Validation of a Service Questionnaire Tool Measuring Respect, Culture, Empowerment and Outcome

by

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Abstract

Respect, culture, empowerment and outcomes are considered as important factors of quality health and socialservices. *New Directions* has developed a Service Questionnaire tool that aims to measure these factors. The current study was conducted with the aim to validate the Service Questionnaire tool. Following a mixed-method study design, this study interviewed some staff at *New Directions* to understand the intention and uses of Service Questionnaire. It then assessed the psychometric properties and factor structure of the different versions of the tool using the data collected from a total of 2,269 service recipients from 2012 to 2016 at New Directions. The psychometric analyses revealed that the Service Questionnaire version 12 measures three factors and version 8 measure two factors. A statistically significant association was found between different service areas and some demographic variables. Both qualitative and quantitative analysis showed that Service Questionnaire tool partially meets the intention for which it was developed and the original factorability. The study suggested a few minor refinements of Service Questionnaire.

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Chapter One

Introduction

1.1 Background of the Study

It is the responsibility of service organizations to provide quality service. This is particularly the case when an organization provides health and social services to marginalized populations. When such groups include individuals with physical and intellectual disabilities, sexually exploited, those that have suffered abuse and systematic discrimination, and people from indigenous communities, it becomes a greater responsibility to ensure quality service. Poor services affect service recipients, the reputation of an organization and may result in serious consequences in program funding. Therefore, organizations seek to provide the best services to the service recipients. However, ensuring quality health and social service is a challenging task. There are numerous barriers which affect the quality of health and social services. For instance, improper planning, lack of applicable and updated knowledge, lack of relevant training, and insufficient expertise in interpreting survey data are some barriers to provide health and social care properly (Nieva, &Sorra 2003).

Several factors have been emphasized by policy makers to ensure the quality of healthcare and social services. These include, among others, mutual respect between service providers and recipients, understanding and considering recipients' culture, and providing a sense of empowerment and self-dependence (Betancourt et al., 2005; Fontaine, 2015; World Health Organization, 2010). Additionally, due to limitations in understanding such factors, service providers also face difficulties while providing services. Such limitations affect the quality of service. Thus, developing tools to measure the quality of services helps to overcome these limitations. Consequently, many social and health care organizations use tools to measure

quality of service. Organizations such as *New Directions*, consider the constructs of respect, culture, empowerment and outcome as domains that should be measured in order to optimize health quality and social services (McGough et al., 2018; Lopez et al., 2010). *New Directions* has developed and used a service questionnaire tool that taps into respect, culture, empowerment and outcome. This study sought to assess and validate the service questionnaire tool currently being utilized by *New Directions*.

1.2 New Directions

1.2.1 Organizational overview

New Directions is a person-centered non-government organization established to serve people with health and social difficulties to improve the quality of life within and around the city of Winnipeg, Manitoba in 1885(New Directions, n.d.). The aim of the organization is to develop an equally privileged community through providing responsive and individualized services where all people have well-being, are honored, and can dream. New Directions provides a variety of services to a wide range of people including children and adults with physical and intellectual disabilities, highly marginalized groups such as sexually exploited individuals, families at risk of violence, and Indigenous communities. Currently, there are 16 programs running under three service areas.

New Directions follows a person-centered service model believing that each person has the right to be treated equally despite the prevailing circumstances in their personal and social life. Moreover, it provides services regardless of the number of the services each individual receives from them, meaning that each of the recipients does not have restrictions to attend many services they are eligible for. Person-centered care, also known as patient-centered care, is an

approach that believes on the "entirety" of a person. This refers to an individual's needs and preferences being given priority in making health and social care decisions by service providers, thus creating a feeling of autonomy for the individual (American Geriatric Society, 2015).

1.2.2 Overview of Programs

On the basis of the difficulty levels and types, New Directions divided their services into three categories: Counseling, Assessment, Support and Prevention Programs; Training and Education Programs; and Residential and Support Programs (New Directions, n.d.).

There are six different programs under Counseling, Assessment, Support and prevention programs. Each of these programs focuses on addressing different types of difficulties among different age groups. For example, Family Therapy program works with families who are under stress and have a child between 12 and 18 years. They consider the family as a unit and serve them on the basis of their social, economic and cultural needs. They provide counseling and advocacy focusing on families' inner resources, values, cultural and spiritual traditions, and community relationships. On the other hand, the Families Affected by Sexual Assault (FASA) program serves the families that have children under 18 and who have been sexually assaulted by someone other than their parents or siblings or caregivers but did not receive care and the situation has been reported to Child and Family Services. Tables 1, 2 and 3 provide a summary of all the programs.

Table 1

Overview of Counseling, Assessment, Support & Prevention programs

Counseling, Assessment, Support & Prevention Programs

Program Name	Target Population	Program objectives	Program services
Family Therapy	Families with children between the ages of 12 and 18 years old who live in Winnipeg or vicinity, who are line workers; teen group; Parents of High Risk	Help families make use of their strengths and resources and build on their coping strategies and skills in addressing problems and achieving their hopes and dreams	Therapy, consultation, advocacy, counseling, outreach support and family systems training
Families Affected By Sexual Assault (FASA)	Families with children [under 18 and who are not in care] who have been sexually assaulted by someone who is not a parent or sibling, and when the sexual assault has been reported to Child & Family Services	By collaborative work with families, provide trauma-informed, developmentally appropriate therapy to help children and their families recover.	Training and consultation for parents, caregivers, and service providers regarding sexual assault.
Parenting Centre	Parents with children 12 years of age and under and who are experiencing significant difficulties such as couple conflict, trauma, parenting difficulties, children's school and/or social problems	The Parenting Centre is a program of New Directions for children that ensure Youth, Adults access information and resources about a diversity of needs and challenges around parenting and family life.	Counseling, play therapy, community outreach, family therapy, training and support to access resources information and way of parenting
FASD Family Support, Education and Counseling Program	Home based support services to families with children 0-14 who have been prenatally exposed to alcohol	To help families and the community to support children and youth with Fetal Alcohol Spectrum Disorder (FASD)	Home-based services, help individuals with FASD, provide information and resources, assistance and advocacy and address issues for target group
Opikihiwawin	Aboriginal adoptees and foster people in all stages of their lives	To respond to the needs of Aboriginal adoptees and foster people in all stages of their lives by providing cultural education, supports and advocacy	Promote and offer cultural support (e.g. Art Classes, Anishinaabe Language Classes, Feasts, Gatherings and Ceremonies, Drumming and Singing)
Manitoba Learning Centre	Children and adults with respect to suspected learning disabilities	To help and plan appropriately to meet the educational and psychological needs of the individual involved with provided assessment	The Manitoba Learning Centre provides assessment services for children and adults with respect to suspected learning disabilities.

Table 2
Overview of Residential & Support Programs

Residential & Support Programs

Program Name	**Target Population**	**Program Objectives**	**Program Services**
Shift-Staffed Homes (Community Residences providing intensive supports to children, youth and adults with developmental disabilities)	Individuals with developmental disabilities	To provide a safe, secure home-like environment in the community for people who need extra support	Provide referrals for target groups to different external and internal programs and agency services
Family Connections	Children, youth, and adults with complex support needs	The program assists individuals and their families to manage experiences and behaviors that make it difficult to stay together	Help to manage the right of self-determination of the target group, foster family connections, support transitional independent living
Supported Apartment Living (SAL)	Target group include people with intellectual disabilities and/or mental health barriers who are choosing to live independently in the community	To provide support for target groups to strengthen their abilities, trust and mutual respect and provide supports respecting their autonomy	Meeting individual specific needs and goals, assist in getting the basic needs, help in social development and skill development for target group
Empowering People in the Community (EPC)	Adults with disabilities	Help target groups to live fulfilled lives, and be fully included in community life	Offers residential services, help advocate person to a fulfilled life, make referrals for target groups, provide family caregivers to strengthen family abilities
Child Centered Services	Children and youth with high needs (e.g. experienced trauma, hardship with healthy development)	Meet the diverse needs, circumstances, and dreams of the children and youth	Provide shared home environment
DEAF Empowerment and Future Support Services	Deaf and Hard of Hearing children, youth and adult with emotional psycho- social, cultural, linguistic, intellectual, recreational, physical, and spiritual needs	To provide holistic, individual centered services recognizing and strengthening their potentials in order to increase his/her self determination	Provide recreational, treatment and learning support

Table 3

Overview of Training & Education Programs

Training & Education Programs

Program Name	Target Population	Program Objectives	Program Services
Training Resources for Youth (TRY)	School going youth and young people between 16 and 19 years of age	TRY is a program to help youth prepare for entry into the workforce or return to school	In-class training, Life-skills training, Counseling, support and advocacy
Resources for Adolescent Parents (RAP)	Pregnant or parenting teens aged under 18	To support young pregnant or parenting teens with the support they need to remove the barriers that interfere with going to school	Counseling services, support during pregnancy, information on nutrition, information on parenting, planning on returning to school and career
Transition, Education & Resources for Females (TERF) Mentor, Youth & Adults	Children, youth, adults and transgender individuals who have been exploited through the sex trade (prostitution)	To provide a safe, supportive, learning and healing environment for	Training for target group by professionals, make referrals to service agencies
Alternative Solutions – Youth & Adults with an Intellectual Disability	Adults with intellectual disabilities and/or a mental health diagnosis at the Program site and in the surrounding community	To provide and allow all the opportunity to take part in activities at their own pace and ability level and allow them to set goals for their Program involvement	Provide facility and community base supports

Source: Adapted from ″New Directions″

1.2.3 Development and use of evaluation tools in New Directions

"Service Questionnaire" or "SQ" is the modified version of an Exit Questionnaire that was developed previously to measure how well New Directions is achieving its goals. One of the goals of New Directions is to develop a quality service centre by preserving the dignity and independence of service recipients considering their needs and preferences. As part of such initiative, the organization developed the Service Questionnaire (SQ) tool to measure their service recipients' perception about the services they receive. Furthermore, this tool is also used to measure the achievement of another goal of New Directions, to provide culturally appropriate health and social services where all of the care recipients are respected and empowered.

The Evaluation Committee of New Directions was created in 2007. The committee collected data from the participants using the Exit Questionnaire and conducted factor analyses with the data. They primarily found four factors respect, family, change and culture. These four factors were then reviewed and in 2008, modified to respect, family, achievement and culture. Those newly revised factors were further modified to culture, respect, empowerment and outcome. These four domains are included in the current Service Questionnaire.

1.2.4 Service Questionnaire (SQ)

Service Questionnaire is an evaluation tool which was developed to collect feedback from the service recipients of different programs at New Directions. It was developed to find out about the strengths and weaknesses of the services provided at New Directions at both programmatic and organizational levels and to improve the quality of these services. It focuses on four domains: culture, respect, empowerment and outcome. For New Directions, "*Respect* refers to how program staff values and issues". "*Culture* means respect and support by the

program staffs given about the culture of the service recipients'. It seeks to measure how program staffs take care of the program's humility and responsiveness to the participants ' culture". *"Outcome* is the change in skills and knowledge (e.g., learning helpful things), behavior, and emotion (e.g., feeling better about one's self) of the service recipients". "*Empowerment* refers to participant's involvement in setting goals, and the program's support to help them reach their goals" (New Direction, 2016). Three items of SQ12 and two items of SQ8 and one item of SQ4 measure respect. And numbers of items are the same for the remaining domains.

New Directions uses two different types of the Service Questionnaire (SQ): programs version and therapist version. The program version counts the length of the time participants were in any program whereas the therapist/counselor version counts the number of times care recipients visited a therapist/counselor. These versions are used in different service areas. Each type of the questionnaire has four different versions: SQ12-5, SQ12-3, SQ 8-3, and SQ 4-3. All versions include demographic information such as age and gender. Moreover, the length of the program each participant attended and the number of times they met with their counselor/therapist are also captured. The four versions of the Service Questionnaires are referred to as SQ12-5, SQ12-3, SQ 8-3, and SQ 4-3. The four SQ scales are used across all 16 programs at New Directions depending on the programs and participants types. Participant types include individuals with limited literacy, developmental delays and language difficulties. Program staffs choose the type of the questionnaire they think is the best fit for the participants. There are 12 items in the SQ 12-5 version where each item has 5 response options (Likert scale) ranging from strongly disagree (1) to strongly agree (5). Similarly, the scales includeSQ12-3, SQ 8-3, and SQ 4-3 which have 12, 8 and 4 items respectively. These scales are developed following

three response options which range: disagree (1) neither agree nor disagree (2) and agree (3). Higher ratings indicate a greater level of participant's satisfaction in the four areas of service delivery. All four versions of the SQ's are equivalent and can be applied to any program at New Directions. SQ 12-3, SQ 8 and SQ 4 can be used for participants with language and reading difficulties (e.g., visual support with smiley faces). To assist with the administration of the SQ, an ASL (American Sign Language) video and an item explanation sheet are also available for each version. Participants can refuse with no penalty to participate in the study survey and all responses are confidential. A diagrammatic representation of the tool can be seen in table 5.

