Abstract
This quality improvement project employed a client-centered process to develop a modified Client Satisfaction Questionnaire (CSQ) 10 (Larsen, Attkisson, Hargreaves, & Nguyen, 1979) for relevance to our hospital-based violence intervention program (HVIP). Former clients (ages 11-12-18) and caregivers who participated in HVIP services self-administered the initial HVIP-adapted CSQ and shared their interpretation of questionnaire items, comfort in responding, missing topics, and preferences for implementation during cognitive interviews. This work met the criteria as a quality improvement activity by our local IRB and did not require IRB approval or determination. We have adhered to the SQUIRE guidelines in preparing this manuscript.
Title: Centering Client Voice in Hospital-based Violence Intervention Programs: Development of a Brief Quality Improvement Tool

Authors: Rachel K. Myers, PhD, MS,1,2,3 Hillary M. Kapa, MPH,1,2 Stephanie M. Garcia, MPH,1,4 Laura Vega, DSW, LCSW,1 Joel A. Fein, MD, MPH1,2,3

1 Center for Violence Prevention, Children’s Hospital of Philadelphia, Philadelphia, PA, United States
2 Center for Injury Research and Prevention, Children’s Hospital of Philadelphia, Philadelphia, PA, United States
3 Division of Emergency Medicine, Department of Pediatrics, Perelman School of Medicine, University of Pennsylvania, Philadelphia, PA, United States
4 PolicyLab, Children’s Hospital of Philadelphia, Philadelphia, PA, United States

Corresponding Author:
Rachel K. Myers, PhD, MS
Center for Violence Prevention
Children’s Hospital of Philadelphia
2716 South Street, 13th Floor
Philadelphia, PA 19146 USA
Tel: 215-590-3118
Fax: 215-590-0425
E-mail: myersr@chop.edu

Acknowledgements:
We gratefully acknowledge the VIP clients and caregivers who generously agreed to participate in this quality improvement project and share their experiences and expertise with our team. We recognize the assistance of Yansy Salmeron and Brittany Dorsonne who helped conduct interviews. We graciously acknowledge Jacqueline Kendrick, MSW, LCSW for her assistance with recruitment and outreach and Carolena Muno for her assistance in conducting literature reviews and preparing the manuscript for submission.

Funding Information: Dr. Fein, Dr. Myers, Ms. Garcia, and Dr. Vega received salary support from the Eunice Kennedy Shriver National Institute of Child Health and Human Development at the National Institutes of Health Award R01HD087406 (PI: Fein). However, the work described herein was conducted outside of those study activities. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health (NIH). The NIH had no role in the design and conduct of the project; collection, management, analysis, and interpretation of the data; preparation, review, or approval of the manuscript; or decision to submit the manuscript for publication.

Conflict of Interest Statement: None of the authors have real or perceived potential conflicts of interest to disclose.
Title: Centering Client Voice in Hospital-based Violence Intervention Programs: Development of a Brief Quality Improvement Tool

Abstract: Hospital-based violence intervention programs (HVIPs) are evidence-informed strategies to support recovery after community-based violence. However, few standardized tools exist to capture client perspectives of program relevance, responsiveness, and acceptability to inform ongoing program quality improvement. Our objective was to develop a tool to systematize collection of client and caregiver satisfaction with services and opportunities for improvement within our pediatric HVIP. We employed a client-centered process to develop this tool and data collection procedures. We modified the Client Satisfaction Questionnaire (CSQ) (Larsen, Attkisson, Hargreaves, & Nguyen, 1979) for HVIP relevance. Four former clients (ages 12-18) and five caregivers who participated in HVIP services self-administered the initial HVIP-adapted CSQ and shared their interpretation of questionnaire items, comfort in responding, missing topics, and preferences for implementation during cognitive interviews. They demonstrated understanding of CSQ items, offered alternate wording to improve clarity and redundancy, and expressed preference for completing the questionnaire electronically. Team members, including direct service providers and evaluators, refined a 12-item version of the HVIP CSQ using this feedback and their own subject matter expertise. Clients and their caregivers now routinely complete the HVIP CSQ at the completion of program services. By engaging program clients and staff in the development process, we are poised to collect client- and proxy caregiver-reported perspectives that are both valid and complete. This brief tool could be utilized by other HVIPs to ensure client voices inform quality improvement efforts. Further,
other community-based programs could replicate our client-centered systematic process to adapt this measure for their own client populations.

