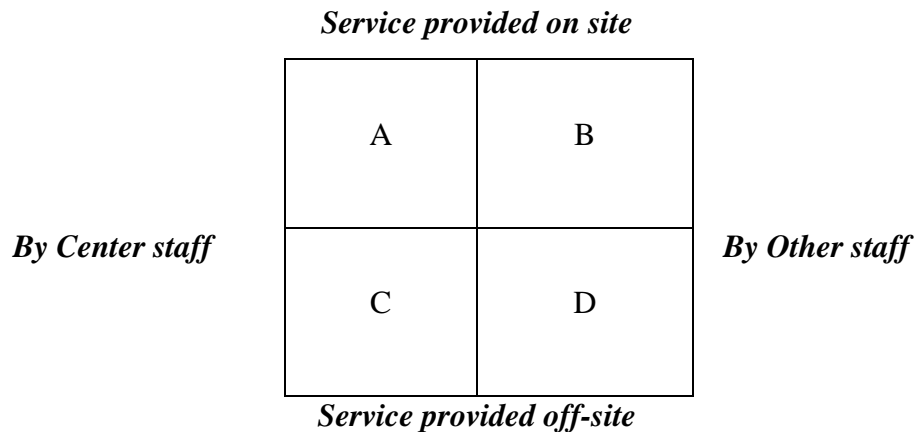
period in Miami-Dade County, African American non-residential clients increased from 43% to 71% while Hispanic clients declined from 44% to 23%, and Non-white Hispanics declined from 8% to 4%. The rather significant increase of African American non-residential clients in Miami-Dade reflects the large increase in the number of children receiving these services at the *North Center*, most of whom are African American or Haitian.

Non-residential clients were younger in 2005-06 than in previous years, a pattern consistent with that of residential clients. For example, 42% of clients who received non-residential services in 2004-05 were ages 18 to 29; however 55% were these ages in 2005-06.

Non-residential Services: Center Level Profiles

We have categorized models of service delivery in domestic violence centers along two dimensions: location of service and provider of service (Figure 1). In Model A, non-residential services are offered at the center and staffed by center personnel. In Model B,

Figure 1: Conceptual model of non residential services



services are offered at the center but are not staffed by center personnel. Model C involves offering services in locations other than the center, staffed by the center’s personnel. In Model D, services are offered away from the center and are not staffed by the center’s

personnel. Three of these models of non-residential services are currently used by domestic violence centers in Miami-Dade County.

Non-residential services at the *North Center* have traditionally followed Model D. These services are provided off-site by the Victim's Assistance Program¹⁵ through a memorandum of agreement. More recently however, the *North Center* has incorporated Model A in a special effort to address the need for domestic violence services in the Haitian community.¹⁶ A social worker aide is employed by the *North Center* to provide a limited range of non-residential services such as information and referral, advocacy, and case management.

The *South Center* provides non-residential services using Models A and C. Staff members provide these services at the center as well as at other locations in the community. Non-residential services at the *South Center* are unique in that these services are available for adults and children who are victims either of domestic violence, or other violent crimes.

Model A best describes how non-residential services are made available at *The Lodge*. These services are provided on-site by staff members of the center. However, *The Lodge* is reconsidering this model in favor of Model C. There is some concern among staff at *The Lodge* that the confidential location of the center and safety of residential clients may be compromised by clients who come to the center for non-residential services. To address this issue, efforts are being made to establish relationships with community based organizations that can accommodate the clients and activities involved in non-residential services.

In the three centers in Miami-Dade County, the total number of clients receiving non-residential services showed rather substantial increases over the past two years,¹⁷ particularly the number of children served (Table 6). During this time, the *North Center*

¹⁵ The Victim's Assistance Program is part of Advocates for Victims.

¹⁶ This outreach program geared to the Haitian community is currently funded by a grant from the Victims of Crime Act.

¹⁷ 2004-05 and 2005-06

increased its total number of clients from 1,914 to 2,132; the *South Center* from 138 to 233; and *The Lodge*, from 97 to 260.

Table 6
Units of Non-Residential Services by Center
2004 – 2006

	North Center			South Center			The Lodge		
	04-05	05-06	Rate of Change	04-05	05-06	Rate of Change	04-05	05-06	Rate of Change
Children receiving non-residential services	258	1,319	411%	90	148	64%	41	160	290%
Adults receiving non-residential services	1,656	813	-51%	48	85	77%	56	100	79%
Total number of clients receiving non-residential services	1,914	2,132	11%	138	233	69%	97	260	168%

Source: DCF Domestic Violence Reports, FY 2004 – 2005 and 2005 - 2006

Source: 2004-2005 and 2005-2006 DVOB Service Reports submitted by The Lodge

Note: Data for the North Dade Victims' Center represents clients receiving services from the Victims' Assistance Program also.

Non-residential Services: Client Profiles

A typical client receiving non-residential services at the *North Center* was a young adult between the ages of 18 and 29. Of the children served, more than half (55%) were between the ages of 5 and 12 years of age. The *North Center* also served the largest proportion of teens (25%) in non-residential services.

At the *South Center*, non-residential clients were somewhat older, and the average non-residential client was between the ages of 30 and 44. Forty percent (40%) of the children served in these families however, were under the age of five. *South Center* staff estimate that victims of violent crimes other than domestic violence account for about 5% of

non-residential clients. Staff has observed that direct relief appears to be a primary motivation for clients to participate in non-residential services. The patterns of attendance observed among non-residential clients at this center showed a definitive decline in participation after cash assistance is received through the Victim's Compensation Program.¹⁸

Non-residential Services: Issues and Recommendations

- **Increasing demand for services.** Requests for non-residential services have increased each year in Miami-Dade County, albeit the type of services requested have changed.

Recommendation: The pros and cons of current models for delivering non-residential services should be further documented and analyzed with respect to staffing, availability of services, and client need assessments.

- **Accessibility of services.** Non-residential services, particularly support groups, may not be offered at times most conducive for maximizing client participation. These services are typically offered in the day or early evening hours either once a week or once a month on weekdays.

Recommendation: Non-residential services should be offered at times most conducive for meeting the needs of domestic violence victims and their children; staffing patterns should be flexible and secondary consideration should be given to traditional weekday only, day-time schedules.

- **Cultural and language barriers.** The center administrators struggle with balancing the qualifications of staff and the socio-cultural characteristics of clients. For example, case assignments are often unbalanced because a center may have only one Spanish or Creole speaking social worker assigned to clients in non-residential services.

Recommendation: Center administrators should continue efforts to increase the cultural and language competency of staff. However, this objective is more difficult to achieve in the public centers, given the personnel policies and practices of Miami-Dade County government.

¹⁸ Cash assistance can be used for such expenses as medical care, funerals, or relocation expenses.

Children's Services

Children are often the most silent victims of domestic violence and they make up a sizeable proportion of domestic violence victims. It is estimated that as many as 60% of children exposed to parental violence are also victims of physical abuse. Indeed, 85% of children who witness violence in their homes become abusers or victims of domestic violence as adults (Miami-Dade County Police Department, 2006). Thus, children have special needs resulting from their experience of violence and displacement from their home. Certified centers are expected to address these needs through residential and non-residential services, and to assign staff to specifically work with children.

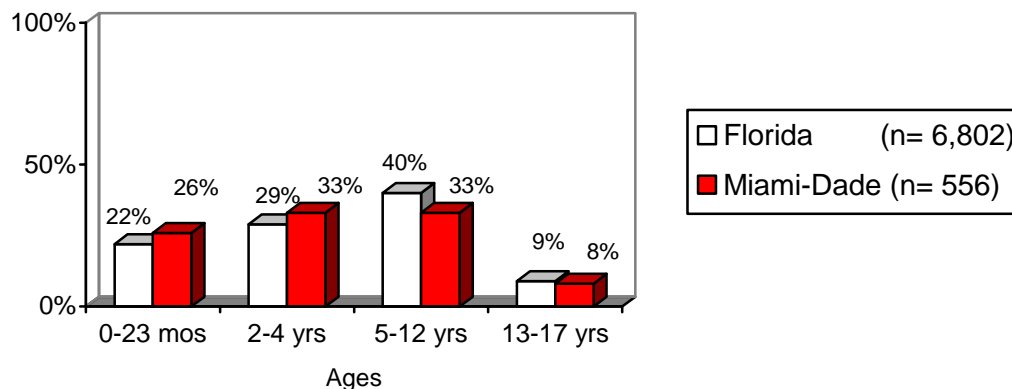
Children's Services in Context: Miami-Dade County and Florida

On any given day, children under the age of 5 are likely to comprise more than half of the residents in Miami-Dade's domestic violence shelters. **In 2005-06, children accounted for 51% of residential clients in Miami-Dade's domestic violence centers**, and 48% of those receiving residential services statewide. Among clients receiving non-residential services, 18% were children in Florida and in Miami-Dade 61% were children.¹⁹ Child victims of domestic violence are found in all age groups although those receiving residential services were younger in Miami-Dade than those statewide; 59% were infants and toddlers under the age of five in Miami-Dade compared to 51% in these ages statewide (Graph 6).