Chapter Two

Literature review

In the recent years, Canada has taken a reformation approach of both institutional and community based health and social care services (Sealy 2012). This approach has identified the need for different programs and social services for Canadians, in particular for people with disabilities, complex family and social problem, marginalized and minorities (Chow 2012). Over the years, the need for reformation of health and social care has received attention. It has become evident that the established health and social service delivery system what was introduced for the acute ill people does not work appropriately to people with disabilities, in complex social and mental conditions, living with improper homes (children with complex problems who are living to adulthood), and have learning disabilities (Mason et al., 2015). Such evidence suggests that integrating programs and social services may allow these populations to receive quality care and services. New Directions and other organizations have identified the following as components of quality health and social care: respect, culture, empowerment and outcome (Winnipeg Regional Health Authority, 2016; Mount Carmel Clinic, N.D; St.Amant's, 2018). For improving the quality of a person-centered care, New Directions focuses on respect, culture, empowerment and outcome.

2.1 Respect

Human beings are naturally creative in their way of thinking and defining. We all are different from one another because our past experiences are also different. With all of the different experiences we have, it is very difficult to put the term respect in the same frame from

different perspectives. However, to make this difficult job easier we can seek precise definitions and apply them to our purpose.

(Darwall 1977) defined respect as the moral judgments that help us to willingly consider others' point of views which may be similar or dissimilar to our own views. In addition, he explains that respect is the complex relationship between a respecter and a respected where respect depends on the characteristics of the respected person which is evaluated by a respecter. This author distinguished between two types of respect; recognition respect and appraisal respect. In some cases, we consider respect depending upon the objective position and roles of a person. A person's role and position become the criteria of judgments which determine how that person will be respected. This kind of respect is called recognition respect. For example, Darwall (1977) stated that "recognition respect is such respect which considers some specific feature of a person's feeling and social situation" (p.38). For instance, a father has some specific features in his position as father which is recognized by the rest of the family members.

On the other hand, appraisal respect is more subjective, where a person's own excellence in any particular area determines how he will be respected (Darwall, 1977). For example, a soccer player is respected when he/she can show his/her exceptional qualities, which brings positive appraisal among soccer fans. This kind of respect is called appraisal respect.

Chadwick (2012) defined respect as the feeling of being concerned about someone's right and acknowledged that person as a person. For Purnell & Fenkl (2019) respect is the important element of interpersonal relationships that brings positive changes in attitude towards a person. Respect matters in establishing effective health and social services. It is an interacting and interdependent factor to cultural competency and cultural safety. According to the Health Council of Canada (2012) respect means listening and talking to service recipients about the

problems in such a way those recipients get the feeling of an equal environment which is expressed through the caregivers' behavior and attitude. This equal environment ensures that they feel positively about the health care provider and feel that they are being respected as a client and also as a person regardless of their socio-demographic status and health conditions.

Beach, Duggan, Cassel, & Geller (2007) defined respect as the recognition of unconditional value, which includes both cognitive and behavioral dimensions of care recipients, treating them as a person and as a client. The former means valuing diversity and the latter drives the service providers to act in accordance with this belief. This first type of respect generally comes from the moral and ethical obligations of a person's own self. The second one is about responsibility and the relationship between a patient and a doctor/care provider considering related regulations. They state that respect is a moral obligation of a service provider that acknowledges the autonomy of a person and gives recognition the unconditional value of a patient as a person. The authors later categorized them as "respect for person" which is more about recognizing the values of a person and "respect for autonomy" which is a general kind of respect. Beach et al. (2005) also consider that respect refers to the dignity between a patient and a health/ social care provider where a patient's historical and social context of ethnic minority is taken into consideration. Ronzi, Orton, Pope, Valtorta, Bruce, & Ronzi, (2018) stated respect as the fundamental interventions of age-friendly health and social care and defined it as the positive attitude towards the care recipients so that they feel accepted, valued and appreciated. Furthermore, they argued that less evidence of the impact of respect on health and social care for older care recipients has been synthesized and recommended to promote respect for improving their health outcomes. Dickinson & O'Flynn (2016) stated that for older people, individuals with

mental illness, and those with learning difficulties, respect is one of the process outcomes that they value.

Respect plays a vital role in health and social services organizations. For example, Beach et al., (2005) found that patients who felt that they were treated with respect were more likely to be satisfied and adhere to therapy and services. Chochinov (2007) conducted a study on palliative care patients and revealed that the way they want to be treated is the most effective way to develop a respectful health and social care. If patients feel that they are treated considering the present situation rather than the past, their value of life is neglected, and patients feel that they are not respected. Chochinov (2013) argued that lack of attention and respect is the source of patients' dissatisfaction. Furthermore, Chochinov added that continuous education and training about patients' respect, dignity and the proper application of the gained knowledge could be the probable solution to this problem.

2.2 Culture

Culture is the knowledge, values, beliefs and customs of a certain society that is being practiced over the years. Detert et al. (2000) defined culture from the point of view of a service organization. According to them, culture is the beliefs and values of the staff of an organization that is expressed by their behavioral practices. Saha, Beach & Cooper (2008) stated that due to a lack of cultural awareness, service providers may make improper decisions about service recipients. Thus, considering the growing number of people from different cultural backgrounds, a culturally competent health care environment is needed (Kohn-Wood & Hooper, 2014). Williams & Rucker (2000) argued that those care providers who are not aware of cultural prejudices more frequently discriminate patients which may result in poorer health outcomes.

The issues of culturally competent health care and social services environments have received increased attention in recent decades (Browne &Varcoe, 2006). For instance, the report published by the *Commission on the Future Health Care in Canada*, recommended the establishment of a culturally competent health care system by providing necessary training to the health care providers (Romanow, 2002). As well, The Health Council of Canada has recently emphasized the importance of providing culturally competent and culturally safe health care for Aboriginal people in Canada (Canada H.C, 2012). Purnell & Fenkl (2019) stated that culture has become an important issue in North America considering the diverse population with different difficulties. They emphasized that care providers need to be aware not only about their culture but also about the cultural differences among different groups in order to develop an acceptable, effective and safe care environment and have better outcomes.

According to Betancourt et al. (2016), a culturally competent health care system aims to adapt and provide quality health care and social services for different groups that lead service providers to be aware of:

1) The influence of culture on health and social services
2) Distinguishes the differences among different cultures
3) Shares the outcomes resulting from these differences among health care providers and recipients.

Betancourt and colleagues (2016) argues that cultural competency may positively relate to quality care and results in better health outcomes. Cultural competency and cultural safety are important factors in health and social care organization.

Cultural safety is a part of a culturally competent health care system. The term "cultural safety" was first introduced by Maori nurses in 1980s (Gray et al., 2003). "Cultural safety" refers to the awareness about stereotypical views about others than the service provider's own culture" (Gray et al., 2003) service providers also need to know about the dissimilarities among different cultures, so that imbalanced power relationships among these cultures may be understandable in such a way that benefits the quality of service. Hence, the service providers' own cultural belief would not be imposed on the care recipients. The reflection on their own culture and acknowledgement about the power relations among different cultural groups will make it easier for the service providers to provide culturally competent health and social services. Cultural safety helps to understand imbalanced power relationships between different cultures, helping service recipients to move through the health and social service system and provides a platform for service providers to know the socio-political and historical context of care recipients (Hart-Wasekeesikaw & Gregory, 2009).

Cultural competency is the comprehensive understanding of facts, information and skills about the cultural backgrounds of service recipients attained by service providers to provide appropriate health and social service facilities (Hooper, 2014). In another study, cultural competency has been defined as problem solving skill that helps service providers to understand the way cultural internalization influences the behavior of care recipients and gives them the ability to understand the pros and cons of the dimension of societal change in order to make a decision in assessing, diagnosing and treating culturally diverse population (Kohn-Wood & Hooper, 2014).

Suh (2004) defines cultural competency from different viewpoints including Medicine, Psychology, Social Work and Education. From the perspective of physicians, cultural competency increases the level of knowledge about different cultures, which in turn increases the awareness of and respect towards the differences among different ethnic groups. A culturally competent psychologist ensures effective care to his or her care recipients through self-acknowledgement of the diversity of different cultures, acquiring different cultural and linguistic ideas, and applying these when providing counseling and psychotherapy. From the social workers' point of view, cultural competency is the process of being aware and the ability to develop skills and attitudes to be appropriate in their respective services. In the field of education, cultural competency is defined as the dynamic process of knowledge and skill development not only about the culture of the teachers' themselves but also about the students' own cultural norms and beliefs (Suh, 2004).

For New Directions, the construct of *Culture* relates to the program's humility and responsiveness to the participant's culture (New Directions 2016). Bramesfeld et al., (2007) states that responsiveness means ensuring a service that connects the service recipients to their cultural values and norms. Cultural humility refers to the self-reflection of service providers, where they may understand the imbalance in the power dynamics between care providers' and recipients' cultures and apply this knowledge for the improvement of quality health and social services (Tervalon& Murray-Garcia, 1998). It gives the sense to service recipients that service providers are aware about cultural values and norms.

2.3 Empowerment

The concept of patient's empowerment grew with the movement against gender discrimination demanding power of participation in policy making levels in health and social services (Sharma & Grumbach, 2017). However, Sharma and Grumbach have defined empowerment as the sense of power that encourages a person to be self-dependent so that he/she can make decisions independently and take control over their life completely. The World Health Organization has recognized empowerment as part and principle of health literacy which promotes knowledge, skill, and information and helps people to have a sense of control over their lives (World Health Organization, Review and Evaluation of Health Promotion, 1998). The World Health Organization (2010) also identified empowerment as one of the components of human rights for disadvantaged groups. They defined empowerment at a health and social care setting as the freedom of power for a person to decide and take control of their life while being in a disadvantaged situation. Powers (2003) states that empowerment is a coercive strategy that is measured by its outcomes, that helps care recipients to choose from different health and social service options and have control over their lives, despite these options being controlled by the care providers. The definition of empowerment varies depending on the time, situation and particular aspect of interest. For example, empowerment is influenced by daily life, politics, social structure, economics and even spiritual faith (Menon, 2002).

Empowerment plays an important role in psychiatric recovery. Lopez et.al (2010) argued that empowerment has a positive influence in the recovery of patients with mental health problems. Salmon & Halln (2003) argued that there is a significant relationship between the patients coping with illness and empowerment. Provencheret al., (2002) studied the effect of empowerment on psychological recovery between employed and unemployed people with

psychiatric disabilities. This study revealed that a person with a low sense of empowerment in both employed and unemployed categories had less initiative to cope with their emotional problems and made fewer changes in their lives. Inglis et al., (2015) compared to participants with an illness and without an illness and stated that if the sense of empowerment increased among any of the participants from both groups, the self-dependency skills would be more likely to increase. Raheb et al. (2018) defined empowerment as the self-management and self-care skills and revealed that both skills helped patients who were receiving hemodialysis to cope with stress and improve their quality of life.

Although, there are many studies on empowerment for service providers to improve the quality of care (Browning 2013, Faulkner & Laschinger 2008, Wagneret.al. 2010), few studies have been conducted from care recipients' empowerment perspectives.

2.4 Outcome

Measuring outcome has become part and parcel in the field of health care services particularly for the recovery oriented and community based health and social care agencies (Segal & Silverman; 2002, Spaulding-Givens & Lacasse 2015). Different researchers have measured outcomes differently. For example, Spaulding-Givens & Lacasse (2015) measured the outcome of in a mental health service delivery setting, where outcomes were measured by Functional Assessment Rating Scale (FARS). Krageloh (2015) measured outcome by using the Patient Reported Outcome Measures (PROM) tool which is identified as the standard outcome measurement tool to measure and improve the quality of life for people with physical and mental health difficulties. For New Directions, outcome means participant's changes in skills and knowledge (e.g., learning helpful things), behavior, and emotion (e.g., feeling better about one's self).

