ORIGINAL ARTICLE

A participatory evaluation project to measure SANE nursing practice and adult sexual assault patients' psychological well-being

Rebecca Campbell, Ph.D.[1], Debra Patterson, MSW, MA[1], Adrienne E. Adams, MA[1], Renae Diegel, RN[2] and Sue Coats, MSW[3]

1 Department of Psychology, Michigan State University, East Lansing, Michigan
2 BBL, CEN, CLNC, CMI-III, SANE-A, D-ABMDI, CFN, CFC, Turning Point Inc., Forensic Nurse Examiner Program
3 Turning Point, Inc.

Keywords
Sexual assault nurse examiners; forensic nursing; participatory evaluation; program evaluation.

Correspondence
Rebecca Campbell, Department of Psychology, Michigan State University, East Lansing, MI 48824-1116. Tel: 517-432-8390;
E-mail: rmc@msu.edu

doi: 10.1111/j.1939-3938.2008.00003.x

Abstract

This paper describes a collaborative project between a team of researcher-evaluators and a Sexual Assault Nurse Examiner (SANE) program to develop an evaluation survey of SANE nursing practice and patient psychological well-being. Using a participatory evaluation model, we followed a six-step process to plan and conduct an evaluation of adult sexual assault patients treated in one Midwestern SANE program. Our collaborative team developed a logic model of "empowering care," which we defined as providing healthcare, support, and resources; treating survivors with dignity and respect; believing their stories; helping them re-instate control and choice; and respecting patients' decisions. We created a corresponding survey that can be administered to patients following exam procedures and tested it with $N = 52$ sexual assault victims. Results indicated that nursing practice was consistent with this empowering care philosophy as the overwhelming majority of patients reported positive psychological well-being outcomes. Implications for evaluating forensic nursing practice are discussed.

Introduction

The work of Sexual Assault Nurse Examiner (SANE) programs is complex and multifaceted as nurses must attend simultaneously to sexual assault patients' psychological, medical, forensic, and legal needs (Department of Justice, 2004; Ledray, 1999; Littel, 2001; Ledray, Faugno, & Speck, 2001). Although the forensic and legal aspects of SANEs have been a primary research focus in the literature to date (see Campbell, Patterson, & Lichty, 2005, for a review), a fundamental role of forensic nurses includes providing patients with physical and emotional care (ANA, 1997; ENA, 2007). As Lynch (2006) noted, "As a professional nurse, the SANE's role encompasses all aspects of the bio-psycho-social needs of all patients, including the survivor of sexual assault" (p. 288). Providing comprehensive medical care and responding to patients' psychological distress is essential for their long-term emotional well-being. Early intervention is particularly important with sexual assault patients because most do *not* seek follow-up care (Campbell, Wasco, Ahrens, Sefl, & Barnes, 2001; Resnick et al., 2000). As a result, if patients' medical and psychological needs are not addressed immediately post-assault, they are at risk for longer-term health problems.

SANE programs are well positioned to address victims' medical and psychological needs given their 24/7 availability and the extensive training and expertise of their nursing staff. Yet, there have been few research studies or evaluation projects that have examined how the care provided by these interventions affects patients' *emotional well-being*. Two case studies have found that sexual assault patients treated in SANE programs characterized the care they received as helpful, supportive, and caring.

Malloy's (1991) evaluation with 70 patients treated in the Minneapolis SANE program found that 85% of the victims identified the nurses' listening to them as one thing that helped them the most during their crisis period. Ericksen et al. (2002) conducted semistructured qualitative interviews with eight victims who were treated in a Canadian "specialized sexual assault service," which included both specially trained physicians and SANEs. The participants emphasized how they felt in control, reassured, safe, well cared for, informed, and respected as a whole person.

These results suggest that SANEs can have a beneficial impact on patients' psychological health, but far more research is needed on this topic. An important next step in this literature is to examine how patient care processes contribute to positive well-being outcomes: How do SANEs interact with their patients to engender these benefits? The field of forensic nursing needs survey instruments that can assess both nursing process as well as patient outcomes. In-depth qualitative studies, such as Ericksen et al. (2002), provide rich, complex data, but qualitative methodology and analysis may be beyond many programs' evaluation capacities (Patton, 2002; Robson, 2000). Therefore, quantitative evaluation measures that capture nonlegal outcomes may be useful to practitioners for quality monitoring and program improvement (see also Speck, 2005, 2006). As such, the purpose of the current project was to develop a survey that could assess nurses' patient care interactions and patients' short-term psychological well-being.