Services to children in Florida's certified domestic violence centers include safety planning, counseling, support groups, recreation, and educational activities. While children are provided both residential and non-residential services, as discussed below, they are most likely to receive direct services while living at a domestic violence center.

¹⁹ Non-residential services to children may be direct or indirect. Direct services involve the participation of children in counseling or other forms of activity; indirect services to children result from interventions on their behalf such as orders of protection.

**Graph 6. Florida and Miami-Dade County:
Children in shelter by age, 2005-06**



Children’s Services: Center Level Profiles and Discussion

The *North Center* was home to 321 children in 2005-06, accounting for 49% of all residential clients. Over half (59%) of these children were infants and toddlers under the age of five. In addition, 178 children were involved in non-residential services.

Fifty-five percent (55%) of the clients who received residential services at the *South Center* during this period were children, and more than half (54%) were infants and toddlers. This center provided residential services to the largest proportion of children between the ages of 5 and 12, and the smallest percent of teens (4%). Non-residential services were provided to 148 children.

At *The Lodge*, 52% of those receiving emergency shelter were children, and 60% of those children were under the age of five. This center had the greatest proportion of teenagers in shelter (10%). *The Lodge* also provided non-residential services to 160 children.

Services for children begin with an initial Family Assessment conducted with the parent and child(ren) during the first 72 hours after their arrival at a center. Parents are asked to share information or concerns about the child’s overall wellbeing including the parent’s perception of how the domestic violence has affected the child. Based upon this assessment and parental consent, children may engage in an additional risk assessment, counseling,

support groups, recreation, educational activities, and non-residential services. The steps and processes involved in providing services to children are summarized in the following discussion.

Risk Assessment. The risk assessment for children over the age of four, conducted by the social worker/advocate in a private session with the child, further explores issues related to the impact of the domestic violence, the child's perceptions of their personal safety, and basic psychosocial issues. This process concludes with the design of a service plan for the child and the review or development of a safety plan. Assessments of developmental benchmarks are made for children under the age of four and where deficits are noted, parents are referred to specialized services in the community.

Counseling. Children may engage in formal or informal counseling sessions with a social worker/advocate at the center. The more formal sessions are scheduled weekly, however informal interactions with children are more frequent and often occur daily during the child's play or recreation time. Children with significant behavioral or psychological issues are referred to agencies that offer specialized therapeutic interventions, (eg. University of Miami's Mailman Center or the Children's Psychiatric Center). Children with severe trauma, whose names are listed in police reports as witnesses to violence in their home, are referred to the Victim's Services Center for Trauma Incident Reduction Therapy. However, families may not follow-up with referrals for a variety of reasons, or continue counseling sessions after residential services are ended.

Support Groups. Age specific support groups for children are offered at each center. Discussions are linked to loosely organized curriculum reflecting areas deemed important by staff or clients. Each center has devised a unique approach for engaging children and youth in these groups. At the *North Center*, for the past eight years a master's level social worker provided by Project Upstart²⁰ facilitates children's groups twice a week. These groups at the *South Center* are conducted by the staff assigned to children's services. *The Lodge* has used a combination of its own staff and volunteer specialists as children's group leaders. For

²⁰ Project Upstart is sponsored by Miami-Dade County Public Schools.

example, volunteers trained in art therapy have facilitated groups and the center is exploring a partnership with the University of Miami Mailman Center's Heroes Program.

Recreation. Indoor and outdoor areas for play and recreation are available for children at each of the centers, although space is limited at the North and South facilities. Sports activities, video games, and celebrations of special events such as birthdays are typically organized by staff with involvement of the parent. In some instances, field trips to events in the community are sponsored through private donations.

The Lodge has the largest amount of dedicated space for outdoor activities and this center has developed the most extensive recreational program. For example, a summer camp for children includes sports events, family cook-outs, and educational activities for children and family members. The summer camp experience has been uniquely beneficial for the children. To illustrate, while black children are more likely to drown because they cannot swim, all children learned to swim during summer camp at *The Lodge*.

Educational Services. Educational services support the attendance and involvement of children in school. Tutoring/homework assistance, clothing, school supplies, and transportation are basic services available to children at each center. Whenever possible, children remain in their home schools and may be transported by the parent, staff, or school bus. The center's staff is most likely to oversee tutoring and homework assistance, however certified teachers are usually available to the *North Center* through their agreement with the school district's Project Upstart. To the extent possible, volunteers are recruited to provide this service for children at *The Lodge*.

Non-residential Services. As previously described, children may be direct or indirect recipients of non-residential services. Direct services involve the child's participation, while indirect services benefit a child through the participation of the parent. Because non-residential services are typically provided during daytime hours, children are rarely involved in the sessions. Furthermore, victims often "claim" the sessions as time for themselves.

Special efforts have been made at *The Lodge* and the *South Center* to involve children in non-residential services. At *The Lodge*, children in families who receive non-residential services are encouraged to participate in other services and activities such as tutorial sessions, field trips, and other group activities. Non-residential services at the *South Center* are available in evening hours, and clients are encouraged to bring their children to the sessions.

Children's Services: Issues and Recommendations

- **Predominance of young children.** Age is a significant predictor of behavior problems among child victims and younger children are more likely than older children to externalize behavioral problems (O'Keefe, 2004). A significant percentage of domestic violence victims in Miami-Dade's centers are infants and toddlers under the age of five.

Recommendation: An increased level of therapeutic interventions should be provided to children; for example, a model of family therapy could be adopted and implemented in all centers.

- **Underserved adolescent needs.** Adolescents in residential services often present unique challenges and the centers are ill equipped to handle their special needs. For example, funds are rarely available for older youth to participate in activities away from the center. The most challenging issues posed by adolescents however, involve adherence to the center's behavioral rules and guidelines (such as curfew), which are often different from their home.

Recommendation: An orientation session for teens should be developed to address issues and concerns specific to this group; in addition, more attention should be given to planning activities that may be more beneficial for adolescents, eg. music, drama, poetry, and other expressive arts.

- **Mental health needs of children.** There are long term consequences for children exposed to violence, particularly in their homes. However, mental health services are not available for most children served by the domestic violence centers.

Recommendation: Counseling services should be expanded beyond the basic accreditation requirement, to include more intensive therapeutic counseling for children receiving residential and non-residential services.

Core Support Services: Center Level Profiles and Discussion

Core support services are offered to both residential and non-residential clients as well as their children. These services include (a) information and referral, (b) counseling, (c) health services, and (d) case management and advocacy. The extent to which clients engage in these service activities is based upon the client's overall motivation as related to individual assessments and family service plans. All of these services are available to varying degrees at each of the three certified centers.

Information and Referral

Information and referral services are intended to link clients with supports and community resources. At the *North and South Centers*, a list of commonly used service providers and contact information is maintained for use by the staff. Advocates/social workers at *The Lodge* use a countywide electronic referral database operated by Switchboard of Miami.

Clients are often uninformed or incorrectly informed about the resources available to them and often need information about a service that may or may not result in a referral. **The most common information and referral needs were consistent among clients in all of the centers and included: (1) cash assistance; (2) housing; (3) employment; (4) child care; and (5) legal assistance, particularly with respect to injunctions for protection (IFP).**

The extent to which information and referral services result in positive outcomes for clients is largely dependent upon resources at both the community and individual level. Inadequate resources at either of these levels results in "dead end" referrals and barriers to effectively meeting client's needs. Barriers identified include the following:

- Community resources are insufficient to meet many needs of domestic violence victims, especially for transitional or affordable housing, mental health services for adult and child victims, and substance abuse treatment.