**Keywords:** Violence; Patient satisfaction; Crime Victims; Survivors; Program evaluation; Quality improvement; Outcome assessment
**Background**

Hospital-based violence intervention programs (HVIPs) continue to gain prominence as a trauma- and evidence-informed means to address the violence epidemic in the United States (Cheng et al., 2008; Purtle et al., 2013). HVIPs’ primary goals are to support psychosocial recovery among individuals who experienced violence-related injury and reduce adverse health and psychosocial outcomes, such as re-injury, post-traumatic stress symptoms, and criminal justice involvement (The Health Alliance for Violence Intervention, 2022). Thus far HVIP evaluations primarily have used administrative data and programmatic records to measure either longer term and rare outcomes (e.g., re-injury, death, incarceration) or internal process metrics (e.g., program outputs such as number of clients served, program retention, needs addressed) (Aboutanos et al., 2011; Bell et al., 2018; Myers, Vega, Culyba, & Fein, 2017). To date, there are limited efforts to systematically collect client feedback to understand their perspectives on the care provided and outcomes achieved.

Healthcare systems are increasingly soliciting routine feedback from patients regarding their clinical encounters. This attention is driven in part by the Patient Protection and Affordable Care Act, which defines patient-reported satisfaction as a key outcome metric for payment to healthcare systems. However, tools to assess satisfaction with healthcare experiences, such as the Hospital Consumer Assessment of Health Providers and Systems (HCAHPS) survey, suffer from several limitations particularly relevant to HVIPs (Tefera, Lehrman, & Conway, 2016). Surveys typically inquire about inpatient or outpatient medical experiences, not about services outside the hospital or physician’s office, and focus narrowly on perceptions of administrative practices and patient education (Gleeson et al., 2016). These measures may fail to adequately measure domains of healthcare experiences occurring in community-based care settings, such as HVIPs, or other factors influencing satisfaction such as cultural competency and need resolution.
Prior efforts to evaluate satisfaction with victim service programs have focused on specific types of victimization (e.g., intimate partner or sexual violence) or singular aspects of services (e.g., satisfaction with the criminal justice or victim compensation processes) (Henninger, Iwasaki, Carlucci, & Lating, 2020; Kunst, Popelier, & Varekamp, 2015). Such efforts incompletely reflect the diverse, cross-sector nature of the services provided by HVIPs, including healthcare, mental health, legal/criminal justice, employment, education, and basic needs, and their more explicit focus on psychosocial recovery and well-being. Creating opportunities for clients to share their experiences supports client empowerment, ensures that their perspectives and preferences are centered in service delivery and improvement efforts, and is vital to creating more equitable systems of care (Block et al., 2020). Further, efforts to assess client satisfaction are particularly critical to support the trauma-informed nature of HVIP services (Substance Abuse and Mental Health Services Administration, 2014). Collecting client feedback will also advance understanding of the impact of HVIPs on individual-level outcomes, which extend beyond those commonly assessed through unobtrusive data sources (e.g., medical record reviews, vital statistic records).

**Purpose**

Satisfaction measures for more diverse care settings are urgently needed to amplify client voice in identifying opportunities for service improvement. Our HVIP provides clients opportunity to voice needs throughout participation (i.e., program enrollment and participation are voluntary, clients self-identify goals during HVIP participation); however, we recognized clients did not have opportunities to provide feedback on their experiences after participation ended to enhance the delivery of care for future clients. We are aware of no specific instruments tailored to the HVIP setting for clients and participating family members to share their program experiences and suggestions for improvement. Thus, the objective of this quality improvement
project was to develop a tool to routinize collection of client satisfaction and feedback from both
clients and caregivers participating in a HVIP serving injured children and adolescents ages 8-18
years and their families. This tool addresses a critical need to enhance our pediatric HVIP’s
responsiveness in supporting recovery for violently injured young people and their families.