To improve the quality of healthcare, different scales have been developed on culture (Arthur et al., 2005, Gamst et al; 2004,Suarez-Balcazar et al., 2011), respect (Carrese et al., 2017), empowerment (Lopez et.al, 2010, Wowra& McCarter, 1999) and outcome (Krageloh; 2015, Spaulding-Givens &Lacasse; 2015) separately for different groups of people, but there are no other measurement scales that measure culture, respect, empowerment and outcome for a variety of population groups including marginalized, children, adults, and elderly with health problems such as sexually exploited, persons with intellectual disabilities and families experiencing violence . From this point of view, the scale that New Directions uses is unique and can contribute significantly to the field of health and social care.

2.5 Study Objectives

The main objective of the study was to validate New Direction's service questionnaire tool that has been developed to measure respect, empowerment, culture and outcome. Accordingly, the study sought to refine the tools and make recommendations.

The specific objectives are:

1. To assess the psychometric properties of the Service Questionnaire tool
2. To make recommendations of the New Direction's service questionnaires

2.6 Significance of the Study

This study used data from a large organization with a large roster of people with complex health and social issues. The main aim of the study was to validate a questionnaire that measures respect, culture, empowerment and outcome. Using a separate scale for each of these factors is very common. However, validating a questionnaire that includes such factors under the same

questionnaire is a significant contribution. A validated tool that measures respect, culture, empowerment and outcome can be used to survey individuals that face different issues such as physical and mental health, social issues, and that are of different cognitive abilities and ages.. Thus, the validation of this tool for New Directions may be useful for other organizations that have similar kind of organizational values, goals, and missions. Identifying the differences among different populations in perceiving respect, culture, empowerment and outcome will help New Directions to take further steps to improve the quality of their services. Additionally, this study can be a good resource for care providers to know about these factors and their application in health and social care.

Chapter Three

Methodology of the Study

3.1 Data Sources

There are two components of the data; quantitative and qualitative. And quantitative data were collected from the service recipients of New Directions from 2012-2016. Qualitative data were collected from the key informants who were involved in developing or administering the Service Questionnaire.

3.1.1 Quantitative Data Source

New Direction's data collection using the Service Questionnaire (SQ) started in 2009. About 2,000 participants made up of children, youth and elderly were randomly selected from large population groups who were receiving services from different programs at New Directions. New Directions uses a cross-sectional survey design in which 25 percent of the participants from each of the programs were selected using a random sampling technique. Survey questionnaires were delivered by program staff to the participants. An explanation sheet was also delivered to the participants. American Sign Language (ASL) video and audio facilities were also provided to the participants who needed them. A brief description and introduction were also given to inform the care recipients about why completing the survey was important to improve the quality of the service at each program. The service recipients were given assurance that the survey would remain confidential and would only be used for the betterment of services at *New Directions*. The survey package includes sample pages survey questionnaires, along with demographic information and an extra page of explanations (See Appendix 1-6). Moreover, factor identification per item can also be found (see Appendix 7). Administrative assistants or program designates were responsible for inputting the data in SPSS.

Females comprised the majority of the sample (57%), participants mean age was 30.97 with standard deviation (SD=14.54). Half of the total participants were adults. The four versions of the questionnaires used to collect data were SQ12_5, SQ12_3, SQ8 and SQ4. The majority of the participants (52%) were administered SQ12_5.

3.1.2 Qualitative Data Source

A face to face interview was conducted to understand the intentions for developing and using the Service Questionnaire at New Directions and to know details about its administration and suggestions for further improvement. Interviewees were *New Directions* staffs who were involved in either developing or using the Service Questionnaire. Eligible key informants for this part of the study were sent a request to participate in the study through management of New Directions. The invitation package included an introduction of the research topic and consent form. Key informants who were interested to take part in this study could directly contact to the researcher via email. After building a rapport between the researcher and the participants, the interviews were conducted on a specified time and place. All interviews were recorded using digital audio recorder. Most of the interview lasted for 30 to 40 minutes.

3.2 Reliability

A reliable test is one that generates consistent, stable and homogenous results in repeated measurement (LoBiondo-Wood & Haber, 2014). A test is reliable when it produces stable, homogenous and equivalent results. Stability and equivalency of a test depends on getting the relatively same result in repeated measurements using the same or a parallel scale. A homogenous scale can measure the same characteristics with its items. The reliability of a scale

is expressed by the correlation coefficient. The level of correlation coefficient ranges from 0 to 1. The more the correlation coefficient is closer to 1, the more the test is reliable. The popular types of reliability tests are test-retest reliability, internal consistency, alternate form of reliability, and split-half reliability (DeVellis, 2016; Golafshani, 2003; LoBiondo-Wood & Haber, 2014). The alternative form of reliability is the correlation between two equivalent sets of questionnaires applied to the same group of people. Split-half reliability comes out from the comparison of correlation from the two halves of the items of a single set of questionnaires often divided in the method of even-odd or randomly. The test-retest reliability is measured through applying the same set of questionnaires at the two points of time on the same group of population and then correlating the scores. Internal consistency is a unique type of reliability test generally measured by correlating the score of one single item from a set of questionnaires with that of other items or overall scores.

3.3 Validity

A test is valid when it truly measures what it was supposed to measure (Golafshani, 2003; Yu, 2005), and when it can find out the specific events and constructs of a scale (DeVellis, 2016) . There are several types of validity including; face validity, content validity, criterion validity, and construct validity (DeVellis, 2016; Golafshani, 2003; LoBiondo-Wood & Haber, 2014). Face validity answers the question of whether the items look like they are measuring what was supposed to be assessed. A scale has content validity when its items are chosen randomly from a list of relevant universe of items or often the items are chosen by the experts in order to increase the quality when the list of items is narrow. Criterion validity is one that focuses on the practical or observational association of the criteria of items. While criterion validity focuses on the

empirical association of items, construct validity focuses on the theoretical association of items (Golafshani, 2003; Wainer& Braun, 2013).

3.4 Measurement

3.4.1 Variable

Four major domains, respect,culture, empowerment and outcomes were measured using the Service Questionnaire. Age, gender, length in the program or the times care recipients' have visited the therapist were also considered as the independent demographic variables. There were four versions of the Service Questionnaire which are SQ12-5, SQ12_3, SQ8 and SQ4. SQ12-5 have five response options ranging from (1) strongly disagree to (5) strongly agree for SQ12-5 and for the rest response options ranges from (1) Disagree to (3) Agree. The list of variables with their measures considered in this study can be seen in table 4.

Table 4

Operational Definition of Respect, Culture, Empowerment and Outcome

Variables	Measurement
Respect	Measure respect towards the participant, their values, and their issues by program staff.
Culture	Measuring humility and responsiveness to the participant's culture
Empowerment	Measure the participant's involvement in setting goals, and the program's support to help them reach their goals

Outcome	measure participant change in skills and knowledge (e.g., learning helpful things), behavior, and emotion (e.g., feeling better about one's self)

New Directions distinguished care recipients based on program and counselor/therapist. This organization applied different versions of the tool to measure participants' perception towards the service quality of program and counselor/therapist types. Table 5depicts the tools used in both versions.

Table 5

Sample of items of both program and counselor version of service questionnaire

SQ version	Program	Counselor
SQ 4	Staff help me to make my own choices	My therapist helps me with things that I worry about.
SQ 8	I feel staff respect people's culture (values, beliefs, traditions).	I feel that my values and beliefs are treated with respect in the program.
SQ 12-3	I feel that the program has supported my contact with my culture (values, beliefs, traditions) as much as possible	I feel that my therapist has been sensitive to my values and beliefs
SQ 12-5	I feel that program has supported my contact with my culture (values, beliefs, traditions) as much as possible.	I feel that my therapist has been sensitive to my values and beliefs.

3.5 Steps of the Study

3.5.1 Step 1: Specify what *New Directions* intended to measure

The main objective of the study was to validate service questionnaire tool that has been developed by *New Directions* to measure respect, empowerment, culture and outcome. To measure what New Directions intended to measure, face to face interviews with five key informants were conducted. The interviews were digitally audio-recorded and transcribed verbatim. The transcripts were thematically analyzed. As well, *New Directions* written documentation related to the development and use of the questionnaires were reviewed to gain further understanding and triangulate the information.

3.5.2 Step 2, 3 & 4: Assess the scale items that have been used, assess the format of the items, and evaluate the items in terms of reliability and validity.

Psychometric properties of the Service Questionnaire such as item analysis, reliability, validity and dimensionality were measured. Chi Square tests for cross-tabulations between programs and item scores were performed to determine if a significantly different score distribution exist among programs, age groups and gender. Reliability analyses were used to test the internal consistency. A descriptive analysis was done to summarize the demographic differences of service recipients considering their age, gender, and length of enrollment in a program and type of programs. Finally, a factor analysis was conducted to determine the original factor construct of the tool developed by New Directions.

3.5.3 Step 5: Refine the items and provide recommendations

Finally, after analyzing all the data and literature, recommendations were made.

3.6 Data Procedures

For univariate analysis, ages were categorized into four groups: age group 1 (below 12 years), age group 2 (12 to 24 years), age group 3 (25 to 64 years) and age group 4 (65 years and above). This ages were categorized into children (below 12), youth (12-24), adult (25-64) and seniors (65 and above). To make it more represent able ages were categorized into five groups: below 16, 17-30, 31-45, 46-60 and 61 and upper. Gender was categorized into four groups: 0 (unspecified), 1 (male), 2 (female) and 3 (transgender). Basically, there were three gender groups, but group unspecified were included in an aim to see the differences among the groups if any participant does not want to reveal gender identity. Enrollment in program was categorized in to three categories: 1 (counseling, education and training Services), 2 (home services) and 3 (shared services). Time in program was categorized into five categories: 1(Less than 1 month), 2 (1 to 3 months), 3 (4 to 6 months), 4 (7 months to 1 year) and 5 (more than 1 year). Time client seen to therapist/counselor was categorized into four categories: 1 (visited 1 time), 2 (visited 2 times), 3 (visited 3 times) and 4 (visited 4 or more times). The categorization for these variables including enrollment in program, time in program, time therapist seen physicians/counselor were come with the original version of the questionnaire developed by New Directions. The mean of each of the four subscales were calculated after recoding the reverse scores. The scores for 3 point Likert scale were transformed into 5 point Likert scale. The mean score was calculated by adding the scores for each item of a subscale for all of the versions and then divided by the items number.

Skewness and kurtosis were calculated to see the distribution pattern of the collected data. Univariate outliers were also examined using Z value. For, multivariate analysis, multivariate outliers were also examined using Mahalanobis analysis. The skewness result showed that data

were negatively skewed. Then, it was analyzed to see if data were significantly different from zero. Data were transformed using log 10 transformation methods as most of the data were negatively skewed and significantly different from zero. These transformed data were used for further analysis. For bivariate analysis, four domains were categorized into two groups: 0 (low) and 1 (high). 0 (low) indicates felt less respected, less empowered, less respected in cultural issues, and outcome met less satisfactorily whereas 1(high) means the opposite.

All qualitative interviews were transcribed and reviewed for analysis. A question guide was followed to see the staff views of developing and using the Service Questionnaire. Analysis was completed following several steps. The major headings represent the salient thematic categories.

3.7 Ethics of the Study

The study used secondary quantitative data. The data was collected by New Directions. Therefore, data used in full compliance with the rules and guidelines of New Directions and the University of Manitoba Research Ethics Board. New Directions as well as the researcher of the study did not and will not disclose the identity of any respondent's researched. The identity of interviewees for the qualitative data was kept anonymous.

Chapter Four

Findings

The findings of the present study were presented in two stages; qualitative results and quantitative results. Quantitative results of the study were presented on the basis of univariate, bivariate and factor analysis accordingly.

4.1 Interview findings

The following themes emerged from the interview regarding the adaptation of Service Questionnaire: intention of adaptation, reasons for continuation, meeting the purposes of the organization, the usefulness of the data and refinement for improvement.

4.1.1Intention of adaptation

The intention for the adoption of the Service Questionnaire most commonly mentioned was to measure the mission, goals and values of *New Directions* and to assess or evaluate services at both programmatic and agency levels. One staff member emphasized the quality of steps rather than quality of the services: “The intention of adapting the Service Questionnaire is to know not only the quality of the services but also the quality of the steps that we are taking. More specifically, one participant mentioned “we do care more about respectful, caring and comfortable services rather than their outcomes (measuring expertise of the staffs)” (p4, 27, 28, 29, 30).