- The literacy level of clients is often a major barrier to accessing services to which they've been referred.
- In addition to issues of language and reading ability, the increasing use of web-based “on-line” applications for services is problematic for clients who lack basic computer skills and are often intimidated by technology. For example, center staff related instances where clients struggle to complete DCF's online application.
- Victims with an undocumented immigration status are often ineligible for many services.
- Previous negative experience with a service provider often results in a client's unwillingness to pursue additional referrals.
- Clients may lack resources needed to follow-up on referrals, eg. transportation, minimum fees, child care and so forth.
- Clients sometimes lack intrinsic motivation and willingness to follow-up on referrals.

Counseling

Individual and group counseling services are available to both residential and non-residential clients at each of the three centers. As previously described, counseling and other services for non-residential clients are provided by the staff at *The Lodge* and the *South Center* and provided by an affiliated entity at the *North Center*.

Residential clients in all of the centers believed that counseling sessions had been helpful.²¹ Individual counseling sessions for residential clients may be informal or formal. Formal or planned counseling sessions are scheduled at least twice per week and they are intended primarily to facilitate case management activities, provide emotional support, and deal with crises when needed. Informal counseling sessions may occur during unplanned encounters between clients and staff and are typically precipitated by a situation needing immediate attention.

Group counseling, also referred to as support groups, are psycho-educational in design and focus on topics such as (a) qualities for healthy relationships, (b) techniques for

²¹ See details in the outcome evaluation section of this report.

building self-confidence and self-esteem, (c) impacts of domestic violence, (d) parenting skills, and (e) assessing community resources. Group counseling sessions are guided by a scripted set of activities and curriculum intended to actively involve group members in the discussion. These weekly sessions are 60 to 90 minutes long.

Several factors influence the extent to which counseling services are delivered as planned. These factors include:

- *Intensity of counseling services.* Clients remain in residential and non-residential services for differing periods of time resulting in varying degrees of involvement in counseling services. Furthermore, attendance is often sporadic. Client turnover, particularly in group sessions, creates problems of continuity in the delivery of services.
- *Staff training and experience* varies among counselors and group facilitators.
- *Client's readiness to engage* in counseling can facilitate or impede the process. For example, the trauma of the abuse sometimes results in the emotional inability of some victims to engage in the counseling process; for other victims, the abuse motivates them to actively engage in counseling services.

Case Management and Advocacy

Case management is viewed as a process in which the social worker/advocate assesses the service and resource needs of clients, coordinates access to essential resources, and monitors the progress of clients in completing the agreed upon services plan. This process is intended to provide an integrated analysis of client needs and outcomes.

In the three Centers, case management services extend from intake through follow-up and are provided on a regular basis in both individual and group contacts. These interactions help to contextualize the domestic violence experience within the client's life, mobilize resources, and attend to immediate crises. Advocacy involves efforts of the staff to obtain services on behalf of their clients. Advocacy activities typically involve mobilizing resources in the service network, building collaborative relationships with service providers, and leveraging resources on behalf of a client.

Advocacy, or “persistent follow-up” activities by staff, is often hampered by staff shortages or staff turnover. Staff shortages are all too frequent at the *North and South Centers*, often resulting in less time for intensive advocacy activities. *The Lodge* on the other hand experienced significant staff turnover and had “new” staff which were often unfamiliar with the nuances of negotiating the community service delivery system and less effective as advocates.

Health Services

In all of the centers, a basic health screening is conducted during the intake process for adults and children who receive residential services. The screening at this point is essentially a client’s health care history. Referrals to health care professionals are given when the client requires medical attention as a result of the abuse, has gone long periods without basic medical attention, or has indications of other medical needs. In many instances, this basic screening process is the access point for linking clients to needed health resources in the community.

The spatial capacity and professional resources vary among the centers and affects the extent to which basic health care needs of clients can be provided on-site. *The North Center* and *The Lodge* have dedicated space for health services and storage of medication, however only the *North Center’s* on-site “clinic” is currently operational. As a result, immunizations for children, nebulizers for respiratory problems, and basic health screenings are available to residential clients at the *North Center*. Services are staffed by a RN through an agreement with The Public Health Trust/Jackson Memorial Hospital.

The Lodge’s health clinic also has beds appropriate for gynecological examinations. However, the center has been unable to secure the services of a physician or other appropriate health professional to provide on-site services, and the clinic is not operational. While efforts continue to staff the on-site facility at *The Lodge*, the center has agreements with community clinics to serve its clients.

Health services for clients at the *South Center* are provided through an agreement with the community clinic. The center does not have the space to accommodate any level of on-site health services.

Across the centers, the health issues most commonly found among adults are diabetes, respiratory problems typically resulting from smoking, and initial signs of heart disease. Children most often have asthma, cold viruses, insect bites, and lice. In addition to referrals for medical attention, health education group sessions are offered, albeit infrequently, to address common health issues identified in the intake process.

Core Support Services: Issues and Recommendations

- **Referral processes.** Updated and comprehensive information about referral resources is available to providers through Switchboard of Miami's electronic data base. However, as a result of the outmoded and inadequate DOS operating system in the *North* and *South Centers*, this resource is not accessible to these staff.

Recommendation. As recommended in the Year 1 and Year 2 reports, the existing computers and operating systems impede maximum services to domestic violence clients and should be replaced.

- **Resources to follow-up on referrals.** Many clients lack transportation and other resources to follow-up on referrals, particularly after they complete residential services.

Recommendation. The DVOB and other key stakeholders should advocate for reduced public transportation and taxi fares for victims to access employment and legal resources.

Community Education and Professional Development

An essential role of domestic violence centers is to inform the community about the issue and advocate for public policy and services that protect victims and potential victims (Krenek, 2000). Domestic violence centers fulfill this role by conducting presentations to a myriad of groups in the community, and by training staff members in other organizations who serve or may encounter victims and their family members.

Community Education and Professional Development in Context: Miami-Dade County and Florida

During the two year period 2004-06, there were modest increases statewide in the number of education and training presentations conducted. Indeed, fewer training sessions for professionals were held by domestic violence centers in Florida and these activities declined an average 7% during this time.²²

Over this same time, domestic violence centers in Miami-Dade significantly increased both the number of community education and training sessions held as well as the number of persons reached. In 2005-06, more than 6,000 people attended presentations and over 100 professional trainings were conducted.²³

Community Education and Professional Development: Center Level Profiles and Discussion

The Lodge and the *North Center* increased both their community education and professional training activities, and the number of people reached. In 2005-06, *The Lodge* was involved in 139 professional trainings and delivered presentations to 64 groups and organizations in the community. Community presentations conducted by the *North Center* reached the greatest number of people (5,402), and participation in professional trainings more than doubled over the past two years (from 24 in 2004-05 to 54 in 2005-06).²⁴

The *South Center* has few organizations and groups in its immediate vicinity, and more limited staff to conduct presentations. The Center's activities in this area have remained fairly constant over the past three years. 2005-06 was a typical year in which seven presentations were made to groups and organizations in the community.

As a condition of certification, domestic violence centers are required to provide community education and professional training services. However, these service activities

²² Reports to DCF bycenter.

²³ DV monthly reports

²⁴ Monthly service reports.

can become secondary to the daily demands of servicing residential clients, especially when a center's staffing is suboptimal.

Community Education and Professional Development: Issues and Recommendations

- **Uncoordinated approach to community education.** Both the *North Center* and *The Lodge* provide these activities in adjoining primary geographical service areas.

Recommendation. Given the proximity of these centers, a coordinated plan of community education could be developed.

- **Redundancy of information.** Education about domestic violence is now provided by a variety of other professionals and specialists in the community. As a result, training sessions from the centers are often seen as less essential or beneficial. For example, law enforcement personnel were once a primary audience for community education sessions on domestic violence. However, content on domestic violence is included in the curriculum for officers in training at the academy, and larger municipalities have domestic violence advocates who provide ongoing training in-house.

Recommendation. Community education and professional development presentations could focus primarily on the range of services provided to victims by the domestic violence centers and identify and describe needed linkages between the centers and other community providers and professionals.

SECTION 2

DOMESTIC VIOLENCE SERVICE OUTCOMES: What are the results for clients?