Methods

Housed at a large [redacted] of the United
States, our pediatric HVIP provides voluntary case management services to young people ages 8-
18 who are treated in the emergency department or trauma unit for injuries related to
interpersonal community violence. Our HVIP promotes holistic recovery and well-being of
clients and their families, offering support to address a range of client and family-identified
needs, including medical, mental health, educational, and basic needs assistance. To support
inclusion of client voices in programmatic quality improvement efforts, we implemented a multi-
phase process to create and deploy a measure of client satisfaction that could be administered to
both clients and caregivers following completion of program services. All activities took place
during Spring and Summer 2021. Due to the nature of this work as quality improvement, it was
not subject to local Institutional Review Board review. Risk to HVIP clients and caregivers
participating in these quality improvement activities (see Phase 2 below) was minimal given that
they were providing insight into questionnaire development and not asked to describe their
personal experiences with our HVIP. In an effort to mitigate any potential discomfort or
confusion, team members who were not direct service providers thoroughly described the project
purpose to participants prior to the pilot test and cognitive interview and reassured them that
their feedback would remain confidential.

Phase 1: Literature Review and Initial Questionnaire Modifications
We conducted a literature review to identify measures of client satisfaction and selected the Client Satisfaction Questionnaire (CSQ-8), an 8-item scale used to measure consumer satisfaction in health and human service systems (Larsen et al., 1979). This measure uses 4-point Likert scales to assess perceived service quality; satisfaction with service quantity and services generally; extent to which services met the respondent’s needs, expectations, and addressed problems; if the respondent would use services again; and whether they would recommend the services to others. As a self-administered tool, the CSQ-8 provides respondents a degree of confidentiality.

We made several initial adaptations to the CSQ-8 to customize item language to the HVIP setting. We retained all items and response scales but made minor changes to simplify question structure and ensure relevance for how young people and their families access HVIP services. For example, we modified the source item “If you were to seek help again, would you come back to our program?” to “If you were to experience violence again, would you come back to our program?” We additionally included three open-ended questions to gather feedback on most and least helpful program components and any suggestions for program improvement. These modifications resulted in an 11-item questionnaire used for pilot testing.

**Phase 2: Pilot Testing and Cognitive Interviewing**

To ensure the self-administered questionnaire was feasible and interpreted as intended, we pilot tested the revised questionnaire and conducted cognitive interviews with former program clients and caregivers. Direct service providers shared contact information for 13 recent program clients and their caregivers. We invited clients and caregivers to participate in pilot testing and cognitive interviews initially via e-mail and then via follow-up phone calls.
Ultimately, four clients and five caregivers, including three adolescent-caregiver dyads, participated. Their demographic characteristics are shown in Table 1. (Insert Table 1 here)

Clients and caregivers independently completed the pilot version of HVIP CSQ via a self-administered, web-based REDCap survey (Harris et al., 2019; Harris et al., 2009). Respondents then participated in a cognitive interview via telephone with a project team member who did not provide direct HVIP services. Cognitive interview participants received $20 electronic gift cards as renumeration.

During the cognitive interviews, we asked clients and caregivers to describe (1) their interpretation of each questionnaire item; (2) how well they were able to answer each item using the response scale and suggestions for improvements; (3) their understanding of key terminology, such as “quality,” “service,” and “needs”; (4) their comfort answering each item honestly; and (5) any missing questions they believed would elicit further feedback. Lastly, we sought insight regarding implementation logistics. We asked participants how they commonly referred to our program so that the questionnaire named the program clearly and recognizably. We assessed preferences for questionnaire distribution (e.g., text message, email, phone call, or in person at program completion), who should share the questionnaire with them (e.g., their direct service provider or another member of the HVIP team with whom they did not interact during their care), and if they felt renumeration was needed to complete this type of satisfaction questionnaire.