Two staff members explained as follows the intention of adapting versions of the Service Questionnaire:“We wanted to develop an instrument that allowed us to check the whole agency services across programs levels regardless of having differences” (P3, 3, 4, 5, 6). “We were

piloting the questionnaire in terms of rating systems because of the people we have like developmental disabilities, so there was some accommodation made for them by facilitating non-numeric sign with faces so that people can easily identify their answer" (P2, 4, 5, 6).

Several interviewees mentioned that the goals, missions and values of the organization is to be responsive to the needs, respectful to the complexity of their lives, respectful to their culture and working to empower people who have been marginalized and oppressed. A couple of the interviewees explained that the outcome was added in the Service Questionnaire to get the feedback of the services from service recipients. According to them, , outcome was added in order to measure whether people were getting what they should get from New Directions by coming to a particular service.

4.1.2 Reasons for Continuation

Three interviewees discussed the reasons for continuing to use the Service Questionnaire. According to them, the Service Questionnaire was continued to be used in order to make changes to the services provided based on the feedback of service recipients. For example one staff persons said "We use Service Questionnaire to get the feedback and we continue to use it to make changes and adjust the programs based on that feedback" (P1, 35, 39).Another staff member mentioned that its practicality is one of the reasons for continuing with the Service Questionnaire. This staff said "it is so well delivered, everyone knows about it, and it's so quick and easy to administer (P5, 12, 13, 17). More so, another participant said "We have already used it for almost 10 years and that's the positive thing and there is no reason to lose all data beforehand, unless you have a good reason to shift up the evaluation." (P4, 45, 46).

4.1.3 Meeting the Purposes of the Organization

When interviewees were asked whether the Service Questionnaire relates to the main purpose of the organization, they associated the four domains of the Service Questionnaire (respect, culture, empowerment and outcome) to the expectations of the organization. Most interviewees said that the Service Questionnaire is measuring respect, culture, empowerment and outcome, which partially meet the organizational goals. For example, one staff member mentioned "respect is our dream and people do not work if they feel that they are disrespected" (P4, 48, 49).Another staff member mentioned that "holism or a holistic service is one of our values; however, this part is missing from the Service Questionnaire" (P5, 21, 22, 23).

Two staff members mentioned that Service Questionnaire is not addressing the individualistic or person-centered service aspect of New Directions goals because questionnaires are close ended and numeric, which limits collecting information about individualized services.

One interviewee discussed the expectations of funder and government stating that "we evaluate quality assurance and customer experience and these domains measure participants experience and feedback in the program" (p1, 32, 33, 34). Another staff person was somewhat critical of the Service Questionnaire addressing the goals of New Directions, mentioning that "although the Service Questionnaire measures domains like respect, culture and empowerment that are tied into our values, it does not really add value for services to figure out of what did we do right or what they could do differently" (P2, 12-16).

4.1.4 Usefulness of the Data

Interviewees were asked about the use of data. Most of them said that they use the data for funding applications. Some of them mentioned that they use the date to see the differences

among participants in how they perceive service areas. One of the interviewees stated "analyzed information gives us a flag to attend the issues and change a little bit of how we are doing at our training and then provision in those areas are taken" (P1, 77, 78).

4.1.5 Refinement for Improvement

In terms of recommendations for refining the tools suggested by interviewees, most of them mentioned adding the idea of self-advocacy, emphasizing that self-advocacy is different from empowerment. A few participants also mentioned the formatting of the tool, suggesting dropping items and adding other areas, as well as adding open ended questions. Some key informants expressed their confusion whether Service Questionnaire was actually measuring four areas (respect, culture, empowerment and outcome). One of the interviewee was particularly interested in adding domains such as connection or relationships between service providers and service recipients. Furthermore, this participant added that sense of belonging could be another important area in the Service Questionnaire tool.

4. 2 Univariate Results

The demographic characteristics of the participants are presented in table 6. There were variations across all categories. A total of 2269 participants were included for univariate analysis.

4.2.1 Gender

Gender was categorized into male, female, transgender and unspecified. Almost all of the participants reported their gender (99%). The majority of the participants were female (57%).

Only 2.5% of the participants were either unspecified or transgender and the rest were male (40%).

4.2.2 Age

Approximately 92% of the Service Questionnaire (SQ) respondents reported their age. These ages ranged from 3 to 86 (*mean* = 30.97, *SD* = 14.54). Of the participants who reported their age, half of them were from 25 to 64 years of age. Approximately 2%were seniors aged65 years and over.

4.2.3 Version of Questionnaire

There are four versions of the SQ. The versions vary in terms of the number of items in a scale (12, 8, or 4), the number of response options (3 or 5), and the use of visual support for response options.There are two versions of the 12-item questionnaire, one has a five-point Likert scale, ranging from 1*(Disagree Strongly)* to 5 *(Agree Strongly),* while the other has a three-point Likert scale ranging from 1 *(Disagree)* to 3 *(Agree)* with visual aids. The 8-item questionnaire and the 4-item questionnaire also have a three-point Likert scale, ranging from 1*(Disagree)* to 3 *(Agree)* with visual representation. Higher ratings indicate a greater level of participant satisfaction in the four areas of service delivery. The four versions of the SQ are equivalent; therefore, each program can use the version(s) of the SQ that is best suited to the needs of their (e.g., if the pictorial versions are more desirable because of language or reading abilities, the 8 or 4 item versions can be used).

The majority of the participants (54%) were given SQ 12-5 program version. SQ 8-3, SQ 4-3, and Sq12-3 made up of 45% of the participants distributing 15% each. Only 4% of the participants were given SQ with American Sign Language (ASL) facility.

Table 6

Demographic Characteristics of the StudyParticipants(N=2269).

Characteristics	Category	Value/Number	(%)
Age, Mean(SD), 30.97 (14.54)		2079[1]	(92.00)
	Below 12, n (%)	84	(3.70)
	12 to 24, n (%)	783	(34.5)
	25 to 64, n (%)	1175	(51.8)
	65 and above, n (%)	37	(1.6)
Gender, n=2246			
	Unspecified, n (%)	42	(1.9)
	Male, n (%)	900	(40.10)
	Female, n (%)	1286	(57.30)
	Transgender, n (%)	18	(.80)
Enrollment in Program, n=2269			
	Counseling, Education and Training Services, n (%)	737	(32.50)
	Home Services, n (%)	729	(32.10)
	Shared Services, n (%)	803	(35.40)
SQ Version, n=2260,[2]			
	Regular 12_5, n (%)	1221	(54.00)
	Regular 8_3, n (%)	377	(16.70)
	Regular 4_3, n (%)	310	(13.70)
	Counselor 12_3, n (%)	351	(15.50)
ASL application, n=90,[3]			
	2014	38	
	2016	49	
Time in Program, n=1192			
	Less than 1 month, n (%)	118	(9.90)
	1 to 3 months, n (%)	243	(20.40)
	4 to 6 months, n (%)	77	(6.50)
	7 months to 1 year, n (%)	126	(10.60)
	More than 1 year	628	(52.60)

[1]missing numbers were excluded from the analysis, only valid numbers and percentages are reported in the study
[2]No were provided SQ Counselor 4 version, and only one participant was given Counselor 8 version.
[3] In 2012, No were provided SQ with ASL, in 2013 only one participant was provided SQ with ASL and in 2015 only two were provided SQ with ASL

Client has seen to Therapist, n=711			
	1, n (%)	40	(5.60)
	2, n (%)	43	(6.00)
	3, n (%)	56	(7.90)
	4 or more, n (%)	572	(80.50)

4.2.4 Time in Programming

There were two types of Service Questionnaires (SQ): program version and therapist/counselor version. The program version counts the length of time participants were in any program whereas the therapist/counselor version counts the number of times care recipients visited a therapist/counselor. Approximately, 85% of the participants reported either the length of the time they had been in the program or the number of times they had seen therapist/counselor. Among them, 64% reported the length of time they had been in their program and the remaining reported the number of times they had seen their therapist/counselor. Of the participants who reported the length of the times, half of them were in a program for more than a year and the remaining were in a program less than one year. The majority of the participants that visited therapist/counselor (80%) did so more than three times.

4.2.5 Service Ratings

The ratings of all service areas including respect, culture, empowerment and outcome of the Service Questionnaires are presented in Table 7. Overall, programs received highly positive feedback in each of the four factors measured. The average scores were above 4.50 in all of the service areas. Noticeably, mean scores were lower for outcome variables in comparison with that of the rest of the service areas. This result suggests that participant's goals were met less satisfactorily than that of other service areas.

Table 7

Total Sample Service Ratings, SQ factor (subscale) Number, Means, Standard Deviation, Range, Minimum, and Maximum.[4]

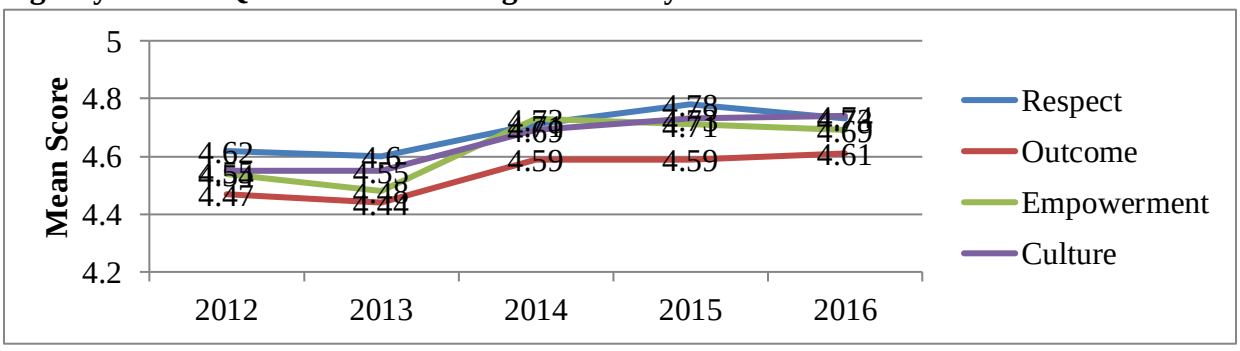
Factor	*n*[5]	Mean Score[6]	SD[7]	Range[8]	Minimum Score	Maximum Score
Respect	2227	4.68	.640	3.67	1.33	5.00
Culture	2224	4.65	.640	4.00	1.00	5.00
Empowerment	2220	4.63	.653	4.00	1.00	5.00
Outcome	2222	4.54	.675	4.00	1.00	5.00

4.2.5.1 Service Ratings by Year

Figure 1 provides participant questionnaires' service ratings of respect, outcome, empowerment and culture from 2012 to 2016. Overall, the mean service ratings were high in all the years. It could be noted from the graph that means service ratings increased after 2014. In all the years, outcome was rated lower than the rest of the service areas.

Figure 1

Agency Service Questionnaire Ratings Results by Year



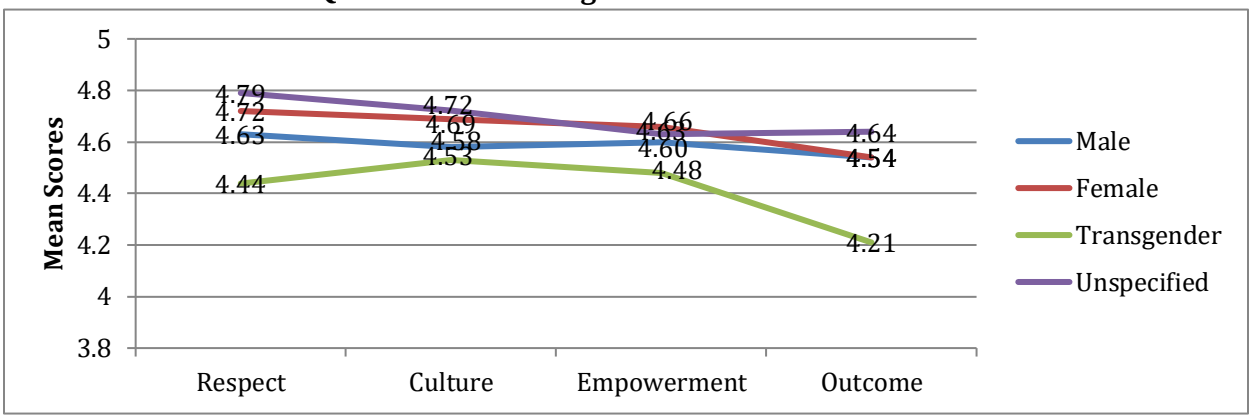
[4]**Minimum & Maximum Scores:** The lowest and highest scores indicated
[5]***n*:** Sample size of a particular group
[6]**Mean Score (*M*):** The average of the numbers.
[7]**Standard Deviation (*SD*):** Tells us how the data is distributed and how spreads out the results/numbers are from the mean score. It is the deviation from the mean score. Small standard deviations tell us that most responses were close to the mean, while higher standard deviations tell us that most responses were far from the mean. Based on the *Bell Curve/Normal Distribution* of scores, generally, most scores will be at or near the mean and fewer scores will be at the margins
[8]**Range:** Measures the spread of data between the minimum and maximum score for a particular grouping/question in order to look at how much variation occurred.