The outcomes of emergency shelter services were evaluated in four areas²⁵: (1) perceptions of safety, (2) counseling, (3) information and referral, and (4) helpfulness of services. Data were collected in pre and post surveys of adults in the shelters.²⁶ Findings presented in the discussion following indicate that for most clients, positive outcomes resulted from emergency shelter services.

Service Outcomes: Perceptions of Safety²⁷

A safe and secure environment provides victims of domestic violence with the respite needed to process their experiences and begin to make decisions about the immediate future for themselves and their children. Safety from the abuser is the most important and immediate outcome that domestic violence centers want to achieve for their clients (Tutty, 1999). Discussions of safety begin when the initial contact is made with a victim in crisis. **Once victims enter a domestic violence center in Miami-Dade County, they have a sense of safety that increases over their stay.**

At intake, 73% of the victims felt “very safe” from being physically harmed or contacted (77%) by the abuser (Table 7). At the end of their stay, 86% felt “very safe” from being physically harmed, and 83% felt “very safe” from being contacted. This change in the client’s perception of safety was large enough to be statistically significant and unlikely to

²⁵ These areas of basic residential services were identified by staff in the centers and in the literature.

²⁶ Further information about the outcome measures and procedures are in footnotes for each outcome section and in Appendix A.

²⁷ An initial intake survey asked residential clients (not in crisis) to assess the extent to which they felt safe from the abuser; the same questions were asked on an exit survey.

occur by chance. **These results indicate the effectiveness of engaging the victim in safety planning, beginning at intake and continuing until the she leaves the center.**

Table 7. Client’s perception of safety at the shelters			
Questions	Response Categories	(n= 218)	
		At Intake %	At Exit %
How safe do you feel here from physical harm by your abuser? Would you say you feel	Not at all safe	4.4	5.0
	A little safe	12.8	6.0
	Very safe	72.7	85.8
	Don't know	10.1	3.2
How safe do you feel here from being contacted by your abuser? Would you say you feel	Not at all safe	4.4	4.4
	A little safe	8.4	7.8
	Very safe	77.4	82.5
	Don't know	9.7	5.3

(χ^2 : 15.87, df: 3, $p < 0.01$)

In each of the individual centers, clients felt safer from their abuser at the end of their stay compared to their arrival and intake at the center (Table 8). At the *North Center*, 77% felt “very safe” at intake “from being contacted by the abuser,” but fewer (67%) felt “very safe” from physical harm. At the end of their stay however, 85% felt “very safe” both from physical harm and from being contacted. **The change in the client’s perception of safety at the *North Center* was large enough to be statistically significant and unlikely to occur by chance.**

Clients at the *South Center* felt “very safe” from physical harm (82%) and of being contacted by the abuser (82%) once in the shelter. Feelings of safety increased overtime. When leaving the shelter, 91% felt “very safe” both from physical harm and of being contacted by the abuser.

Questions	Response Categories	North Center (n= 136)		South Center(n= 23)		The Lodge (n= 59)	
		At Intake%	At Exit%	At Intake%	At Exit%	At Intake%	At Exit%
How safe do you feel here from physical harm by your abuser? Would you say you feel	Not at all safe	5.0	5.1	0	0	4.7	6.8
	A little safe	15.6*	6.6*	13.6	8.7	6.3	3.4
	Very safe	67.4*	84.6*	81.8	91.3	81.3	86.4
	Don't know	12.1*	3.7*	4.5	0	7.8	3.4
How safe do you feel here from being contacted by your abuser? Would you say you feel	Not at all safe	3.5	3.7	4.5	0	6.3	8.6
	A little safe	8.5	8.8	9.1	4.3	7.9	6.9
	Very safe	76.6	81.6	81.8	91.3	77.8	81.0
	Don't know	11.3	5.9	4.5	4.3	7.9	3.4

(χ^2 : 13.81, df: 3, $p < 0.05$)

At *The Lodge*, clients felt “very safe” at intake both from physical harm from the abuser (81%) or being contacted (78%). Perceptions of safety increased by the exit survey when 86% believed themselves to be “very safe” from physical harm and 81% felt “very safe” from being contacted by the abuser.

Service Outcomes: Counseling²⁸

Despite their circumstances, clients entering the centers were able to identify areas of personal strength prior to counseling. With one exception, scores on the pre-counseling assessment were above 3.0 (of possible 4.0) in all areas. The pre and post counseling assessments were analyzed comparing the direction of change between pre and post measures and by comparing mean scores. **In all three domestic violence centers, clients who received counseling scored higher on the post assessment than on the pre assessment.**

²⁸ Counseling services were assessed using a pre and post questionnaire completed by clients who were in residence for at least 7 days and who would participate in individual or group counseling; the post was completed at the end of counseling services or upon the client's exit from the center. Scores range from 1 to 4, with higher scores indicating improvements in the construct assessed.

Collectively, clients made the greatest improvements after counseling in the areas of “control over one’s life,” “problem solving,” and “ability to obtain services” (Table 9).

Table 9. All Centers: Counseling Survey Changes Pre- Post			
Area Assessed	Improved %	No change %	Declined %
Social Support*	43.4	37.2	19.4
Problem Solving*	50.4	26.9	22.7
Control over One’s Life*	58.0	19.3	22.7
Blame for Abuse*	48.4	29.4	22.2
Willingness to Discuss Abuse*	40.8	39.2	20.0
Ability to Obtain Services*	50.4	32.2	17.4
Ability to Express Needs*	32.8	52.0	15.2

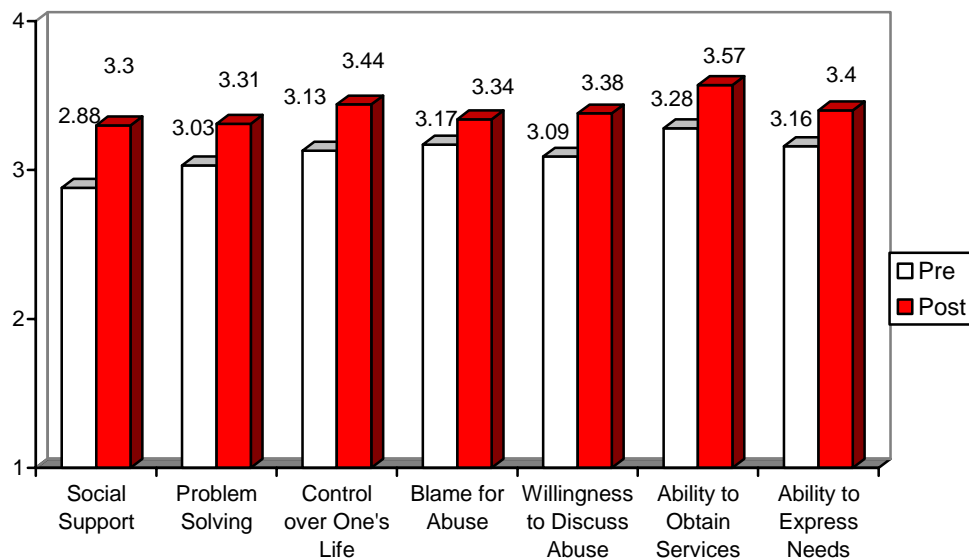
*(statistically significant, p< 0.01)

At the *North Center*, the areas in which shelter clients had the highest improvements between pre and post assessment scores were “control over one’s life” (63%), “ability to obtain services” (57%), and “problem solving” (56%) (Table 10). Most clients did not change their appraisal of their “ability to express needs” (51%), although 35% improved in this area.

Table 10. North Center: Counseling Survey Changes Pre- Post			
Area Assessed	Improved %	No change %	Declined %
Social Support	47.4	38.2	14.5
Problem Solving	55.6	25	19.4
Control over One’s Life	63.4	18.3	18.3
Blame for Abuse	46.7	34.7	81.3
Willingness to Discuss Abuse	47.9	31.5	20.5
Ability to Obtain Services	57.1	27.1	15.7
Ability to Express Needs	35.1	51.4	13.5

A comparison of the mean scores on the counseling pre and post assessment provided another perspective. At the start of counseling services for residents at the *North Center*, mean baseline scores show that clients assessed their most problematic area as insufficient social supports, but were most confident in their ability to obtain services (Graph 7). **On the assessments following counseling services, scores improved in all areas for clients at the *North Center* and these changes in pre and post counseling scores were large enough to be statistically significant in all of the areas assessed.** The greatest gains were made relative to “control over one’s life,” “ability to obtain services,” and “problem solving,” suggesting that at this center counseling was most effective and empowering to clients in these areas.