In this project, we used a participatory evaluation model (Cousins & Earl, 1992, 1995; Cousins & Whitmore, 1998). This approach stands in stark contrast to traditional program evaluation paradigms whereby evaluators function as independent "outsiders," planning and conducting projects on their own with minimal input and involvement from program staff (Rossi, Lipsey, & Freeman, 2003; Scriven, 1993, 1997). Within the past 10 years, there has been growing use of more collaborative approaches in evaluation scholarship (see Mark, 2001, for a review). For example, in participatory evaluation methods, the evaluation is organized as a team project with researchers-evaluations and program stakeholders (Cousins & Earl, 1992, 1995; Cousins & Whitmore, 1998). Program staff are directly involved in planning and conducting the evaluation (Torres & Preskill, 2001). Two key advantages of participatory evaluation made this an appropriate evaluation paradigm for this project. First, this approach values and capitalizes on the experience and expertise of program staff (Cousins & Earl, 1992), which is particularly important in SANE evaluations given the complexities of their work. Second, Patton (1997) noted that participatory evaluation tends to increase utilization. The more stakeholders participate, the more likely they are to use the evaluation's findings to improve programs.

We formed a participatory team of researchers-evaluators and multiple stakeholders within the SANE program and its parent agency, a community-based, domestic violence-sexual assault service agency. This group included the executive director and director of programs from the parent agency, the SANE program director, all program nurses, the advocate supervisor, and the volunteer advocates.[1] To provide a structure for our work together, we used a six-step evaluation planning process, which had been previously developed by the researcher-evaluators from our experiences conducting state- and national-level training on evaluating SANEs, rape crisis centers, and domestic violence agencies (Campbell, 2007; Campbell et al., 2004; Patterson, Campbell, Lichty, Adams, & Greeson, 2005). Table 1 presents an overview of these steps. In this paper, we will describe how our team worked together through these six steps and share the resulting evaluation survey and patient results.

Methods and results

Steps 1 and 2: Identification of evaluation outcomes, goals, and objectives

Consistent with the participatory evaluation framework, we began by jointly identifying the primary *outcomes*, *goals*, and *objectives* for the evaluation. As noted previously, existing research on SANEs has focused heavily on forensic and legal outcomes (Campbell et al., 2005); instead our aim was to expand the literature by focusing on the *outcome* of patient psychological well-being. The research-evaluation team met with the SANE director and directors from its parent agency to discuss the overall *goals* of the program with respect to patient well-being. As expected, this discussion addressed the importance of comprehensive medical/health care, proper forensic evidence collection techniques, and crisis intervention, but what was most striking to the evaluation-research team was that this program had a distinctive guiding philosophy about *how* this work should be done with patients. Its parent organization has a strong organizational commitment to an empowerment model, which carried through to its SANE program. Their goal was to provide "empowering care" to sexual assault patients, which they described as providing health care, support, and resources; treating survivors with dignity and respect; believing their stories; helping them re-instate control and choice; and respecting patients' decisions.

To refine this goal further and develop objectives for the evaluation, the research-evaluation team

Table 1 Six-step process for planning and conducting program evaluations

Evaluation step	Description of step		Example from this project
Step 1: Define outcomes and narrow scope	The scope of an evaluation must be narrowed because it is impossible to evaluate all program activities within a single project. In SANEs, clarify whether evaluation will address psychological, medical/health, forensic, or legal outcomes. Although it is possible to evaluate multiple outcomes in one project, we recommend focusing on only one outcome and then expand over time to include multiple outcomes.		Scope = Nurses' patient care processes and victims' short-term psychological outcomes Outcome = Short-term psychological well-being
Step 2: Define evaluation goals and objectives	An evaluation goal states the desired effect program services will have on clients/patients.		Goal = SANE program services will promote patients' psychological recoveries
	An evaluation objective states in specific terms the intended effect on clients/patients.		Objective = Patients will report feeling cared for, treated with compassion and respect, supported, and believed, and informed by the SANE nurses
	Each outcome can have multiple goals, and each goal will have multiple objectives.		
Step 3: Design program evaluation	The design of an evaluation comes from the intersection of four main elements. These elements can be framed as four planning questions and the answers to these questions determine design:		
	(1) Who to collect data from?	Patients directly? Records?	Collected from patients
	(2) How many times to collect data?	Once? More than once?	Collected one time only
	(3) Data as numbers or words?	Quantitative (rating scales)? Qualitative (in own words)? Both?	Primarily quantitative rating scales; a few open-ended questions
	(4) How to collect data?	Survey? Interview? Observational record?	Survey (orally administered)
Step 4: Conduct evaluation and collect data	The evaluation design (step 3) provides a template for how and when to collect data. Evaluation data collection should not interfere with program services. Data can be collected by program staff, but it is preferable that the person who provided the service should not be the one to collect the evaluation data (possible response bias).		Advocates orally administered survey to patients after all exam procedures were completed during a normal wait time (e.g., medication wait time)
Step 5: Analyze data/present findings	Quantitative data can be analyzed with SPSS or Excel. Data should be checked prior to analysis for data entry errors or coding mistakes. Qualitative data can be grouped into themes; software such as Ethnograph, NVivo, or AtlasTi can be used or grouping can be done "by hand" with two coders working independently.		Data were analyzed in SPSS and descriptive statistics are presented in Tables 4 and 5
Step 6: Use findings for improvement	Share findings with program stakeholders and develop action plan for using results to improve program functioning. Share findings with scientific and practice community.		User-friendly report developed for program staff with in-person meeting to discuss findings. Findings confirmed that program philosophy is being implemented as intended and is associated with positive outcomes for sexual assault patients.