4.2.5.2 Service Ratings by Gender

Figure 2 shows participant's gender based service questionnaire ratings in all service areas including respect, culture, empowerment and outcome. Both male and female participants rated high in all the service areas than that of transgender participants. This evidence suggests that both male and female were more satisfied with the services they were getting from the organizations than transgender participants. Additionally, this is also noticeable from the mean scores of outcome that were lower among transgender participants than the rest. This evidence suggests that there is some difference in how transgender participants experience the programs compared to males and females. However, this result should be used with cautious as the population sizes for this particular group was very small compare to the rest of the groups.

Figure 2

Gender based Service Questionnaire ratings



4.2.5.3 Service Ratings by Age Groups

Table 8 summarizes the service ratings by different aged groups. Reported ages of SQ respondents ranged from 3 to 86 that were categorized into five categories; ≤ 15, 16-30, 31-45, 46-60, and 61 ≥. Overall, the mean scores in all the service areas except respect were reported higher by the seniors than the younger participants. The evidence suggests that younger

participants felt less empowered, less culturally respected and their skills and goals were met less satisfactorily when compared to seniors. Nonetheless, the satisfaction ratings were high overall.

Table 8

Aged based service ratings (N=2269)

Factor	Age	*n*	Mean	SD[9]	Minimum	Maximum
Respect	≤ 15	215	4.68	.679	1.67	5.00
	16-30	889	4.63	.652	1.33	5.00
	31-45	598	4.71	.629	1.67	5.00
	46-60	283	4.76	.570	2.00	5.00
	61 ≥	72	4.69	.693	1.67	5.00
Outcome	≤ 15	215	4.30	.839	1.67	5.00
	16-30	888	4.56	.633	1.67	5.00
	31-45	598	4.54	.663	1.67	5.00
	46-60	289	4.60	.663	1.67	5.00
	61 ≥	72	4.65	.627	2.33	5.00
Empowerment	≤ 15	214	4.54	.751	1.00	5.00
	16-30	887	4.62	.627	1.00	5.00
	31-45	597	4.65	.641	1.00	5.00
	46-60	282	4.65	.683	1.00	5.00
	61 ≥	71	4.72	.607	2.33	5.00
Culture	≤ 15	214	4.54	.711	1.67	5.00
	16-30	889	4.57	.683	1.00	5.00
	31-45	598	4.75	.569	1.00	5.00
	46-60	484	4.73	.593	2.00	5.00
	61 ≥	72	4.72	.536	3.00	5.00

[9] Standard deviation is an indicator of how representative the mean is of the observed data. The standard deviations presented here are small and tell us that most responses were close to the mean for each factor; most responses were within 1 standard deviation from the mean for each factor.

4.2.5.4 Service Rating by Length of Time in Program

Table 9 depicts the mean service ratings of the participants who were enrolled in different programs at New Directions. The reported mean ratings were reported higher by the participants who were enrolled for longer duration in a program than that of participants who were enrolled for shorter time. This evidence suggests that there are some differences in perceiving services by participants who enrolled longer time in programs than their counterparts. Overall, however, the ratings were high.

Table 9

Mean Factor Ratings by Participants' Length of Time in Programs(N=1192)

Factor	Time in programming	*n*	Mean	Standard Deviation[10]	Minimum	Maximum
Respect	Less than 1 Months	118	4.55	.622	2.67	5.00
	1 to 3 Months	243	4.56	.658	1.67	5.00
	4 to 6 Months	75	4.70	.605	2.33	5.00
	7 Months to 1 Year	122	4.57	.760	1.67	5.00
	More than 1 Year	617	4.60	.736	1.67	5.00
Outcome	Less than 1 Months	118	4.43	.642	1.67	5.00
	1 to 3 Months	243	4.56	.636	1.67	5.00
	4 to 6 Months	75	4.61	.540	3.00	5.00
	7 Months to 1 Year	122	4.57	.711	1.67	5.00
	More than 1 Year	617	4.64	.640	1.67	5.00
Empowerment	Less than 1 Months	118	4.43	.707	1.67	5.00
	1 to 3 Months	242	4.61	.562	2.67	5.00
	4 to 6 Months	75	4.62	.641	1.67	5.00
	7 Months to 1 Year	122	4.63	.789	1.00	5.00
	More than 1 Year	615	4.71	.611	1.00	5.00

[10] Standard deviation is an indicator of how representative the mean is of the observed data. The standard deviations presented here are small and tell us that most responses were close to the mean for each factor; most responses were within 1 standard deviation from the mean for each factor.

Culture	Less than 1 Months	118	4.38	.727	1.33	5.00
	1 to 3 Months	243	4.44	.726	1.00	5.00
	4 to 6 Months	75	4.68	.666	2.33	5.00
	7 Months to 1 Year	122	4.63	.607	2.33	5.00
	More than 1 Year	616	4.64	.692	1.33	5.00

4.2.5.5 Service Rating by number of visit to a Therapist/Counselor

Table 10 shows the mean service ratings of the participants based on the number of visits to a therapist or a counselor. The mean service ratings of the participants were reported higher by the participants who visited a therapist/counselor more times than those who did not. Satisfaction was nonetheless high overall.

Table 10

Mean Factor Ratings by Participants' Visit with Therapist/Counselor (N=711)

Factor	Visit With Therapist/Counselor	*n*	Mean	SD[11]	Minimum	Maximum
Respect	1	40	4.62	.655	2.67	5.00
	2	42	4.70	.782	1.67	5.00
	3	56	4.79	.429	2.33	5.00
	4 or More	565	4.82	.422	1.67	5.00
Outcome	1	40	4.12	.785	1.67	5.00
	2	42	4.23	.915	1.67	5.00
	3	56	4.30	.635	3.00	5.00
	4 or More	564	4.53	.671	1.67	5.00
Empowerment	1	39	4.55	.669	1.67	5.00
	2	42	4.55	.733	2.67	5.00
	3	56	4.62	.610	1.67	5.00
	4 or More	564	4.67	.607	1.00	5.00

[11] Standard deviation is an indicator of how representative the mean is of the observed data. The standard deviations presented here are small and tell us that most responses were close to the mean for each factor; most responses were within 1 standard deviation from the mean for each factor.

Culture	1	40	4.61	.639	1.33	5.00
	2	42	4.73	.643	1.00	5.00
	3	56	4.75	.445	2.33	5.00
	4 or More	565	4.78	.503	2.33	5.00

4.2.5.6 Service Rating by Questionnaire Versions

Table 11 depicts service mean scores with standard deviations of the participants by questionnaire versions. Overall, program received high mean scores in all of the service areas for each of the four questionnaire versions. Participants who were given regular 12 service questionnaire version rated the lowest than that of regular 8, regular 4 and counselor 12. This evidence suggests that service ratings may differ with the version of the questionnaire that participants were given to complete. SQ 4 had the highest mean scores whereas SQ12 regular had the lowest.

Table 11

Respondents Service Ratings by Questionnaire Versions

Factor	Visit With Therapist/Counselor	*n*	Mean	SD[12]	Minimum	Maximum
Respect	Regular 12	1211	4.60	.679	1.33	5.00
	Regular 8	368	4.76	.551	1.67	5.00
	Regular 4	294	4.80	.622	1.67	5.00
	Counselor 12	350	4.69	.577	2.22	5.00
Outcome	Regular 12	1207	4.41	.665	1.00	5.00
	Regular 8	368	4.69	.644	1.67	5.00
	Regular 4	295	4.72	.771	1.67	5.00
	Counselor 12	350	4.67	.560	1.67	5.00

[12] Standard deviation is an indicator of how representative the mean is of the observed data. The standard deviations presented here are small and tell us that most responses were close to the mean for each factor; most responses were within 1 standard deviation from the mean for each factor.

Empowerment	Regular 12	1207	4.50	.716	1.00	5.00
	Regular 8	367	4.78	.550	1.67	5.00
	Regular 4	295	4.82	.565	1.67	5.00
	Counselor 12	349	4.79	.472	2.22	5.00
Culture	Regular 12	1210	4.57	.671	1.00	5.00
	Regular 8	368	4.76	.551	1.67	5.00
	Regular 4	294	4.80	.622	1.67	5.00
	Counselor 12	350	4.67	.588	2.22	5.00

4.2.5.7Service Rating by Program Type

Table 12 depicts the respondents mean score by program type. Families felt more respected, empowered and felt their culture was treated more respectfully than the rest of the participants. Outcome was rated higher by adults with intellectual disabilities whereas families rated this service area lower. Children, Youth, Young Adults (CFS) rated lowest in the service area of culture. Overall, most of the respondents in all of the programs scored high in all service areas.

Table 12

Respondents Service ratings by Program Type

Factor	Program Type	*n*	Mean	Standard Deviation[13]	Minimum	Maximum
Respect	Children, Youth, Young Adults (CFS)	603	4.63	.636	1.33	5.00
	Families	1040	4.77	.531	1.67	5.00
	Adult with Intellectual Disabilities	584	4.56	.781	1.67	5.00
Outcome	Children, Youth, Young Adults (CFS)	603	4.58	.612	1.67	5.00
	Families	1037	4.45	.716	1.00	5.00
	Adult with Intellectual Disabilities	582	4.65	.645	1.67	5.00
Empowerment	Children, Youth, Young Adults (CFS)	602	4.63	.606	1.00	5.00
	Families	1037	4.77	.672	1.00	5.00
	Adult with Intellectual Disabilities	581	4.56	.660	1.00	5.00
Culture	Children, Youth, Young Adults (CFS)	602	4.50	.683	1.00	5.00
	Families	1040	4.73	.559	1.33	5.00
	Adult with Intellectual Disabilities	582	4.65	.689	1.33	5.00

[13] Standard deviation is an indicator of how representative the mean is of the observed data. The standard deviations presented here are small and tell us that most responses were close to the mean for each factor; most responses were within 1 standard deviation from the mean for each factor.

4.3 Bivariate Psychometric Results

The bivariate results show an association between different demographic variables and service areas which are presented from table 13-20.

4.3.1 Gender and Perceived Service Areas for SQ12-5

Table 13 shows the association of service areas and gender for SQ 12-5. According to the table (Chi-square test), there is a statistically significant association between gender and the service areas; respect ($P \leq 0.016$), culture ($P \leq 0.000$) and empowerment ($P \leq 0.002$). However, no statistically significant association was found for gender and outcome domain. Female participants felt they more highly respected, empowered, and culturally respected compared to male respondents.

Table 13

Gender based Service experience of Respect, Culture, Empowerment and Outcome for Service Questionnaire 12-5

Service areas	Level	Gender			
		Unspecified (n)	Male (n, %)	Female (n, %)	Transgender (n)
Respect 12-5 ($\chi^2 = 10.36$, $P \leq 0.016$)	Low	2	120 (30)	170 (23)	2
	High	8	274 (70)	593 (77)	2
Culture 12-5 ($\chi^2 = 27.47$, $P \leq 0.000$)	Low	1	119 (30)	128 (17)	2
	High	8	279 (70)	628 (83)	2
Empowerment12-5 ($\chi^2 = 14.76$, $P \leq 0.002$)	Low	2	122 (30)	155 (21)	1
	High	6	274 (70)	601 (79)	3
Outcome 12-5 ($\chi^2 = 6.82$, $P \leq 0.078$)	Low	1	67 (17)	123 (16)	3
	High	7	330 (83)	633 (84)	1

4.3.2 Gender and Perceived Service Areas for SQ 12-3

Gender based Service experience of Respect, Culture, Empowerment and Outcome for Service Questionnaire 12-3 was calculated and no significant association was found.