Graph 7: North Center: Counseling self-assessment pre-post mean scores



In general, clients at the *South Center* had slightly higher scores in all areas on the post assessment.²⁹ However, these changes were not great enough to reach a level of statistical significance (Table 11). Although more than half of the clients’ scores improved relative to “blame for the abuse” (56%), 53% had “no change” in “willingness to discuss

²⁹ Given the small number of cases at the South Center, mean scores and SD are not reported in these data.

abuse” or “ability to express needs” (50%). Furthermore, in the realm of social support, equal proportions of clients had scores that improved and declined.

Area Assessed	Improved %	No change %	Declined %
Social Support	26.3	47.4	26.3
Problem Solving	44.4	22.2	33.3
Control over One’s Life	37.5	31.3	31.3
Blame for Abuse	55.6	27.8	16.7
Willingness to Discuss Abuse	36.8	52.6	10.5
Ability to Obtain Services	36.8	42.1	21.1
Ability to Express Needs	33.3	50	16.7

At the end of counseling services, residential clients at *The Lodge* showed the most improvement in “control over one’s life” (56%) (Table 12). These clients also made sizeable improvements in altering perceptions about “blame for abuse” (46%), “ability to obtain services (44%), “social support” (44%), and “problem solving” (41%). However, even after counseling sessions, the “willingness to discuss the abuse” remained relatively unchanged for many victims (29% improved; 29% declined; 42% no change).

Area Assessed	Improved %	No change %	Declined %
Social Support	44.1	29.4	26.5
Problem Solving	41.4	34.5	24.1
Control over One’s Life	56.3	15.6	28.1
Blame for Abuse	45.7	25.7	28.6
Willingness to Discuss Abuse	29	41.9	29
Ability to Obtain Services	43.8	37.5	18.8
Ability to Express Needs	27.3	54.5	18.2

Similar to the *North Center*, mean scores on the counseling pre assessment at *The Lodge* were above 3.0 (of possible 4.0) in all areas (Table 13). These clients were most confident in the ability to express their needs “without fear of being abused,” and less confident of having helpful social support.

Table 13. The Lodge: Counseling Survey Pre-Post Mean Scores

Area Assessed	n	Possible Score Range	Baseline		Follow-up		P
			Mean Score	S.D.	Mean Score	S.D.	
Social Support	34	1-4	3.01	0.77	3.19	0.77	N.S.
Problem Solving	29	1-4	3.20	0.63	3.35	0.41	N.S.
Control over One’s Life	32	1-4	3.25	0.52	3.38	0.49	N.S.
Blame for Abuse	35	1-4	3.23	0.53	3.29	0.64	N.S.
Willingness to Discuss Abuse	31	1-4	3.30	0.70	3.37	0.60	N.S.
Ability to Obtain Services	32	1-4	3.40	0.53	3.43	0.57	N.S.
Ability to Express Needs	33	1-4	3.53	0.51	3.56	0.63	N.S.

N.S.= Not Statistically Significant

As shown by somewhat higher scores in all areas on the post assessment, counseling services resulted in positive changes in all areas for clients at *The Lodge*. However, these changes were not great enough to reach a level of statistical significance.

Service Outcomes: Information and Referral³⁰

A typical domestic violence victim comes to a shelter with limited information about their choices or rights. This information gap is substantially reduced over the course of a client’s stay at any of the three certified centers in Miami-Dade County. At intake, more than half of all clients had “none” or “a little” information about their choices (52%), or their rights as victims (59%). When they exited a shelter, 72% had “a lot of information” about

³⁰ These data were collected on the client’s exit survey from a center. Residential clients were asked to report their needs for information or referrals in 11 areas before coming to the center, and to report if they had received the information or referral needed while at the center.

their choices, and 78% about their rights (Table 14). **In each of the centers, change in client’s knowledge in these two areas was large enough to reach statistical significance.³¹ This finding suggests that all of the centers are effective in educating victims about their voices and rights.**

Questions	Response Categories	(n= 234)	
		At Intake %	At Exit %
How much information do you have about the choices available to you as a victim of domestic violence?*	None/Nothing	16.7	3.0
	A little information	35.5	19.7
	A lot of Information	45.7	72.2
	Don’t Know	2.1	5.1
How much information do you have about your rights as a victim of domestic violence?***	None/Nothing	17.8	3.0
	A little information	41.3	14.6
	A lot of Information	37.0	78.5
	Don’t Know	3.9	3.9

(* χ^2 : 49.68, df: 3, $p < 0.01$; *** χ^2 : 88.74, df: 3, $p < 0.01$)

At the *North Center*, more than a half of clients at intake indicated they had “none” or “a little information” about their choices and rights (Table 15). However, at the end of their stay, more than two-thirds of the clients believed they had “a lot of information” in these areas (66% and 72% respectively).

Clients at the *South Center* claimed the most knowledge about their choices and rights on the intake measure. More than a half of the 24 respondents indicated they had “a lot of information” about their choices and rights. However at the end of their stay 88% reported having “a lot of information” about their choices and 92% had “a lot of information” about their rights (Table 15).

³¹ North Center: $p < 0.01$; South Center: $p < 0.05$; The Lodge: $p < 0.01$.

Table 15. Client’s knowledge of choices and rights, by Center

Questions	Response Categories	North Center (n= 136) α		South Center(n= 23) β		The Lodge (n= 59) δ	
		At Intake %	At Exit %	At Intake %	At Exit %	At Intake %	At Exit %
How much information do you have about the choices available to you as a victim of domestic violence?*	None/Nothing	12.5	2.8	12.5	8.0	27.3	1.5
	A little information	39.6	23.8	33.3	4.0	27.3	16.7
	A lot of Information	45.8	66.4	54.2	88.0	42.4	78.8
	Don’t Know	2.1	7.0	0	0	3.0	3.0
How much information do you have about your rights as a victim of domestic violence?***	Not at all safe	14.1	4.2	8.3	4.0	29.7	0
	A little safe	45.1	18.3	41.7	4.0	32.8	10.6
	Very safe	35.9	72.5	50.0	92.0	34.4	86.4
	Don't know	4.9	4.9	0	0	3.1	3.0

(* α^2 : 23.71, df: 3, p< 0.01; * * α^2 : 41.14, df: 3, p< 0.01)

(* β^2 : 7.94, df: 3, p< 0.05; * * β^2 : 11.13, df: 3, p< 0.05)

(* δ^2 : 24.10, df: 3, p< 0.01; * * δ^2 : 41.48, df: 3, p< 0.01)

Clients at *The Lodge* reported the greatest increases of information about their choices and rights over the course of their stay at the shelter (Table 15). Clients entering *The Lodge* claimed “none” or “a little information” about their choices (55%) and rights (62%). By the end of their stay, clients had “a lot of information” in both of these areas (choices, 79% and rights, 86%).

To assess the effectiveness of information and referral services in general, clients were asked on the exit survey to consider the extent to which the information and referrals they received at the shelter were appropriate for their needs. While responses varied somewhat between the centers, **most clients reported that they received information and referrals to address their needs. The most common areas of need were for housing, relocation assistance, counseling for self, and transportation.**

At the *North Center*, more than half of the clients indicated that before coming to the shelter they needed information or referrals for housing (82%), relocation assistance (79%), counseling, and transportation (62%) (Table 16). More than a third needed information and referrals about other services including employment and training (47%), education programs for self (36%), and counseling for their children (36%). Clients received information in all of these areas while at the shelter, however most information and referrals involved relocation assistance (79%), counseling for self (79%), and housing (75%).