Phase 3: Measure Refinement

Our team, including both direct service staff and evaluators, reviewed interview results to integrate client and caregiver feedback and refine a final version of the HVIP CSQ. We also identified additional missing constructs that were relevant to HVIP service quality and generated
or adapted existing questions from the client satisfaction literature, including the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 4.0 Child Medicaid Questionnaire and the Empowerment and Satisfaction Questionnaire-Long Form (ESQ-LF) (Agency for Healthcare Research and Quality, 2007; Victim Service Program Evaluation Collaboration, 2002).

**Phase 4: Establishing Implementation Logistics**

Finally, with feedback obtained from the cognitive interviews and our internal expert team, we defined a procedure for disseminating the HVIP CSQ and prepared a comprehensive how-to guide.

**Results**

**Measure Refinement**

During cognitive interviews, clients and caregivers shared that the items on the pilot CSQ were clear overall but offered suggestions to enhance the simplicity and comprehension of several items. They noted opportunities for streamlining response scales, flagging items with indistinct or unnecessarily complex response options (e.g., a scale including both options “almost all of my needs were met” and “most of my needs were met” and another scale including an ambiguous response option “indifferent/mildly satisfied”). They also indicated words with negative connotations (e.g., “problems”) that should be replaced to improve questionnaire tone.

Caregivers expressed confusion about whether the subject of some items (“you”) referred to their experience or their child’s. This was particularly confusing for caregivers of older adolescents, many of whom more independently interacted with their direct service provider without caregiver involvement. One caregiver explained that the wording made her uncertain if she should be considering only her program experiences and not her child’s and believed that the
questionnaire “should be more about the clients and not so much the parents since [adolescents] have experience with the [provider].”

With this feedback, we revised the questionnaire to enhance clarity. This included simplifying vocabulary (e.g., replacing “satisfied” with “happy” and removing words like “quality”). We consolidated and clarified response scales (e.g., replaced “indifferent/mildly satisfied” with “neither happy nor unhappy”). Based on clients’ and caregivers’ suggestions, we added an item to rate overall program experience on a familiar 1-10 scale. We revised one questionnaire item (“Have services you received helped you with your problems?”) to use more positive framing (“Did the program help you/your child to feel better?”). We created separate versions of the questionnaire for each respondent group—an adolescent/young adult version that uses “you” and “your” pronouns to reflect the client’s experience and a caregiver version that references “you and your child” to capture caregiver perspectives of services provided to themselves and their child. We also added an instruction at the beginning of the questionnaire to think broadly about program services provided to anyone in their family.

Additionally, we made changes to the questionnaire based on our program staff’s experiences. We added four items to measure constructs of importance to HVIPs, which are centered on empowerment and agency. These included items to assess the degree to which respondents perceived program staff to be (1) culturally competent and (2) careful listeners, in line with our program value to be client-centered and family-led. We also added two outcome-focused items to measure to what extent the program enhanced (1) knowledge of community services and (2) self-efficacy to access community services.

Observing that clients and caregivers infrequently completed the open-ended questions during the pilot administration, we collapsed these questions into a single item asking
respondents to share any additional thoughts or suggested program improvements to minimize response burden. We also removed an item asking if respondents would recommend the program to others to avoid confusion given that HVIPs typically have limited eligibility criteria (i.e., must have a qualifying injury treated within select hospital departments) and do not provide referral-based services to the community at large.

These modifications resulted in a 12-item HVIP CSQ, which includes 11 fixed-choice questions and 1 open-ended question, with parallel wording for both an adolescent/young adult and caregiver version (Table 2). (Insert Table 2 here)

**Implementation Logistics**

We developed a web-based survey in REDCap, which links client and caregiver responses and allows personalization of questionnaire invitations to include client and program staff names. Questionnaire records are maintained separately from program databases to protect confidentiality and are not accessible to direct service staff but could be linked to individual client outcomes to enable future evaluation. During cognitive interviews, clients shared feedback on several aspects of questionnaire implementation which informed our development of a distribution process.