Table 14

Gender based Service experience of Respect, Culture, Empowerment and Outcome for Service Questionnaire 8-3

Service areas	Level	Gender			
		Unspecified (n)	Male (n, %)	Female (n)	Transgender (n)
Respect 8 ($\chi^2 = 9.62$, P≤0.023)	Low	0	23(15)	13 (6)	0
	High	4	128 (85)	204 (94)	1

4.3.3 Gender and Perceived Service Areas for SQ 8-3

Table 14shows the association of service areas and gender for SQ 8-3. According to the table (Chi-square test), there was a statistically significant association between gender and service areas of respect (P≤0.023). No statistically significant association was found between gender and service areas of culture, empowerment and outcome. It could be said from the table that females are more likely to perceive being respected than male.

4.3.4 Age and Perceived Service Areas for SQ12-5

Table 15 shows the association of service areas and age for SQ 12-5. According to the table (Chi-square test), there was a statistically significant association between age and all of the service areas; respect (P≤0.002), culture (P≤0.000), empowerment (P≤0.003) and outcome (P≤0.011). Overall, seniors were more likely to feel being respected, empowered, culturally respected and outcome the services were also met more expectedly by them compared to younger people.

Table 15

Age based Service experience of Respect, Culture, Empowerment and Outcome for Service Questionnaire 12-5

Service areas	Level	Age				
		Below 16 n, (%)	17-30 n, (%)	31-45 n, (%)	46-60 n, (%)	61 and upper n, (%)
Respect 12-5 (χ^2 = 16.57, P≤0.002)	Low	27 (34)	117 (32)	89 (21)	36 (22)	8 (23)
	High	53 (66)	252 (68)	338 (79)	130 (78)	27 (77)
Culture 12-5 (χ^2 = 59.72, P≤0.000)	Low	28 (34)	119 (32)	49 (12)	27 (17)	9 (26)
	High	52 (66)	252 (68)	371(88)	137 (83)	26 (74)
Empowerment 12-5 (χ^2 = 15.94, P≤0.003)	Low	28 (34)	108 (30)	81(19)	40 (24)	9 (26)
	High	52 (66)	258 (70)	341(81)	126 (76)	26 (74)
Outcome 12-5 (χ^2 = 13.11, P≤0.011)	Low	24 (30)	64 (17)	61(14)	28 (17)	3 (9)
	High	57 (70)	302 (83)	363(86)	136 (83)	32 (91)

Table 16

Age based Service experience of Respect, Culture, Empowerment and Outcome for Service Questionnaire 12-3

Service areas	Level	Age				
		Below 16 n(%)	17-30 (n)	31-45 n(%)	46-60 n(%)	61 and upper n(%)
Culture 12-3 (χ^2 = 16.80, P≤0.002)	Low	3 (9)	45(19)	2 (6)	0 (0)	0 (0)
	High	10 (91)	198 (81)	33 (94)	24 (100)	10 (100)
Empowerment 12-3 (χ^2 = 16.52), P≤0.002)	Low	3 (9)	27 (11)	0 (0)	0 (0)	0 (0)
	High	10 (91)	216 (81)	35 (100)	24 (100)	10 (100)
Outcome 12-3 (χ^2 = 11.95, P≤0.018)	Low	5 (38)	39 (16)	3 (9)	1 (4)	0 (0)
	High	8 (62)	204 (84)	32 (91)	23 (96)	10 (100)

4.3.5 Age and Perceived Service Areas for SQ12-3

Table 16shows the association of service areas and age for respondents of SQ 12-3. According to the table (Chi-square test), there was a statistically significant association between age and all of the service areas; culture (P≤0.002), empowerment (P≤0.002) and outcome (P≤0.018) except respect. Overall, adults 17 to 30 years of age were less likely to feel empowered, culturally respected and outcome the services were also met less expectedly by them compared to the remaining participants.

Table 17

Age based Service experience of Respect, Culture, Empowerment and Outcome for Service Questionnaire 8-3

Service areas	Level	Age				
		Below 16 (n)	17-30 (n)	31-45 (n)	46-60 (n)	61 and upper (n)
Empowerment 8-3 (χ^2 = 16.58, P≤0.002)	Low	19 (29)	29 (20)	11 (14)	2 (4)	0 (0)
	High	47 (71)	118 (80)	66 (86)	48 (96)	15 (100)
Outcome 8-3 (χ^2 = 34.22, P≤0.000)	Low	32 (48)	34 (23)	11 (14)	4 (8)	2 (13)
	High	34 (52)	113 (77)	66 (86)	46 (92)	13 (87)

4.3.6 Age and Perceived Service Areas for SQ8-3

Table 17shows the association of service areas and age for SQ 8-3. According to the table (Chi-square test), there was a statistically significant association between age and service areas of empowerment (P≤0.002) and outcome (P≤0.000). No statistically significant association was found between age and respect and culture domains. Overall, younger participants were less likely to feel empowered and outcome of services were also met less expectedly by them compared to older individuals.

4.3.7 Duration in Programs and Perceived Service Areas for SQ12-5

Table 18 shows the association of service areas and times participants were in programs as per SQ 12-5. According to the table (Chi-square test), there was a statistically significant association between time in program and service areas of culture (P≤0.045) and empowerment (P≤0.011). No statistically significant association was found between time in program and respect and empowerment. Overall, who received services for more than three months were more likely feel to be culturally respected and empowered compared to the who got services for less time.

Table 18

Relationship between duration in program and Perceived Service areas for Service Questionnaire 12-5

Service areas	Level	Duration in Program				
		Less Than 1 Months n(%)	1-3 Months n(%)	4-6 Months n(%)	7 Months-1 year n(%)	More than 1 year n(%)
Culture 12-5 ($\chi^2 = 9.76$, $P \leq 0.045$)	Low	25 (38)	35 (44)	9 (31)	14 (35)	53 (26)
	High	40 (62)	44 (56)	20 (69)	26 (65)	149 (74)
Empowerment 12-5 ($\chi^2 = 13.09$, $P \leq 0.011$)	Low	26 (40)	30 (38)	6 (21)	11 (28)	44 (22)
	High	39 (60)	49 (62)	23 (79)	28 (72)	158 (78)

4.3.8 Duration in Programs and Perceived Service Areas for SQ12-3

Chi-square tests for cross-tabulation were also performed between time in program and service domains for SQ 12-3. No statistically significant association was found between time in program and service domains.

4.3.9 Duration in Programs and Perceived Service Areas for SQ8-3

Chi-square test for cross-tabulation was also performed between time in program and service domains for SQ 8-3. According to the table 19 (Chi-square test), there was a statistically significant association between time in program and service areas of respect ($P \leq 0.001$) and culture ($P \leq 0.011$).No statistically significant association was found between time in program and service domains of empowerment and outcome. Overall, participants who received services for more than three months were more likely to feel respected and culturally respected compared to the participants who received services for less time.

Table 19

Relationship between duration in program and service areas for Service Questionnaire 8-3

Service areas	Level	Duration in Program				
		Less Than 1 Months n(%)	1-3 Months n(%)	4-6 Months n(%)	7 Months-1 year n(%)	More than 1 year n(%)
Respect 8-3 (χ^2 = 17.94, P≤0.001)	Low	4 (57)	4 (19)	1(13)	0 (0)	18 (12)
	High	3 (43)	17 (81)	7 (87)	35(100)	126 (88)
Culture 8-3 (χ^2 = 12.96, P≤0.011)	Low	3 (43)	10 (48)	0 (0)	6 (17)	29 (20)
	High	4 (57)	11 (52)	8 (100)	29 (83)	115 (80)

4.3.10 Number of Times Care Recipient's SawTherapist/Counselor and Perceived Service Areas for SQ12-5 and SQ12-3

Chi-square test for cross-tabulation was also performed between time client visited therapist/counselor and service domains for SQ 12-5 and12-3. No statistically significant association was found between time in program and service domains.

Table 20

Relationship between duration in program and service areas for Service Questionnaire 8-3

Service areas	Level	Time Client Seen Therapist/Counselor			
		1 n(%)	2 n(%)	3 n(%)	4 or more n(%)
Empowerment 8-3 (χ^2 = 12.10, P≤0.007)	Low	1(17)	2 (29)	2 (100)	9 (8)
	High	5 (83)	5 (71)	0 (0)	109 (92)
Outcome8-3 (χ^2 = 13.17, P≤0.004)	Low	5 (83)	3 (43)	1(50)	22 (19)
	High	1 (17)	4 (57)	1 (50)	96 (81)

4.3.11Number of Times Care Recipients Saw Therapist/Counselor and Perceived Service Areas for SQ8-3

Chi-square test for cross-tabulation was performed between times in program and service domains for SQ 8-3. According to table 20 (Chi-square test), there was a statistically significant association between the amount of time care recipients saw therapist/counselor and service areas of empowerment ($P \leq 0.007$) and outcome ($P \leq 0.004$).No statistically significant association was found between time care recipients saw therapist/counselor and service domains of respect and culture. The result of the relationship between times care recipients saw therapist/counselor should be interpreted with caution because of the population distribution was not equal. For example, only two participants had seen therapist/counselor for three times. Thus, this result is not included in the analysis. It could be said from this table that those participants who visited therapist/counselor more times are more likely to feel empowered and feel that their outcome from the service was more likely met than those who visited less times.

4.4.1 Basic Scale Data for Factor Analysis

The mean of each of the four subscales was calculated after recoding the reverse scores. The scores for 3 point Likert scale were transformed into a 5 point Likert scale. The mean score was calculated by adding the scores for each item of a subscale for all of the versions and then divided by the item number. Mean scores of respect, culture, empowerment and outcomes were 4.68, 4.65, 4.63 and 4.54 respectively on a scale of 1 disagree strongly to 5 agree strongly. Most of the participants reported high mean scores. There were participants who reported both low and high levels of mean scores for respect, culture, empowerment and outcome. The means, standard deviations and ranges are reported in table 7.

The normality of the score items was calculated. The means, standard deviations, skewness and kurtosis for individual items for SQ12-5, SQ8-3 and SQ12-3 were reported in table 21, 22 and 23 accordingly. Univariate outliers were also examined using Z value (Tabachnick&Fidell, 2007). Multivariate outliers were also examined using Mahalanobis analysis. Data were transformed using log 10 transformation methods as most of the data were severely skewed negatively. This transformed data were used for further analysis.

Table 21

Means, Standard Deviations, Skewness and Kurtosis for Service Questionnaire (SQ 12-5)

Item	N	Mean	Standard Deviation	Skewness[14]	Kurtosis[15]	Skewness[16]	Kurtosis[17]
SQ12-5.1: *I feel that (program) has supported my contact with my culture as much as possible./I feel that my therapist/clinician has been sensitive to my values and beliefs*	1194	4.58	.811	-2.205	4.997	-1.197	-.348
SQ12-5.2r: *I have felt that (program) staff did **not** respect me.*	1194	4.65	.946	-2.844	7.071	-2.122	2.756
SQ12-5.3:Since starting the (program), I feel better about myself	1193	4.27	.882	-1.159	1.051	-.184	-1.748
Sq12-5.4: I have felt appreciated and valued by staff of program I have felt appreciated and valued by my therapist	1195	4.61	.725	-2.013	4.069	-1.153	-.471
Sq12-5.5: While in the (program), I learned helpful things	1195	4.55	.729	-1.696	2.956	-.827	-1.131
SQ 12-5.6: I felt that my culture was treated with respect in the (program). /I have felt that my values and beliefs were treated with respect in the (program).	1192	4.63	.765	-2.429	6.435	-1.337	.022
*Sq12-5.7r: I have felt that staff do**not** pay attention to what is important to me. /I have felt that my therapist/clinician does **not** pay attention to what is important to me.*	1197	4.53	1.053	-2.252	3.921	-1.586	.709
Sq12-5.8: I feel I have the opportunity to make my own choices	1192	4.55	.821	-2.082	4.303	-1.075	-.618
Sq12-5.9: I feel culture is important in the (program)./I have felt my values and beliefs are important in my sessions at the (program).	1190	4.50	.845	-1.752	2.765	-.906	-.994
Sq12-5.10 I have felt staff help me to plan my own goals	1189	4.52	.828	-1.879	3.477	-.916	-.953
Sq12-5.11 Staff have helped me to learn where to get help when I want it I feel my therapist/clinician has helped me to learn where to get help when I want it	1187	4.42	.862	-1.576	2.305	-.628	-1.405
Sq12-5.12 The (program) influenced how I do some things	1186	4.40	.819	-1.461	2.301	-.420	-1.614