Table 16. Comparison of information and referrals needed and received by clients before and after shelter services

Questions	North Center (n= 144)		South Center (n= 22)		The Center (n= 66)	
	Before coming to the shelter	While at the shelter	Before coming to the shelter	While at the shelter	Before coming to the shelter	While at the shelter
Before coming to the shelter, I needed information and/or referrals about...						
While at the shelter, I received information and/or referrals about...	Yes %	Yes %	Yes %	Yes %	Yes %	Yes %
Housing.	82.1	75.4	87.0	90.9	91.0	87.9
Health care services for myself	43.3	67.5	65.2	72.7	65.2	73.0
Health care services for my children	31.8	49.1	59.1	55.0	47.5	62.5
Childcare services	42.1	53.9	52.4	68.2	47.4	60.7
Educational programs/schools for myself	36.5	41.1	45.5	57.1	57.1	60.0
Educational programs/schools for my children	26.4	33.0	61.9	60.0	44.1	50.0
Employment or employment training	46.7	44.5	65.2	70.0	59.0	59.0
Relocation assistance	79.3	78.9	63.6	80.0	78.1	75.4
Transportation services	62.1	65.9	72.7	75.0	62.5	71.9
Counseling services for myself	76.6	79.1	78.3	90.5	86.6	86.6
Counseling services for my children	36.2	46.0	56.5	68.4	45.8	59.3

Before coming to the shelter, clients at *The Lodge* needed information and referrals primarily for housing (91%), counseling for themselves (87%), and relocation assistance (78%). Furthermore, more than half also had a need for health care (65%), transportation (63%), employment training (59%), and educational programs (57%). Clients received the information or referrals they needed while at the shelter with the exception of housing and relocation assistance. This finding undoubtedly reflects the dearth of community resources for affordable housing.

Clients (proportionally) at the *South Center*³² reported the greatest level of need for information and referrals. In all areas addressed, more than a half of the 22 respondents indicated a need for the service before coming to the center. At the end of their stay, clients had indeed received most of the information or referrals desired. For example, the center provided housing and counseling information and referrals to 20 clients, and 16 or more clients were assisted in the areas of transportation, health care, and employment training.

Helpfulness of Services: Client Opinions³³

Feedback from residential clients provided another perspective about the effectiveness of services at the domestic violence centers. Client satisfaction was assessed in three areas: (1) overall helpfulness of services, (2) helpfulness of counseling, and (3) matters related to children. **In each of the areas examined, clients were satisfied with the services received and believed them to be helpful.**

Overall Helpfulness of Services

At the end of their stay, shelter residents were asked to assess the extent to which the services they received had been helpful. **For 11 of the 12 types of services considered, a**

³² Given the small number of respondents at the South Center (n=22), percentage distributions are not meaningful and therefore not reported with respect to this measure

³³ These data were collected on a client exit survey. Residential clients were asked to assess to which the services they had received had been helpful for them and their children.

majority of clients believed the services had been helpful (Table 17: “very much” or “a little”).³⁴

Service Area	North Center (n= 143)			The Lodge (n= 67)		
	Not at all %	A little or Very Much %	Don’t Know or not relevant %	Not at all %	A little or Very Much %	Don’t Know or not relevant %
Meeting the goals included in your safety plan?	3.5	91.0	5.6	1.5	95.6	3.0
The legal system?	14.0	65.1	21.0	15.6	71.9	12.5
Housing?	18.9	70.6	10.5	10.8	86.1	3.1
Employment?	22.7	53.9	23.4	18.8	61.0	20.3
Education?	27.3	42.7	30.1	14.5	59.6	25.8
Childcare?	19.1	51.0	29.8	13.8	58.6	27.6
Medical Needs?	18.9	53.9	27.3	7.9	71.4	20.6
Material goods like food, clothing or supplies?	9.9	84.5	5.6	1.5	95.4	3.0
Financial assistance?	19.4	63.2	17.4	13.6	72.8	13.6
Counseling for you?	11.2	78.3	10.5	1.5	92.3	6.2
Counseling for your children?	21.6	43.9	34.5	15.8	61.4	22.8
Substance abuse referrals?	21.9	29.9	48.2	15.9	44.4	39.7
Other? (n= 2)		2			4**	

*(I felt safe, shoes and love); **(Transportation, safetimes, therapy, that I am valuable)

The services rated “very much” helpful by clients in all three centers were: (1) help in meeting safety plan goals; (2) provision of material goods, and (3) counseling for the victim. At *The Lodge*, 55% of the clients reported being helped “very much” in 8 of the 12 categories of services. Clients at the *North Center* reported being helped “very much” in 4 of the 12 categories.³⁵

³⁴ Data from the South Center is not included, given the small number of clients reporting.

³⁵ Given the small number of respondents at the South Center (n=22), percentage distributions are not meaningful and therefore not reported with respect to this measure.

The services rated most helpful were the same areas of need that clients said they had before coming to a center: safety planning and learning about issues that contribute to domestic violence (Table 18). Eighty-two percent of the clients entering the *North Center* needed safety planning help and 90% of those leaving the shelter believed they had learned how to create a safety plan. A similar proportion of clients (81%) wanted to learn about domestic violence issues, and 90% were satisfied that they had acquired this learning during their stay at the *North Center*.

Table 18. Comparison of what client’s wanted to learn and learning received at the shelters

Questions	North Center (n=135)	South Center (n= 22)	The Lodge (n= 66)
Before coming to the shelter	Yes %	Yes %	Yes %
I wanted to learn/learned about the issues that contribute to domestic violence in my life	81.4	85.7	80.3
I needed help creating a safety plan	82.1	85.7	83.3
While at the shelter			
I learned about the issues that contribute to domestic violence in my life	89.6	100	92.3
I learned how to create a safety plan	87.3	100	86.6

Before coming to the *South Center*, 19 of the 22 clients said they needed help in the same two areas mentioned above for clients at the *North Center*. All of the clients (22) were satisfied that they received the help needed.

Similarly at *The Lodge*, 83% of the clients expressed the need for safety planning when they arrived at the center and 80% wanted help in learning about domestic violence issues in their lives. At the end of their stay, most clients believed they had received this information (87% and 92% respectively).

A relatively small number of clients considered the services received “not at all” helpful particularly in the areas of employment and education. This response is consistent with the feedback from clients about information and referral needs previously discussed. For these and other longer term services for victims, the centers are largely dependent upon

the successful linkage of clients with community resources both during and after they leave the shelter. Furthermore, clients must have pre-requisite knowledge and skills required by employers or education programs.

Table 19. Client’s assessment of counseling services, by Center

Issue Assessed	North Center (n= 74)			South Center (n= 19)			The Lodge (n= 39)		
	Disagree %	Agree %	Strongly Agree %	Disagree %	Agree %	Strongly Agree %	Disagree %	Agree %	Strongly Agree %
Advocates/social workers helped me develop the skills I needed to be able to meet my goals	4.1	53.4	42.5	0	39.1	60.9	0	28.2	71.8
Counseling has given me new ways of looking at abuse	2.8	54.2	43.1	0	52.2	47.8	7.7	33.3	59.0
I have a better understanding about the effects that abuse has had on my life	1.4	53.4	45.2	4.3	47.8	47.8	5.3	34.2	60.5
I believe that I have made progress towards accomplishing my goals	5.6	50.0	44.4	4.3	52.2	43.5	2.6*	30.8	64.1
Advocate/social workers listened respectfully and took me seriously	2.7	41.1	56.2	0	13.0	87.0	0	15.4	84.6
Advocates/social workers understood the impact the abuse had on me	2.7	45.2	52.1	0	8.7	91.3	2.6	20.5	76.9
Advocates/social workers let me know I am not alone	0	45.2	54.8	0	0	100	0	26.3	73.7
Advocates/social workers helped me develop a safety plan	1.4	37.0	61.6	0	17.4	82.6	2.6	23.1	74.4

“Strongly Disagree” was not selected by the respondents; *(2.6% of the respondents selected also “strongly disagree.”)

Helpfulness of Counseling

Clients in all three centers for domestic violence found that counseling services had been helpful (Table 19). The combined responses of “strongly agree” and “agree” exceeded 95% for all aspects of counseling assessed. A majority of clients across all centers “strongly agreed” that the advocates/social workers had listened to them respectfully and taken their situation seriously. This opinion was most strongly held among clients at *The Lodge* (85%) and the *South Center* (87%).

Clients did have some differences of opinion between centers about the areas of counseling they found most helpful. For example, in the *North Center* areas of counseling with the highest “strongly agree” responses from clients related to assistance received in developing a safety plan (Table 19). At the *South Center*, the highest “strongly agree” responses related to counseling that helped the victim know she was “not alone” in her situation (Table 19). Clients at *The Lodge* (Table 19) and the *South Center* reported a high level of satisfaction (“strongly agree” responses) with the extent to which they were listened to, treated respectfully, and taken seriously during counseling.