recommended that we co-develop a logic model to articulate the process of how the nurses work with their patients. Logic models can be constructed at multiple levels of analysis from entire programmatic functioning across multiple outcomes (e.g., psychological, medical/health, forensic, legal, etc.) to more narrow foci on specific outcomes (e.g., only psychological outcomes) (McLaughlin & Jordan, 2004; United Way, 1996; W.K. Kellogg Foundation, 2004). In this project, we created a logic model specific to this concept of empowering care. The

Table 2 SANE empowering care evaluation logic model: behavioral examples of program activities

Activities	Behavioral examples of activities
In order to address the problem of sexual assault in our community, we will accomplish the following activities:	To accomplish these activities, we engage in the following behaviors:
Build rapport and establish trust with patients	Introducing ourselves, calling the patient by her name, maintaining eye contact, listening, being truthful about the exam, being open and honest, and sticking to our word
Put patients at ease and show compassion	Talking with patient throughout the exam, having a soft tone when speaking, comforting them (e.g., "I'm here for you"), reassuring them during the exam (e.g., "You're so brave"), treating the situation seriously, not treating the patient like an object, not being judgmental, not rushing through the exam, listening to patients tell their story, and keeping them covered and not exposed as much as possible.
Provide patient-directed care by treating patients one-on-one, working within the patients' boundaries, adapting to each patient's needs	Allowing patients to refuse anything in the exam, allowing patients to take a break or stop the exam, explaining each step of the exam, explaining how long the exam will take and what to expect, showing patients the instruments that will be used, allowing patients to help with the exam, allowing patients to watch the exam on camera if they choose, and answering all patients' questions.
Convey professionalism to patients	Introducing ourselves as a Registered Nurse, explaining that we are specially trained, telling patients how many exams we have done if asked, not expressing shock to anything they see or are told, using the same language as the patient, and not talking down to patients.
Provide resource referrals and follow-up information	Providing clear information/instructions regarding medications and referrals for counseling services.

research-evaluation team members attended two staff meetings to talk directly with all forensic nurses working in this program. Although team members were already quite familiar with the work of SANE programs in general and this SANE program in particular from ongoing collaborations, we purposively started these discussions at a very basic step-by-step level so that we could hear from the nurses in their own words how they approached their work with their patients. For example, the nurses noted that a key activity was to establish rapport and trust with their patients; in response, we asked them to describe what they do *specifically* to try to make that happen. Upon reflection, the nurses gave multiple behavioral examples, such as introducing themselves by first name, calling their patients by their names, maintaining eye contact, listening, being truthful about the exam, being open and honest, and "sticking to their word" (e.g., if they said they would not do something, they would not do it). Table 2 presents a summary of key programmatic activities and behavioral examples of each as described by the nurses. The research-evaluation team used our notes from these discussions to develop a logic model of empowering care following the commonly used structure of inputs-activities-outputs-outcomes (McLaughlin & Jordan, 2004; United Way, 1996; W.K. Kellogg Foundation, 2004) (see Table 3). Based on this logic model, we focused the evaluation *objectives* around the short-term outcomes, namely, the extent to which patients felt cared for, treated with compassion and respect, supported, and believed, and informed by the SANE nurses.