**Modality.** Clients predominately preferred to receive the questionnaire via text message or email, though some mentioned phone calls would be helpful. Therefore, our protocol and database allow for multimodal distribution, including text message using the Twilio-REDCap integration function. The questionnaire can be sent repeatedly via respondents’ preferred method of contact.

**Renumeration.** Clients expressed that compensation for this questionnaire was unnecessary, with one caregiver summarizing, “You guys are trying to help us. This
questionnaire is about how well you guys did. It’s feedback.” Due to these responses and a lack of precedent for providing compensation for service quality questionnaires in the healthcare setting, we determined we would not provide remuneration for completion.

Sender. Clients reported that they most commonly referred to the program by the name of their direct service provider (e.g., “I say I work with [provider name]”) and would be most likely to respond to the questionnaire if sent by their provider or if their provider shared advanced notice that the questionnaire was forthcoming. Accordingly, questionnaire instructions and the first item were personalized to include the name of the client’s assigned provider to assist with program recognition. While we elected to have a team member who did not work directly with the family send the questionnaire to engender a sense of confidentiality and promote honesty, we developed a process for direct service providers to notify clients and families of the questionnaire opportunity and collect their mode preference (text, email, phone call) at program discharge.

Discussion

Our HVIP CSQ tool and implementation process enable our pediatric HVIP to begin systematic collection of client and caregiver report of service satisfaction, which will ensure our program is responsive in meeting needs of clients and families and help identify opportunities to optimize care. In line with our programmatic values of being both client-centered and family-led, our development process employed a client-centered approach to refine questions and determine data collection processes. These efforts resulted in item wording, response options, and implementation logistics that were relevant to the experiences and preferences of our program clients, poising our HVIP to collect valid, complete data. We believe that this tool can be utilized by other HVIPs and similar programs to identify implementation successes and improvement opportunities.
Understanding satisfaction with and the acceptability of services is vital to understand the impact of HVIPs on health inequities disproportionately experienced by our program’s clients. Emerging research has begun to address this concern through adaptation of measurement tools related to specific health and social conditions (see Stewart, Thrasher, Goldberg, & Shea, 2012). However, we are unaware of widespread work to adapt satisfaction and quality measures for the growing field of HVIPs and other violence prevention services. Our process ensured that both our questionnaire and distribution align with the needs of the respondent audience. Similar to healthcare systems’ increasing consideration of alignment in implementation of evidence-based practices, we believe that alignment is essential to collecting valid and complete client-reported data (see Lundmark et al., 2021).

To date, efforts to assess satisfaction exist more widely in the areas of medical care provision and coordination, community-focused supportive services, or disease-specific case management (Buja et al., 2020; Schutt & Woodford, 2020; Turchi et al., 2009). An HVIP-relevant measure of client satisfaction is critically important for this emerging area of victim service programming. Frequently studied HVIP outcomes focus on objective client-level outcomes such as re-injury, incarceration, and fatalities, with limited study of client satisfaction with service delivery and more proximal outcomes of HVIPs (Bell et al., 2018; Brice & Boyle, 2020). Understanding client satisfaction with services and their perception of program benefits may provide insight regarding the likelihood of program engagement, longer-term wellbeing and safety, and the enduring impact of program services (Cheng et al., 2008; Kubiak, Fedock, Kim, & Bybee, 2016). These metrics are important dimensions of program success, which must be considered as HVIPs replicate and expand and move towards widespread adoption of HVIP Standards and Indicators (The Health Alliance for Violence Intervention, 2023).
More generally, our client-centered approach to adapting an existing measure for the HVIP setting provides a replicable framework for development of client-facing measures for program improvement, outcome assessment, and future research. Drawing on the expertise of our program clients, we modified items to ensure they were clear and aligned with clients’ lived experience and the ways in which they spoke or thought about program services, an important consideration in establishing content validity (Morgado, Meireles, Neves, Amaral, & Ferreira, 2017; Sousa & Rojjanasrirat, 2011). Conversely, many client- or patient-reported measurement tools have been developed or implemented in populations that identify as white and of high socio-economic status, whose demographics are dissimilar from those of most individuals participating in HVIPs, who tend to be younger and identify as members of racial and ethnic minority groups (Borus, Polanco-Walters, Alfieri, Yim, & Vargas, 2022). This discrepancy may lead to inaccurate measurement and conclusions (Ramírez, Ford, Stewart, & A. Teresi, 2005; Stewart et al., 2012).