[14] Skewness Before data transformation
[15] Kurtosis before data transformation
[16] Skewness after data transformation
[17] Kurtosis after data transformation

Table 22

Means, Standard Deviations, Skewness and Kurtosis for Service Questionnaire (SQ 8-3)

Items	N	Mean	Standard Deviation	Skewness[18]	Kurtosis[19]	Skewness[20]	Kurtosis[21]
SQ8-3.1: I feel that (program) has supported my contact with my culture	359	2.82	.448	-2.594	6.187	-2.077	2.516
SQ8-3.2:I feel the program respects me	362	2.92	.315	-4.410	20.237	-3.711	12.219
SQ8-3.3: Since starting the program, I feel better about myself	360	2.79	.472	-2.185	4.094	-1.713	1.088
SQ8-3.4: I feel staff care about what is important to me	359	2.90	.365	-3.985	15.855	-3.359	9.681
SQ8-3.5: I feel staff respect people's culture	360	2.88	.377	-3.419	11.678	-2.827	6.284
SQ8-3.6: While in the program I learned things that will help me	361	2.84	.399	-2.550	6.061	-2.122	2.652
SQ8-3.7: The staff help me do the things that are important to me	359	2.86	.383	-2.609	6.370	-2.209	3.023
SQ8-3.8: The staff help me to keep on trying	358	2.87	.389	-3.171	9.933	-2.608	5.059

[18] Skewness Before data transformation
[19] Kurtosis Before data transformation
[20] Skewness after data transformation
[21] Kurtosis after data transformation

Table 23

Means, Standard Deviations, Skewness and Kurtosis for Service Questionnaire (SQ 12--3)

Items	N	Mean	Standard Deviation	Skewness[22]	Kurtosis[23]	Skewness[24]	Kurtosis[25]
SQ12-3.1: *I feel that (program) has supported my contact with my culture as much as possible./I feel that my therapist/clinician has been sensitive to my values and beliefs*	356	2.81	.447	-2.306	4.731	-1.843	1.550
SQ12-3.2r: *I have felt that (program) staff did **not** respect me.*	360	2.78	.565	-2.408	4.438	-2.037	2.339
SQ12-3.3:Since starting the (program), I feel better about myself	359	2.77	.482	-2.020	3.341	-1.566	.592
Sq12-3.4: I have felt appreciated and valued by staff of program I have felt appreciated and valued by my therapist	359	2.87	.374	-3.003	8.905	-2.503	4.470
Sq12-3.5: While in the (program), I learned helpful things	358	2.88	.384	-3.285	10.722	-2.708	5.609
SQ 12-3.6: I felt that my culture was treated with respect in the (program). /I have felt that my values and beliefs were treated with respect in the (program).	360	2.86	.387	-2.529	5.899	-2.143	2.725
*Sq12-3.7r: I have felt that staff do**not** pay attention to what is important to me. /I have felt that my therapist/clinician does **not** pay attention to what is important to me.*	357	2.65	.626	-1.572	1.240	-1.124	-.589
Sq12-3.8: I feel I have the opportunity to make my own choices	359	2.89	.342	-3.375	11.582	-2.849	6.357
Sq12-3.9: I feel culture is important in the (program)./I have felt my values and beliefs are important in my sessions at the (program).	358	2.75	.498	-1.910	2.858	-1.458	.259
Sq12-3.10 I have felt staff help me to plan my own goals	359	2.82	.452	-2.523	5.802	-2.014	2.247
Sq12-3.11 Staff have helped me to learn where to get help when I want it I feel my therapist/clinician has helped me to learn where to get help when I want it	359	2.89	.320	-2.779	6.725	-2.592	4.800
Sq12-3.12 The (program) influenced how I do some things	358	2.76	.483	-1.872	2.719	-1.449	.220

[22] Skewness Before data transformation
[23] Kurtosis before data transformation
[24] Skewness after data transformation
[25] Kurtosis after data transformation

Principal Component Analysis was carried out to identify the component structure. The content of each version of the Service Questionnaire scale was explained further. The factor structures for these scales were determined based on parallel analysis, factor loading and scree plot analysis. Parallel analysis was conducted to examine the upper factor limit. Parallel analysis tells us the factor limit based on an eigenvalue greater than one. Factor analysis was also conducted for each version of the questionnaire comprising of original items to see if the reverse worded items made any differences on factor building. However, similar results including 2, 3 and 4 factor solutions were found. Thus, the transformed items were included for the final analysis.

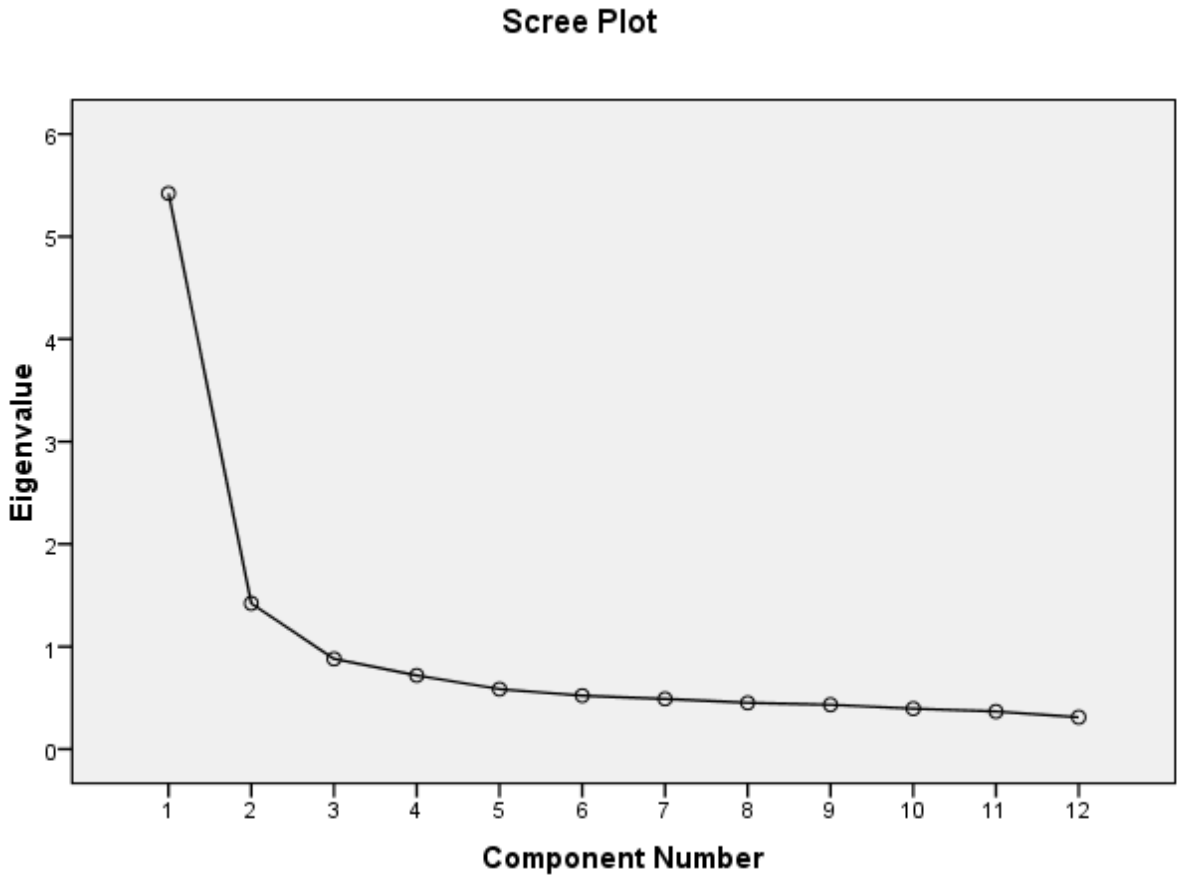
4.4.2 Factor Structure for SQ12-5

A total of 1125 participants were counted for SQ12-5 with a class interval of 95. Initial correlation of the component matrix revealed that there are large number of components having a coefficient value larger than .30 (see table 24). A Kaiser-Mayer-Olkin value of .910 exceeded the recommendation value of .60 (Kaiser 1970) and the Bartlett's test of sphericity (Bartlett, 1954) reached statistical significance at $P \leq .001$, supporting the factorability of the correlation matrix. A two factor solution was found for SQ12-5 having eigenvalues greater than one; 5.42 and 1.42 explaining 57.07% of the variance. Inspection of the scree plot revealed a clear break after the second component (see figure 3). Items loading .50 and above were included for interpretations. Variables having eigenvalues less than .25 in loading were not included in interpretation. To aid in the interpretation of the two components, Varimax factor rotation was performed. Table 25 shows the factor loadings of the scale items. ItemsSQ12-5.1, SQ12-5.4, SQ12-5.6 and SQ12-5.9 have a cross loading of approximately .30 or over. Thus, these items were identified as defective.

Factor one, included a total of 6 items and factor 2 included only 2 items. All three of the empowerment items and three of the outcome items loaded more strongly onto component 1. Two of the three respective items loaded strongly on component 2, which is identifiably a respect factor.

Figure 3

Scree Plot showing principal component analysis with Varimax rotation of SQ12-5



Based on the result of PCA, the author could not specify a model that comprised of all 12 items of SQ12-5. Problems with 12 items PCA included: a) few items were found having cross loading across different factors; b) component having items from mixed factors. Component one

that was exceptionally defined by few items having two themes; outcome and empowerment, suggesting investigating further for content validation as wording of these items were very similar. For example, item 11 (*SQ12-5.11: Staff have helped me to learn where to get help when I want it/I feel my therapist/clinician has helped me to learn where to get help when I want it*) that measure empowerment and item 5 *(SQ12-5.5: While in the program, I learned helpful things)* that measure outcome were much closer in wording. These two items might be difficult to differentiate by the participants. In fact, a person may easily mix these two because both phrases "staff helped me to learn where to go when needed" and "learned helpful things" could be perceived as one theme; "learning" by the . Thus, empowerment as a whole could be perceived as the outcome of a service. Component two grouped two respect items, which is clearly a respect factor. Therefore, two factor solutions could be suggestive for SQ12-5.

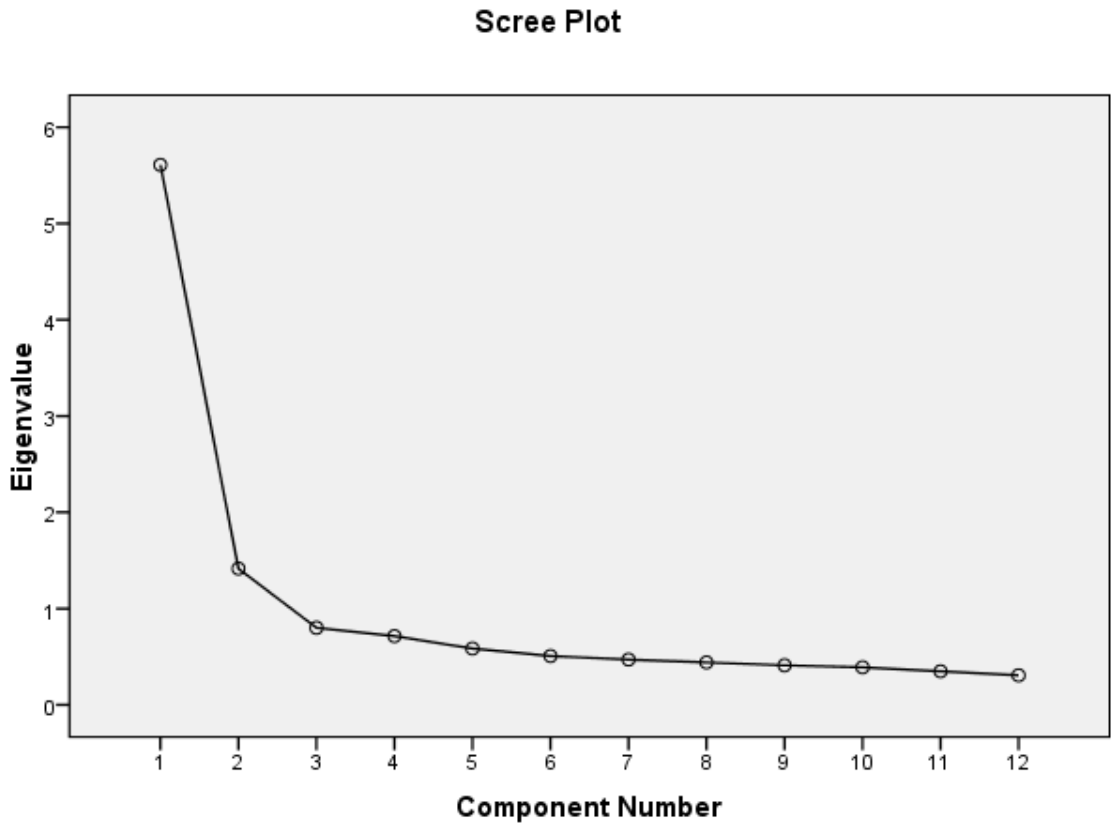
4.4.3 Factor structure for SQ12-5 for Female