Step 3: Development of evaluation design and evaluation questionnaire

For this evaluation, we used a cross-sectional survey design whereby SANE patients would be asked to complete a brief evaluation assessment. Return rates are often very low for mail surveys (often <10%) (Dillman, 1978, 2000), so we explored whether evaluation data could be collected with patients at the time of their exam or very soon thereafter. It was critically important to the research-evaluation team as well as the SANE staff that the evaluation should not interfere with patient care. Therefore, we decided to have the advocates who volunteer in the SANE program explain the evaluation project to the patients after all exam procedures were completed during naturally occurring "down time" (e.g., during the wait period after medication administration) or by phone during routine follow-up contact (see Campbell, Adams, & Patterson, 2007, for more details regarding design methodology). Our aim was to have the evaluation flow seamlessly into the SANE program's routine interactions with their patients. By having the advocates administer the evaluation questions—which

Table 3 SANE empowering care logic model: full model

			Outcomes		
Inputs	Activities	Outputs	Initial	Intermediate	Long-term
In order to accomplish our program activities we will need the following:	In order to address the problem of sexual assault in our community, we will accomplish the following activities:	We expect that once accomplished these activities will produce the following evidence of service delivery:	We expect that these activities will lead to the following initial outcomes:	We expect that these activities will lead to the following intermediate outcomes:	We expect that these activities will lead to the following long-term outcomes:
• Forensic nurses • Program coordinator • Consulting physician • Medical/forensic equipment • Private, safe space to conduct exams • Sexual assault patients • Positive relations with police and local hospitals to identify and refer survivors • Space for regular meeting to continually assess quality of care provided • Funding	• Build rapport and establish trust with patients • Put patients at ease and show compassion • Provide patient-directed care by treating patients one-on-one, working within the patients' boundaries, adapting to each patient's needs • Convey professionalism to patients • Provide resource referrals and follow-up information	• Sexual assault survivors of diverse ages, races/ethnicities, classes, languages, religions, sexualities, and abilities seeking medical attention and/or forensic evidence collection will be referred to our SANE program where trained forensic nurses will conduct medical forensic exams in accordance with our empowering care model	• Survivors will feel they were cared for by a professional • Survivors will feel a sense of control • Survivors will feel someone cared and believed them • Survivors will feel respected • Survivors will feel they were treated with care and compassion • Survivors will feel hopeful about the future and the potential for healing • Survivors will understand the medications they received • Survivors will know where to go for help, information, and/or additional services	• Emotional healing for survivors • Survivors will gain a sense of closure • Survivors will be able to go on with their lives (i.e., maintain employment, have an intimate relationship, have relationships with family/friends) • Improved standard of care for sexual assault survivors • Survivors will engage in follow-up services (e.g., counseling)	• Survivors will see long-term improvement in physical health • Survivors will see long-term improvement in psychological well-being

focused exclusively on the care provided by the nurses—we were also able to minimize potential response biases. All adult sexual assault patients (18 years old or older) treated in the SANE program would be eligible for participating in the evaluation unless they had a cognitive disability that would preclude them from being able to understand and answer the questions. Informed consent was obtained orally as approved by the Institutional Review Board of Michigan State University.

The evaluation-research team took the lead in drafting the evaluation questionnaire with the charge that it should be brief, easy to understand, and correspond to the short-term outcomes in the logic model. We had several meetings with the nurses, advocates, SANE program director, as well as the parent agency directors to review, critique, and revise the items. The resulting questionnaire consisted of two sections: the first focused on program activities and the consistency with which nurses engaged in those behaviors (e.g., "How often did the nurse explain what was going to happen next in the exam?" and "How often did the nurse ask if you had questions?"). The questions were framed as "how often" the nurses engaged in each behavior rather than a yes/no assessment (e.g., "did the nurse . . ."') because it was important to this program that they consistently engaged in these empowering behaviors throughout the entire exam process. The second section of the questionnaire corresponds to short-term outcomes (e.g., "How informed did you feel by the nurse?" and "How much control did you feel that you had during the exam?"). The complete survey can be found in Tables 4 and 5.

Step 4: Collecting the data

The research-evaluation team developed a comprehensive training program for all the SANE program advocates that included instruction on the following topics: overview of program evaluation; an explanation of the survey development process; an introduction to the survey; discussion of the data collection protocol; informed consent procedures; and survey administration. This material was covered through large and small group discussion as well as role plays to practice administering the evaluation. In addition, we developed a written reference guide, "10 Things to Know about Survey Administration," to summarize key issues from training. Data were collected in 15 consecutive weeks, during which the SANE program treated 76 eligible patients, of which 52 consented to participate in the evaluation (48% overall response rate; see Campbell et al., 2007, for more details).