Many existing efforts to assess the quality of program services and satisfaction of crime victims, such as those served by HVIPs, have focused specifically on the criminal justice process and legal services, not the comprehensive range of services provided by HVIPs (Kunst et al., 2015). Our approach to measurement refinement, which drew on the expertise of adolescents and caregivers with first-hand experience as recipients of HVIP services and insight of program staff, is consistent with best practices for optimizing measure validity (Magasi et al., 2012). Further, this approach created a tool that extends our program’s trauma-informed values, namely by creating opportunities for formal inclusion of client voice in improving program services and delivery of care. Using a client-centered approach, we developed a tool that has evidence of preliminary content validity and is poised for continued validation. Importantly, this instrument
may allow individuals who have been historically marginalized to give voice to their program experiences and support the continued improvement of care delivery.

This work has several limitations. First, we conducted this research in a single pediatric HVIP. While our program clients are children and adolescents ages 8 to 18, we explicitly developed the tool to permit both client self-report as well as proxy caregiver report, making it adaptable to a range of HVIP and community-based violence prevention program settings. Programs serving exclusively adult clients or without significant engagement of caregivers or other family members may elect to not use the proxy report measure. Second, all of our clients identified as members of racial minority groups who resided in United States and therefore may have different perspectives on the experience of program services than clients of majority racial or ethnic backgrounds or who reside in more geographically isolated or rural communities. However, our clients reflect the demographics of those most likely to participate in HVIP services. Finally, clients were invited from a list of recent program clients shared by HVIP direct service providers. These clients were recommended for their high engagement in services, making them likely to respond to the invitation to provide feedback on questionnaire development. While perspectives of clients with different opinions about the program or who were less engaged in services are not likely represented herein, we believe this to be less of a concern for measurement development than for future assessment of program quality and satisfaction, where ensuring inclusivity in diversity of experience would be of utmost importance.

Implications for Practice

The 12-item HVIP CSQ, developed with program client, caregiver, and staff voice, is optimized to capture client-reported perspectives of program quality and identify opportunities
for improvement in delivery of HVIP services. Implementing this tool in HVIPs serving geographically and demographically diverse populations can support further validation and establish benchmarks for continuous monitoring of service quality. Because of our program’s focus on supporting young victims of violence, our instrument provides an opportunity for adolescents and young adults, as well as proxy reports by caregivers or other involved individuals, to report on their program experiences and satisfaction. The HVIP CSQ also provides a foundation for other community-based programs serving youth, young adults, and families who might adapt this tool for their own unique client populations and services using the systematic process outlined in this work.
References


Ivatury, R. R. (2011). Brief violence interventions with community case management services are effective for high-risk trauma patients. *J Trauma, 71*(1), 228-236; discussion 236-227. doi:10.1097/TA.0b013e31821e0c86


Bell, T. M., Gilyan, D., Moore, B. A., Martin, J., Ogbemudia, B., McLaughlin, B. E., . . .


Substance Abuse and Mental Health Services Administration. (2014). *SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach*. Retrieved from Rockville, MD.