Matters Related to Children. Parents gave positive feedback about the counseling and information services their children received in residential services (Table 20). **Furthermore, there was a high level of agreement³⁶ that the staff helped parents to more fully understand the impact of domestic violence on their children** (*North Center*, 64%; *South Center*, 82%; *The Lodge*, 65%).

Parents were somewhat unsure³⁷ however, about the extent to which services at the center had helped their children “acknowledge that violence is an issue in our family,” or “know the violence is not their fault.” It should be noted that many children receiving residential services are under the age of six and may be unable to verbally communicate their understanding of this rather complex issue.

³⁶ “Strongly Agree” and “Agree” responses combined.

³⁷ “Don’t know or not relevant” responses

Table 20. Parent's assessment of children's services by center

North Center (n= 140)	Strongly Disagree and Disagree %	Strongly Agree and Agree %	Don't know or not relevant %
My case manager/advocate has helped me understand what my children are going through as a result of the abuse that I have experienced	10.7	64.3	25.0
My children have plans for staying safe if violence occurs again	13.7	54.0	32.4
The children's Case Manager/Advocate(s) explained to the children that the abuse is not their fault	11.6	45.9	42.3
My children can acknowledge that violence is an issue in our family	12.5	41.2	46.3
My children know the violence is not their fault	9.4	47.8	42.8
South Center (n= 22)			
My case manager/advocate has helped me understand what my children are going through as a result of the abuse that I have experienced	4.5	81.8	13.6
My children have plans for staying safe if violence occurs again	0	68.2	31.8
The children's Case Manager/Advocate(s) explained to the children that the abuse is not their fault	0	63.7	36.4
My children can acknowledge that violence is an issue in our family	9.5	52.4	38.1
My children know the violence is not their fault	4.8	61.9	33.3
The Lodge (n= 63)			
My case manager/advocate has helped me understand what my children are going through as a result of the abuse that I have experienced	6.4	65.0	28.6
My children have plans for staying safe if violence occurs again	8.2	55.8	36.1
The children's Case Manager/Advocate(s) explained to the children that the abuse is not their fault	5.1	57.6	37.3
My children can acknowledge that violence is an issue in our family	10.4	46.5	43.1
My children know the violence is not their fault	8.5	50.8	40.7

SUMMARY OF SERVICE OUTCOMES

Positive outcomes accrued for victims of domestic violence who received emergency shelter services in Miami-Dade County. The centers provided a sense of safety, helpful counseling, and useful information and referrals. Housing and relocation assistance were noted as the greatest challenges for meeting the needs of victims, again reinforcing the need for longer term affordable housing and transitional housing resources in Miami-Dade County.

SECTION 3 SERVICE DELIVERY MODALITIES

In most communities, domestic violence centers are operated by community based nonprofit organizations. Miami-Dade County is unique considering that domestic violence centers are operated under the auspices of both government and a non-profit community based organization. An objective of the process evaluation was to identify differences, if any, between the two operational models. This discussion looks at how services are staffed and identifies dimensions which differ between the public and private centers.

STAFFING PATTERNS AND ISSUES

Domestic violence centers in Miami-Dade County have similar staffing patterns. However, there are differences between the approaches to staffing in the public-government operated centers (the *North and South Centers*) and *The Lodge*, operated by a private-nonprofit organization; there are also differences in the processes and issues involved in staff recruitment and retention.

Staffing: Center Level Profiles

The *North Center* and the *South Center* are staffed by personnel who are employed by Miami-Dade County and subject to the county's personnel and operational policies. Twenty-one full-time positions (or FTEs) are allocated to the *North Center*³⁸ and 10 to the *South Center*. Duties for providing direct services are assigned to three categories of county positions: Social Service Supervisor 1, Social Worker 1, and Social Worker Aide. The Social Service Supervisors are responsible for managing the center's daily operations and oversight of staff activity. Social Workers are primarily responsible for case management and counseling, however they often perform a range of other activities in the center. Social Worker Aides in the *North and South Centers* provide services during evenings and weekends and assist other staff as needed.

³⁸ Non-residential services are not provided by these staff.

The Lodge has 15 full-time and 4 part-time staff positions allocated for direct services. In contrast to county titles, staff position titles at *The Lodge* incorporate an expectation of “action” to benefit clients. An Advocacy Supervisor³⁹ provides oversight of staff and manages the center’s daily operations. Residential Advocates are responsible for a similar range of services assigned to social workers in the *North* and *South Centers*. In addition, *The Lodge* has staff positions specifically designated for outreach services, children’s services, elderly services,⁴⁰ and a volunteer coordinator. Functions associated with these services are delegated among the various staff in the *North and South Centers*.

Staff Recruitment and Selection

Recruiting interested and qualified staff is a challenge for the domestic violence centers. Oftentimes, potential employees are put off by the idea of working in residential settings, have no interest or experience applicable to domestic violence services, and are unable or unwilling to work evening or weekend shifts. However, given the perceived benefits and “permanency” of becoming a county employee, *The Lodge* may be at a relative disadvantage vis-a-vie the *North and South Centers* in attracting staff.

Personnel policies of Miami-Dade County guide the process for filling staff positions at the *North and South Centers*. The process is protracted and involves several levels of approval. A vacancy is rarely filled in less than 90 days and may indeed take longer if candidates are not current county employees or the required screenings and reference checks are delayed. When a vacancy occurs at either of these centers, the following steps take place:

1. A job description is developed by the county personnel department.
2. The job opening is advertised first within the county’s ranks and often, but not always, to the general public.
3. Applications are submitted to county personnel and screened to assure that basic qualifications are met.
4. A ranked list of qualified applicants is sent to the Violence Intervention and Prevention Services Division Office; Existing county employees and veterans are given preferred status.
5. The list of candidates to be interviewed is forwarded to the center’s site administrator; candidates are interviewed and a candidate is selected.

³⁹ Referred to as the Social Service Supervisor 2 in the North and South Centers.

⁴⁰ A grant funds this position.

6. The site administrator submits a written rationale for selecting the candidate and submits this to county personnel.
7. The candidate is contacted by county personnel and asked to complete a background check, drug test, and physical examination; references are checked.
8. When this process is completed, the candidate is notified of his/her selection by the Division Director and usually begins work two to four weeks later.

The process for filling vacancies at *The Lodge* involves fewer steps and is usually completed in less than 90 days.

1. The Advocacy Supervisor in collaboration with the designated human resources officer at the center reviews the job description and advertises for the position in the organization and in various community venues such as employment websites, local university placement offices, career fairs, and newspapers.
2. Applications are reviewed for sufficiency by the human resources officer and forwarded to the Advocacy Supervisor or designee.
3. Candidates are interviewed one or more times, references are checked, and a selection is made.
4. The candidate is notified of his/her pending selection and undergoes the requisite drug and health screenings and background check.
5. When this process is completed, the candidate is notified of his/her final selection and usually begins work two to four weeks later.

Staffing Issues

Prolonged staff vacancies. For several reasons during the past three years, each of the centers has operated without a full complement of staff for extended periods of time ranging from 45 days to more than a year. Protracted staff vacancies have occurred most often in the *North and South Centers* due mostly to the lengthy County procedures for filling vacancies. Furthermore, Site Administrators who are most affected by insufficient staff, have little formal recourse or authority to advocate for their positions with the county personnel office. Staff vacancies at *The Lodge* have been for shorter periods of time, but have been more frequent. Vacancies at *The Lodge* have most commonly been due to a lack of qualified applicants for the position.

Vacancies are costly. Overtime is paid to existing staff and when personnel from a temporary agency are assigned, these costs often exceed the position salary.

Staff Retention/Turnover. Staff retention was greater at the *North and South Centers* than at *The Lodge*. For example, during the three year evaluation period *The Lodge* had four different Advocacy Supervisors and experienced a turnover in all of the advocate staff positions. Staff turnover at the *North and South Centers* during the same period of time involved two positions. Several factors seem to contribute to these differences in staff retention.

To be employed by the County is typically perceived as having a greater degree of permanency, better benefits and pay, and opportunities for multiple job positions compared to non-profit community based organizations. This perception serves to discourage employee turnover in the centers staffed by Miami-Dade County. Once employed by the County, most employees remain in positions until they are assigned or transferred elsewhere or successfully apply for another position in the County.