Step 5: Analyses/findings

In the first section of the questionnaire, patients were asked *how often* the nurses engaged in eight behaviors on a four-point scale (1 = *none of time*; 2 = *some of the time*; 3 = *most of the time*; 4 = *the whole time*). As noted previously, it was important to this SANE program that nurses consistently engaged in these empowering behaviors throughout the entire exam process. As can be seen in Table 4, the nurses were very consistent in their interactions with patients. The overwhelming majority of patients stated that the nurses engaged in all eight of these behaviors "the whole time" throughout the exam process, and all mean ratings were above 3.5 (on four-point scale). Nonparametric chi-square goodness-of-fit tests were performed on each item to determine whether there were a significantly higher proportion of responses in the "the whole time" category than would be expected by chance. All tests were statistically significant, $P < .01$ (with a Bonferroni correction to control type I error across the multiple univariate tests). All patients stated that the nurses took their needs and concerns seriously and listened to them all of the time (100% consistency ratings). Ratings were also quite high for all other items, with slightly lower percentages regarding whether nurses asked if the patients had questions (73% total consistency). It is important to note that the nurses did ask the patients if they had questions (the category "none of the time" was 0%), but they were less consistent about continually checking throughout the entire exam process. Similarly, most patients were given the opportunity to help with the exam if they wanted to, but 8% noted that they were never given this opportunity (72% total consistency). Four percent of the patients noted that the nurse never explained why each part of the exam was important, but 81% indicated that the nurses did so throughout the exam.

The second section of the survey focused on short-term psychological well-being outcomes whereby patients used a four-point scale (1 = *not at all*; 2 = *a little*; 3 = *somewhat*; 4 = *a lot/completely*) to indicate the degree to which they felt cared for, treated with compassion and respect, supported, and believed, and informed by the SANE nurses. All patients used the highest rating (a lot/completely) for outcomes regarding care and compassion, feeling informed, clear instructions for medication, and re-contacting the program if they had problems or concerns. Somewhat lower ratings were obtained for the items regarding feeling control during the exam process (71% highest rating), which may be expected as the procedures for evidence collection are highly routinized. Most of the patients stated that they did *not* feel pressure from the nurse to go through with prosecution, which was a positive finding for this SANE program

Table 4 SANE patients' responses to survey section 1

In your interaction with the nurse, how often did. . ..	None of the time	Some of the time	Most of the time	The whole time	Mean (SD)
1. The nurse explain what was going to happen next in the exam	0%	0%	4%	96%	3.96 (0.20)
2. The nurse ask if you had questions	0%	8%	19%	73%	3.65 (0.63)
3. You have a chance to help with the exam if you wanted to (e.g., pull or comb own hair)	8%	16%	4%	72%	3.40 (1.04)
4. The nurse tell you how parts of the exam might feel before she did them	0%	4%	4%	92%	3.88 (0.43)
5. The nurse take your needs and concerns seriously	0%	0%	0%	100%	4.00 (0.00)
6. The nurse listen to you	0%	0%	0%	100%	4.00 (0.00)
7. You feel you could take a break during the exam or say no to any part of the exam	0%	0%	8%	92%	3.92 (0.28)
8. The nurse explain why each part of the exam was important	4%	0%	15%	81%	3.73 (0.67)

Table 5 SANE patients' responses to survey section 2

During and after your interaction with the nurse. . .	Not at all	A little	Somewhat	A lot or completely	Mean (SD)
1. How much care and compassion did you feel that the nurse showed?	0%	0%	0%	100%	4.00 (0.00)
2. How much control did you feel that you had during the exam?	0%	4%	25%	71%	3.67 (0.56)
3. How informed did you feel about what was happening in the exam?	0%	0%	0%	100%	4.00 (0.00)
4. How clear were the nurse's instructions about the medications?	0%	0%	0%	100%	4.00 (0.00)
5. How informed did you feel about where to go for follow-up medical care?	0%	8%	4%	88%	3.79 (0.59)
6. How much pressure did you feel from the nurse to go through with prosecution?	70%	4%	13%	13%	1.70 (1.15)
7. How likely will you be to contact the nurse if you have a problem?	0%	0%	0%	100%	4.00 (0.00)
8. How likely will you be to attend counseling at (parent agency)?	22%	13%	26%	39%	2.83 (1.19)
9. How informed did you feel by the nurse?	0%	0%	7%	93%	3.93 (0.26)

because, consistent with an empowerment philosophy, they wanted patients to make that decision independently after obtaining complete information about their options. This SANE program also hoped to provide information and linkages to their parent agency's counseling program, and it appears that it was also successful in that regard as only 22% of the patients stated that they were unlikely to attend counseling.