### Table 1. Cognitive Interview Client Demographic Characteristics.

<table>
<thead>
<tr>
<th>Program Clients</th>
<th>M/n</th>
<th>SD/%</th>
</tr>
</thead>
<tbody>
<tr>
<td>(n = 4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age (years)</td>
<td>16.5</td>
<td>1.3</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>2</td>
<td>50%</td>
</tr>
<tr>
<td>Female</td>
<td>2</td>
<td>50%</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>1</td>
<td>25%</td>
</tr>
<tr>
<td>Black or African American</td>
<td>3</td>
<td>75%</td>
</tr>
<tr>
<td>Ethnicity, Latinx</td>
<td>0</td>
<td>0%</td>
</tr>
</tbody>
</table>

#### Caregivers

<table>
<thead>
<tr>
<th>(n = 5)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>5</td>
</tr>
<tr>
<td>Item</td>
<td>Response Options</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>-----------------------------------------------------------</td>
</tr>
<tr>
<td>1. Using any number from 0 to 10, what number would you use to rate</td>
<td>0 (Worst)--10 (Best)</td>
</tr>
<tr>
<td>the services you/your child received from [case manager name] while</td>
<td>All my needs were met</td>
</tr>
<tr>
<td>in the program?</td>
<td>Most of my needs were met</td>
</tr>
<tr>
<td></td>
<td>A few of my needs were met</td>
</tr>
<tr>
<td></td>
<td>None of my needs were met</td>
</tr>
<tr>
<td>2. To what extent has our program met your/your child's needs?</td>
<td>All my needs were met</td>
</tr>
<tr>
<td></td>
<td>Most of my needs were met</td>
</tr>
<tr>
<td></td>
<td>A few of my needs were met</td>
</tr>
<tr>
<td></td>
<td>None of my needs were met</td>
</tr>
<tr>
<td>3. How happy are you with the amount of help you/your child received?</td>
<td>Very happy</td>
</tr>
<tr>
<td></td>
<td>Mostly happy</td>
</tr>
<tr>
<td></td>
<td>Neither happy nor unhappy</td>
</tr>
<tr>
<td></td>
<td>Quite unhappy</td>
</tr>
<tr>
<td>4. Did the program help you/your child to feel better?</td>
<td>It helped me a great deal</td>
</tr>
<tr>
<td></td>
<td>It helped somewhat</td>
</tr>
<tr>
<td></td>
<td>It did not help</td>
</tr>
<tr>
<td></td>
<td>It made me feel worse</td>
</tr>
<tr>
<td>5. Overall, how happy were you with the services you/your child</td>
<td>Very happy</td>
</tr>
<tr>
<td>received?</td>
<td>Mostly happy</td>
</tr>
<tr>
<td></td>
<td>Neither happy nor unhappy</td>
</tr>
<tr>
<td></td>
<td>Quite unhappy</td>
</tr>
<tr>
<td>6. If you/your child were to experience violence again, would you</td>
<td>Definitely</td>
</tr>
<tr>
<td>choose to have your child come back to our program?</td>
<td>Maybe</td>
</tr>
<tr>
<td></td>
<td>Probably not</td>
</tr>
<tr>
<td></td>
<td>Definitely not</td>
</tr>
<tr>
<td>Item</td>
<td>Response Options</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>7. How often did program staff listen carefully to you/your child?</td>
<td>Always, Usually, Sometimes, Never</td>
</tr>
<tr>
<td>8. Program staff respected parts of your culture or identity that are important to you.</td>
<td>Always, Usually, Sometimes, Never</td>
</tr>
<tr>
<td>9. Because of the program, you know more about community resources that are available to you/your child.</td>
<td>Definitely, Maybe, Probably not, Definitely not</td>
</tr>
<tr>
<td>10. Because of the program, you feel better prepared to access community resources, such as legal, medical, educational, or mental health services.</td>
<td>Definitely, Maybe, Probably not, Definitely not</td>
</tr>
<tr>
<td>11. You are prepared to apply skills and tools you learned during the program.</td>
<td>Definitely, Maybe, Probably not, Definitely not</td>
</tr>
<tr>
<td>12. Is there anything else you would like to share about [program name], such as what was helpful or unhelpful or ways that [program name] could be improved?</td>
<td>Free text</td>
</tr>
</tbody>
</table>

¹Item source reflects the original source of survey items and whether the item was adapted from existing measures or created based on client and staff feedback.