Staff turnover at *The Lodge* was fueled by the dynamics commonly faced by new organizations and service delivery systems. These included (a) ideological differences regarding operational and management policies; (b) conflicts over leadership approaches and styles; (c) frequent changes in policy, procedures, and staffing assignments to accommodate developing program demands and to meet requirements for certification; and (d) ineffective patterns of communication between management and other staff often resulting in misinformation and rumors detrimental to staff morale.

In some instances, employees have left *The Lodge* for jobs offering higher salaries and benefits. The center's ability to be competitive in the marketplace will continue to be a challenge, given available resources.

Involuntary transfers. In the *North and South Centers*, staff is subject to involuntary transfers. Involuntary transfers, referred to as "bumping" in the county system, occurs when an employee from another county department is reassigned to the domestic violence center to fill a vacancy or to replace an existing employee with less seniority. This typically happens

when downsizing has occurred in another department or a freeze on new hires in the County has been imposed. While staff that comes to the center through this process may have some experience in human services, they begin with little or no familiarity or interest in domestic violence or residential services, and are often displeased about the transfer.

Recommendation. *The DVOB, in its role as advisor to the County Commission, should request that all options be considered that will result in protecting staff at the North and South Centers from involuntary transfers as well as hiring freezes that prevent the centers from filling critical existing positions.*

SECTION 4

GOVERNMENT AND COMMUNITY BASED DOMESTIC VIOLENCE CENTERS: ARE THERE DIFFERENCES?

Over the three year evaluation period, we noted the differences in the organizational structure and dynamics between the county and community based centers. The differences

Table 21. Comparison of County and CBO capacity to operate domestic violence centers.

Organization Attribute	Greater Capacity	Few Differences	Less Capacity
Ability to attract and retain staff.	County		CBO
Ability to respond to changing service and staffing needs.	CBO		County
Ability to attend to infrastructure needs of the center.	CBO		County
Ability to engage in formal cooperative arrangements with other organizations.	CBO		County
Ability to access supplemental funding resources.		X	
Clarity of decision making/accountability structure.	CBO		County
Activism and ability to advocate for policy and program changes.		X	County

that emerged were categorized into attributes which are consistent with characteristics of effective domestic violence (and other human services) organizations most frequently mentioned in the literature. The six attributes assessed are summarized in Table 21.

Community based centers have a greater capacity than county centers to adapt to changing client and organization needs, engage in formalized collaborations, and have clear systems

of decision-making. County centers have a greater capacity to attract and retain staff. Few differences were observed between the types of centers relative to the ability to access supplemental funding resources and advocate on behalf of domestic violence victims.

Ability to attract and retain staff. Miami-Dade County has a greater capacity than community based organizations to attract and retain staff for the domestic violence centers. Job seekers are more likely to pursue employment in county government than in community based organizations. In many instances, County salaries are higher for social workers than salaries in community based organizations and include liberal fringe benefits including various retirement options that are generally unaffordable in non-profit organizations. Furthermore, job security increases with seniority and county employees can build a career path in government service; given this option, staff turnover at the *North and South Centers* rarely occurs because a person has resigned from the county, but typically occurs when a person transfers to another county job.

This system of employee transfers gives the county a staffing capability that is not available to the typical community based organizations. In the case of staff vacancies at the centers, the county has an existing pool of employees that can be transferred from other departments, temporarily or permanently to fill these vacancies.

Ability to respond to changing service and staffing needs. The community based organization is best able to respond in a timely fashion when changes in services or staffing are needed. Once a need for change has been identified and documented at the center level, the recommendation is approved by the director, and the agency's board for implementation. This process can be accomplished in a month or two, depending on the complexity of the issue. For example, *The Lodge* started a summer camp program to address the educational and recreational needs of children during school recess. The current staffing pattern is being revised in response to an observed need for additional administrative and management support at the center.

The process for accomplishing both of these tasks in the county centers would involve approvals from at least four levels of administrators in addition to the site administrator and typically take at least four to six months. Furthermore, changes in staffing roles, assignments, and so forth would also require review and approval from the county's personnel department.

Ability to attend to infrastructure needs of the center. The needs of the *North* and *South Centers* for equipment and repairs are often significantly hampered by the county's centralized purchasing procedures for goods and services. Furthermore, the needs of the domestic violence centers are often not a high priority in the larger county system, and the centers seem to lack a "champion." For example, after more than three years, promises to replace the outmoded DOS operating system computers at the *North* and *South Centers* have yet to be fulfilled; despite repeated requests, the basketball court at the *North Center* continues to be in disrepair and mostly unusable for clients. The *South Center* operated in temporary quarters and with fewer beds for more than two years after sustaining moderate damages from a hurricane.

In contrast, community based organizations have greater capacity to attend to infrastructure needs in a timely fashion. After securing appropriate bids, the community based organizations is able to purchase needed equipment and attend to routine repairs. Given the support of a cadre of volunteers, including board members, this center also benefits from donations of equipment and other maintenance and program services.

Ability to engage in formal cooperative arrangements with other organizations. The county's procedural requirements often stifle efforts to establish formal inter-agency agreements for services at the centers. In addition to the levels of administrative approvals needed to enter into a Memorandum of Understanding (MOU) with another organization, approval of the proposed agreement is also needed from the County Attorneys' Office. Community based organizations have greater capacity in this area, given that fewer levels of reviews and approvals are required.

Ability to access supplemental funding resources. The County and community based organizations have fairly equal ability to access supplemental funds for program services. Given its status as a nonprofit tax exempt organization, the community based center is eligible to apply for government and foundation grants and to seek funding from private donors. The county centers have similar access to outside funders through the staff and the Safe Space Foundation, a nonprofit organization established to support the centers and provide them entry to government and private grants opportunities. Indeed, the county centers have been the recipients of several state and federal grants.

Clarity of decision making/accountability structure. The community based organization has a greater capacity to establish and maintain a management and decision-making structure that facilitates the operations of a domestic violence center. The center is directly responsible to the community based organization's board of directors who make the final policy decisions affecting the center. Members include professionals in the domestic violence community.

In contrast, the *North* and *South Centers* are part of a large and complex bureaucratic structure involving multiple decision-making levels in the Department of Human Services and elsewhere but with little or no community input. Within the department, site administrators report to the Advocate for Victims Program Director, who reports to the Violence Intervention and Prevention Services Division Director, who reports to an Assistant Director of the Department, who reports to the Department Director. In addition, the county's budget office must approve staffing and other resource allocations for operating the centers; purchases of most equipment and supplies must be done through the county's procurement system and repairs involve the GSA office. Priority consideration is given to generic county policies and procedures and may conflict with those that may be most appropriate for victims of domestic violence. Policies that guide services and resources must be reviewed and approved primarily by individuals who are minimally informed about domestic violence issues or standards of service delivery.

Activism and ability to advocate for policy and program changes. Both county and community based centers have the capability of advocating for policies and services that benefit victims of domestic violence. However, county staff particularly those in higher levels of decision-making, are less likely than their counterparts in the community based organizations to incorporate activism in perceptions of their roles.

SECTION 5

CONCLUDING OBSERVATIONS AND COMMENTS

Throughout this evaluation report, several issues were raised related to the patterns of utilization and delivery of domestic violence services in specific areas. The three certified domestic violence centers in Miami-Dade County vary distinctly in administrative structure and capability. Furthermore, the extent to which the DVOB has any oversight over of the county run centers is unclear. This makes the DVOB's vision of "developing a system of services for victims of domestic violence that is guided by a set of service standards" especially challenging to achieve. Nevertheless, sustained efforts aimed at executing this vision would be worthwhile, especially considering new shelters are in the process of being built.

Toward that end, the common client outcome tools developed in consult with personnel from all three centers during this evaluation process should continue to be used. Furthermore, service documentation tools and cross-site collaboration protocols should be established along with an appropriate computerized system for data collection and analysis. The computer operating system being used by the county's *North* and *South Centers* is antiquated, inflexible, and marginally useful. The computer system at *The Lodge* has the capacity to generate useful service data, however *The Lodge* has yet to fully operationalize the capabilities of its system.

In spite of the challenges and opportunities for enhancing the domestic violence services system, the services provided by Miami-Dade's certified centers have resulted in positive outcomes for victims of domestic violence. Most importantly, victims in these centers experience a period of safety for themselves and their children.

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