Step 6: Using findings

The research-evaluation team prepared a written report to the SANE program and its parent agency that described steps 1–5. The report was designed to be user friendly with most information summarized in bullet points and reference tables. In addition, the team met with program directors to present the report and answer questions; additional meetings were held with the nurses and advocates to share the findings. The program directors noted that evaluation was useful because the data came directly from patients, which provides the most direct and accurate assessment of care. The nurses certainly hoped that they were doing a good job with their patients and embodying principles of empowering care, but without direct feedback it is difficult to know whether these goals were indeed being achieved. The evaluation data confirmed that nurses are meeting patients' needs and responding to their concerns. This evaluation project was also helpful in establishing a long-term collaborative relationship between the researcher-evaluators and the SANE program, who continue to partner on other projects. The findings were also shared with program

funders and community partners to strengthen support for the program.

Discussion

In this project, we used a participatory evaluation approach to co-develop a survey measuring SANE nursing care practice and patients' short-term psychological outcomes. Our goal was to expand the literature on the effectiveness of SANE programs by examining nonlegal and nonforensic outcomes. By selecting this focus we do not suggest that legal issues are less important, but rather that there are many other aspects of SANE practice that merit further research. In addition, because there are a multitude of factors that influence legal case outcomes besides the contributions of SANEs, it may be fruitful to focus evaluation efforts on outcomes more proximal to the work that nurses do with their patients.

In this collaboration, we defined effectiveness by the extent to which the nurses provided "empowering care," which was conceptualized as providing health care, support, and resources; treating survivors with dignity and respect; believing their stories; helping them re-instate control and choice; and respecting patients' decisions. The results strongly suggest that the nurses were consistent with this practice philosophy as all eight items that assessed nurse–patient interactions had means of 3.40 or higher (on a 4.00 scale). All patients reported that the nurses took their needs and concerns seriously and listened to them the entire time. The patients' ratings for short-term psychological outcomes were similarly very positive (most were 3.60 or higher on 4.00 scale), and four of the nine items had the highest (4.0) rating from 100% of the patients surveyed. Also consistent with an empowering care perspective, the patients recognized that the nurses respected their wishes because the majority stated that they did not feel any pressure from the nurses to go forward with prosecution. Fewer patients indicated that they were likely to seek counseling services at the SANE program's parent agency, but nearly 40% expressed strong interest in doing so. For program staff, it was important that patients at least know such resources were available to them should they want them in the future.

The evaluation survey we developed in this project may be useful to other forensic nurses for program evaluation. This instrument is not copyrighted, so it can be implemented by other programs without cost, but we offer the following caveats and lessons learned from our experience developing and testing this measure. First, this survey was developed for internal evaluation and program improvement, not research; therefore, we did not pursue full reliability and validity analyses. However, based on the data we collected in this project, each section of the questionnaire has acceptable levels of reliability (Cronbach's alpha > 0.70), suggesting that it is reasonable to use this instrument for internal evaluation and quality assurance monitoring purposes. With respect to validity, the collaborative process by which we created the measure likely contributed to high face validity and content validity as the SANEs were actively involved in item development (see Singleton & Straits, 2004). Second, we wanted to assess both nursing practice (section 1) and patient outcomes (section 2) as dictated by the logic model we developed, but other programs may wish to use only one section given their evaluation goals. Third, we used a response scale of "how often" nurses engaged in various behaviors to assess consistency of practice (section 1). This rating scale is preferable to a yes/no format for capturing variability in patients' experiences, but programs need to consider whether their practice philosophy is consonant with the idea that nurses should be engaging in such behaviors consistently throughout the entire exam. These response choices may not be appropriate for all programs. Section 2 could be modified to use an alternative response format such as 1 = *strongly disagree*; 2 = *disagree*; 3 = *neutral*; 4 = *agree*; and 5 = *strongly agree* (question stems would need minor adjustments as well). Finally, also in section 2, we included an item regarding patients' interest and intent to attend counseling at the parent organization. This item was included for this project because of a programmatic goal to help patients become aware of other services in the parent organization (and respect their choice whether or not they actually seek counseling). Other SANE programs may not have such institutional linkages, and therefore this item would not be appropriate to include in the survey.

This work also informs forensic nursing practice by outlining a comprehensive six-step process for participatory evaluation. Other programs may find this framework helpful for creating their own evaluation survey instruments and/or modifying existing measures for adaptation to their local evaluation needs. The measures we created in this project were specific to the organizational philosophy of this SANE program and its parent organization. Other programs may or may not share similar goals, but the *process* we outlined provides a model for working with evaluators in a participatory, collaborative way. However, it is important to note that participatory program evaluation requires staff time and commitment, so SANEs need to be willing to invest in their evaluators and help them understand their work, and at the same time, evaluators need to be respectful of nurses' time. In this project, we found it was most efficient to draw upon the unique

strengths of the researcher-evaluators and the forensic nurses. For example, the evaluators had extensive experience in developing surveys, so rather than working as a large, totally inclusive group for what can be a cumbersome and sometimes frustrating task, the researcher-evaluators gathered content ideas from staff meeting discussions, and then developed drafts (which we could do more quickly) for the nurses to review and critique. SANE programs should work with their evaluators to determine a level of involvement and engagement that is mutually informative. It may not be necessary for all six steps to be carried out jointly, but overall this model can help build the evaluation capacity of SANE programs by guiding the process of planning and conducting an internal evaluation.

In conclusion, we identified two primary benefits from this project that have broader implications for forensic nursing practice. First, participatory evaluation projects can strengthen the evaluation capacity of SANE programs. By working through this six-step model, the nurses, advocates, and administrative staff in this SANE program gained new information, knowledge, and expertise in program evaluation. Developing evaluation capacity enhances SANE programs' sustainability as many grant funders require evaluation. As SANE programs diversify their funding sources, it is to be expected that they will face increased demand for evaluations of their services. In this project we created evaluation questionnaires that this particular SANE program, and others, if so interested, can use to respond to these evaluation mandates. Second, program evaluation provides an opportunity to solicit feedback directly from patients. In our planning meetings, many nurses discussed how they certainly hoped they were making a positive impact on their patients' lives, but they "don't really know for sure," as one stated, and that it was "hard not knowing." In this evaluation, patients' responses were quite positive, which provided some much-needed affirmation and support to the nurses. Professional burnout is common in human services professions, and those who work with traumatized populations are at a particularly high risk (Townsend & Campbell, 2007). The prevention of burnout also enhances the sustainability of SANE programs because positive findings can help mitigate the stress nurses experience when caring for traumatized patient populations. Mixed or negative findings can help program staff focus on targeted areas for improvement, which can also be motivating. Incorporating program evaluation into the practice of SANE programs opens new channels of communication between nurses and their patients, which can be personally and professionally rewarding.

References

American Nurses Association. (1997). *Scope and standards of forensic nursing practice*. Waldorf, MD: American Nurses Publishing.

Campbell, R. (2007, May). SANE-SART practice and evaluation. Invited talk presented at the National Sexual Assault Response Team Training Conference, Tampa, FL.

Campbell, R., Adams, A. E., & Patterson, D. (2008). *Methodological challenges of collecting evaluation data from traumatized clients/consumers: A comparison of three methods*. Manuscript submitted for publication.

Campbell, R., Dorey, H., Neageli, M., Grubstein, L. K., Bennett, K. K., Bonter, F., et al. (2004). An empowerment evaluation model for sexual assault programs: Empirical evidence of effectiveness. *American Journal of Community Psychology*, 34, 251–262.

Campbell, R., Patterson, D., & Lichty, L. F. (2005). The effectiveness of sexual assault nurse examiner (SANE) program: A review of psychological, medical, legal, and community outcomes. *Trauma, Violence, & Abuse: A Review Journal*, 6, 313–329.

Campbell, R., Wasco, S. M., Ahrens, C. E., Sefl, T., & Barnes, H. E. (2001). Preventing the "second rape:" Rape survivors' experiences with community service providers. *Journal of Interpersonal Violence*, 16, 1239–1259.

Cousins, J. B., & Earl, L. M. (1992). The case for participatory evaluation. *Educational Evaluation and Policy Analysis*, 14, 397–418.

Cousins, J. B., & Earl, L. M. (Eds.). (1995). *Participatory evaluation in education: Studies in evaluation use and organizational learning*. London: Falmer.

Cousins, J. B., & Whitmore, E. (1998). Framing participatory evaluation. *New Directions for Evaluation*, 80, 5–23.

Department of Justice. (2004). *A national protocol for sexual assault medical forensic examinations: Adults/adolescents*. Washington, DC.

Dillman, D. A. (1978). *Mail and telephone surveys: The total design method*. New York: Wiley.

Dillman, D. A. (2000). *Mail and Internet surveys: The tailored design method* (2nd ed.). New York: Wiley.

Emergency Nurses Association. (2007). *Care of sexual assault and rape victims in the emergency department*. Retrieved June 17, 2007, from http://www.ena.org/about/position/PDFs/21A9D5D9F4C549DE9EE8B7156F45C040.pdf

Ericksen, J., Dudley, C., McIntosh, G., Ritch, L., Shumay, S., & Simpson, M. (2002). Clients' experiences with a specialized sexual assault service. *Journal of Emergency Nursing*, 28, 86–90.

Ledray, L. (1999). *Sexual assault nurse examiner (SANE) development & operations guide*. Washington, DC: Office for Victims of Crime, U.S. Department of Justice.

Ledray, L. E., Faugno, D., & Speck, P. (2001). SANE: Advocate, forensic technician, nurse? *Journal of Emergency Nursing*, 27, 91–93.

Littel, K. (2001). Sexual assault nurse examiner programs: Improving the community response to sexual assault victims. *Office for Victims of Crime Bulletin*, 4, 1–19.

Lynch, V. A. (2006). *Forensic nursing*. St. Louis, MO: Elsevier Mosby.

Malloy, M. (1991). *Relationship of nurse identified therapeutic techniques to client satisfaction reports in a crisis program*. Unpublished thesis, University of Minnesota, Minneapolis, Minnesota.

Mark, M. M. (2001). Evaluation's future: Furor, futile or fertile? *American Journal of Evaluation*, 22, 457–479.

McLaughlin, J. A., & Jordan, G. B. (2004). Using logic models. In J. S. Wholey, H. P. Hatry, & K. E. Newcomer (Eds.), *Handbook of practical program evaluation* (2nd ed., pp. 7–32). San Francisco, CA: Jossey Bass.

Patterson, D., Campbell, R., Lichty, L., Adams, A., & Greeson, M. (2005, September). Planning and implementing program evaluation for Sexual Assault Nurse Examiner programs. Workshop presented at the International Forensic Nursing Scientific Assembly, Arlington, VA.

Patton, M. Q. (1997). *Utilization-focus evaluation* (3rd ed.). Thousand Oaks, CA: Sage.

Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage.

Resnick, H. S., Holmes, M. M., Kilpatrick, D. G., Clum, G., Acierno, R., & Best, C. L. (2000). Predictors of post-rape medical care in a national sample of women. *American Journal of Preventive Medicine*, 19, 214–219.

Robson, C. (2000). *Small-scale evaluation*. London: Sage.

Rossi, P. H., Lipsey, M. W., & Freeman, H. E. (2003). *Evaluation: A systematic approach* (7th ed.). Thousand Oaks, CA: Sage.

Scriven, M. (1993). Hard-won lessons in program evaluation. *New Directions for Program Evaluation*, 58, 5–92.

Scriven, M. (1997). Truth and objectivity in evaluation. In E. Chelimsky & W. R. Shadish (Eds.), *Evaluation for the 21st century* (pp. 477–500). Thousand Oaks, CA: Sage.

Singleton, R. A., & Straits, B. C. (2004). *Approaches to social research* (4th ed.). New York: Oxford University Press.

Speck, P. M. (2005). *Program evaluation of current SANE services to victim populations in three cities*. Unpublished dissertation, University of Tennessee Health Science Center, Memphis, Tennessee.

Speck, P. M. (2006). SANE program evaluation questionnaire (*SPEQ*©) pilot in three cities. Paper presented at the American Academy of Forensic Sciences Annual Meeting, Seattle, WA, February 2006.

Torres, R. T., & Preskill, H. (2001). Evaluation and organizational learning: Past, present, and future. *American Journal of Evaluation*, 22, 387–395.

Townsend, S. M., & Campbell, R. (2007). *Organizational correlates of secondary traumatic stress and burnout among sexual assault nurse examiners*. Manuscript under review.

United Way of America Task Force on Impact. (1996). *Measuring program outcomes: A practical approach*. Alexandria, VA: United Way of America.

W.K. Kellogg Foundation. (2004). *Logic model development guide*. Battle Creek, MI.

Endnotes

1 Program stakeholders can also include clients and funders (Cousins & Earl, 1992, 1995). In this project, we did not include clients/patients due to safety and confidentiality concerns. We also did not include funders in our stakeholder group. This evaluation was not mandated by a funder and was undertaken voluntarily. This SANE program has diverse funding sources, and we felt it would have been practically difficult to partner with multiple funders. In addition, because this evaluation was conducted pro bono, we did not have an evaluation funder with whom to partner. The researcher-evaluators donated time and resources to this project because of their shared interests in developing patient-centered evaluation of SANE programs.