A total of 782 female participants were counted for SQ12-5 with a class interval of 95. Initial correlation of the component matrix revealed the presence of a large number of components having coefficient value larger than .30 (see table 30). A Kaiser-Mayer-Olkin value of .916 exceeded the recommendation value of .60 (Kaiser 1970) and the Bartlett's test of sphericity (Bartlett, 1954) reached statistical significance at P≤ .001, supporting the factorability of the correlation matrix. A two factors solution was found having eigenvalues greater than one; 5.61 and 1.42 explaining 58.53% of the variance. Inspection of the scree plot revealed a clear break after the second component (see figure 6). Items loading .50 and above were included for interpretations. Variables having eigenvalues less than .25 in loading were not included in interpretation. To aid in the interpretation of the two components, Varimax factor rotation was

performed. Table 31 shows the factor loadings of the scale items. Items SQ12-5.1, SQ12-5.6, and SQ12-5.9 has a cross loading of approximately .30 or over. Thus, these items were identified as defective. Factor one, included a total of seven items and factor 2 included only two items. All the three of the empowerment items, three of the outcome items and one respect item loaded more strongly onto component 1. Two of the three respect items loaded strongly on component 2, which is identifiably a respect factor.

Figure 6

Scree Plot showing principal component analysis with Varimax rotation of SQ12-5 for female



Based on the result of PCA, the author could not specify a model that comprised of all 12 items of SQ12-5. Problem with 12 items PCA included: a) few items were found having cross loading across different factors, b) component having items from mixed factors. Component 1 is a clear odd having items from three different factors. Although, wording for items of empowerment and outcome were closer, one item that was from respect factor made this model very ambiguous. Component two grouped 2 respect items, which is clearly a respect factor.

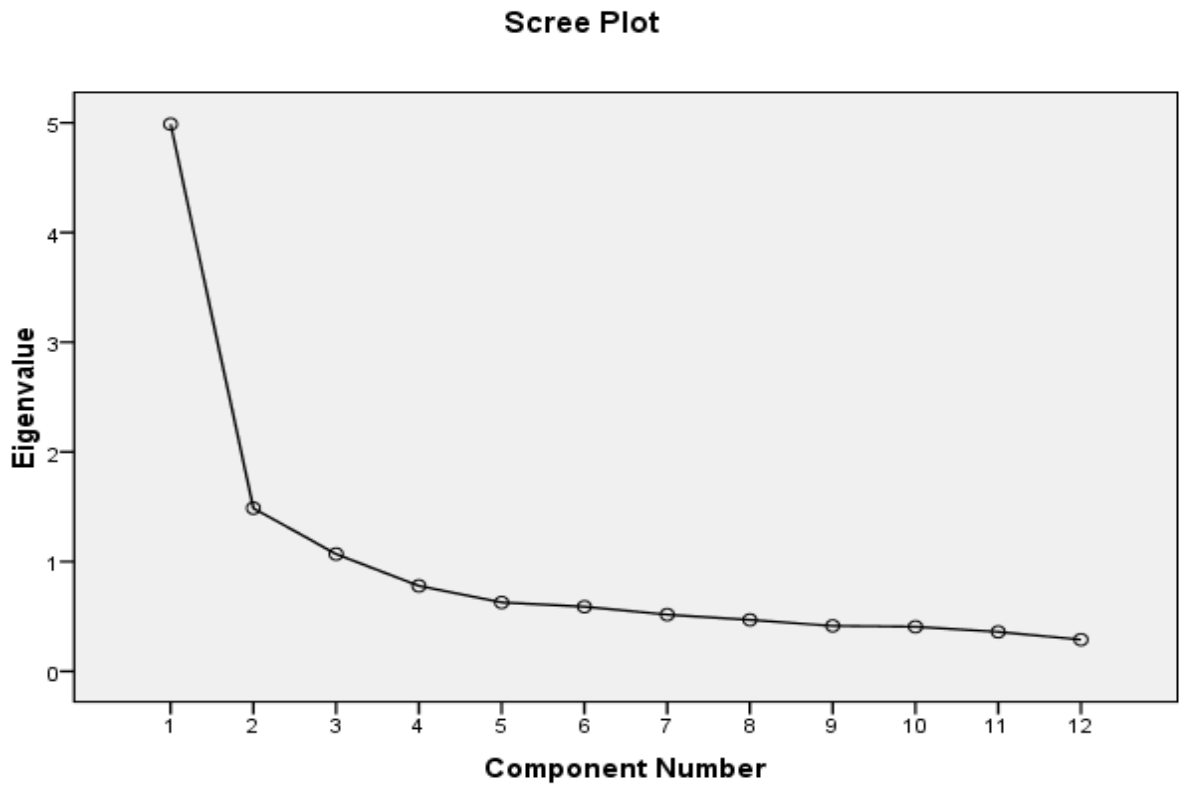
4.4.4 Factor structure for SQ12-5 for Male

A total of 413male participants were counted for SQ12-5 with a class interval of 95. Initial correlation of the component matrix revealed the presence of a large number of components having coefficient value larger than .30 (see table 32). A Kaiser-Mayer-Olkin value of .910 exceeded the recommendation value of .60 (Kaiser 1970) and the Bartlett's test of sphericity (Bartlett, 1954) reached statistical significance at P≤ .001, supporting the factorability of the correlation matrix. A tree factors solution was found for male participants having eigenvalues greater than one; 4.99, 1.49 and 1.07 explaining 62.88% of the variance. Inspection of the scree plot revealed a clear break after the third component (see figure 7). Items loading .50 and above were included for interpretations. Variables having eigenvalues less than .25 in loading were not included in interpretation. To aid in the interpretation of the two components, Varimax factor rotation was performed. Table 33 shows the factor loadings of the scale items. Items SQ12_4, SQ12_6 SQ12_8, SQ12_10 and SQ12_11 has a cross loading of approximately .30 or over. Thus, these items were identified as defective. Factor one included a total of three items, factor 2 included two items, and factor 3 included two items. All the three of the outcome items loaded more strongly onto component 1, which is clearly an outcome factor. Two of the

three culture items loaded strongly on component 2, which is identifiably a culture factor. Although item 12-5.6 which is having a cross loading of .30 was identified as defective, the loading of this item was loaded onto component 2 and that matches clearly with culture factor. The third factor loaded two of the respect items, which is identifiably a respect factor.

Figure 7

Scree Plot showing principal component analysis with Varimax rotation of SQ12-5 for Male



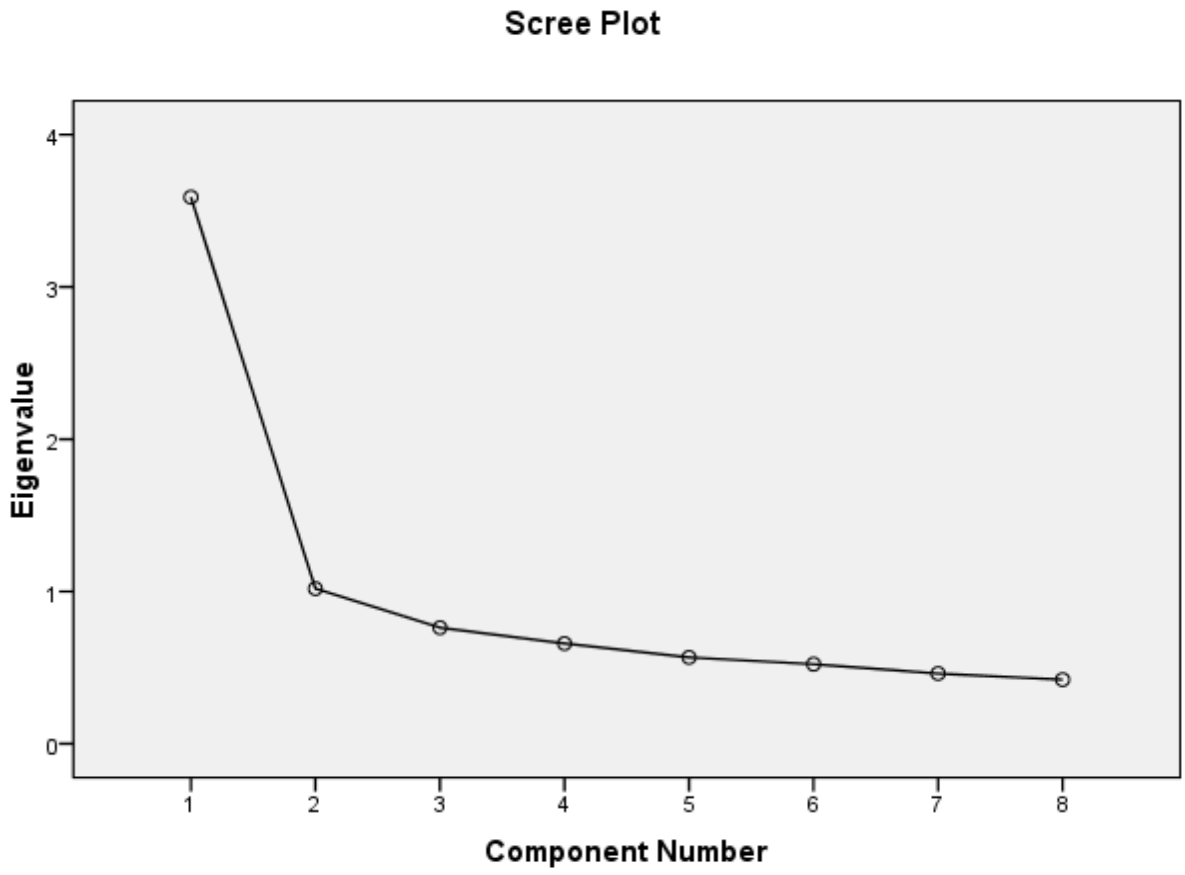
Based on the results of PCA for male, the author could not specify a model that comprised of all 12 items of SQ12-5. Problem with 12 items PCA included: a) few items were found having cross loading across different factors, b) component having items from mixed factors. Thus, a three factor solutions having 8 components was identified for the male participants of SQ12-5.

4.4.5 Factor Structure for SQ8-3

A total of 308 participants were counted for SQ8-3 with a class interval of 95. Initial correlation of the component matrix revealed the presence of a large number of components having coefficient value larger than .30 (see table26). A Kaiser-Mayer-Olkin value of .867 exceeded the recommendation value of .60 (Kaiser 1970) and the Bartlett's test of sphericity (Bartlett, 1954) reached statistical significance at P≤ .001, supporting the factorability of the correlation matrix. A two factors solution was found for SQ8-3 having eigenvalues greater than one; 3.59 and 1.01 explaining 57.60% of the variance. Inspection of the scree plot revealed a clear break after the second component (see figure 4).

Figure 4

Scree Plot showing principal component analysis with Varimax rotation of SQ8-3



Items loading .50 and above were included for interpretations. Variables having eigenvalues less than .25 in loading were not included in interpretation. To aid in the interpretation of the two components, Varimax factor rotation was performed. Table 25 shows the factor loadings of the scale items. Items SQ8-3.1, SQ8-3.7 and SQ8-3.8 has a cross loading of approximately .30 or over. Thus, these items were identified as defective. Factor one, included a total of three items and factor 2 included two items. The two respect items and one of the culture items loaded more strongly onto component 1. Two of the outcome items loaded strongly on component 2, which is identifiably an outcome factor.

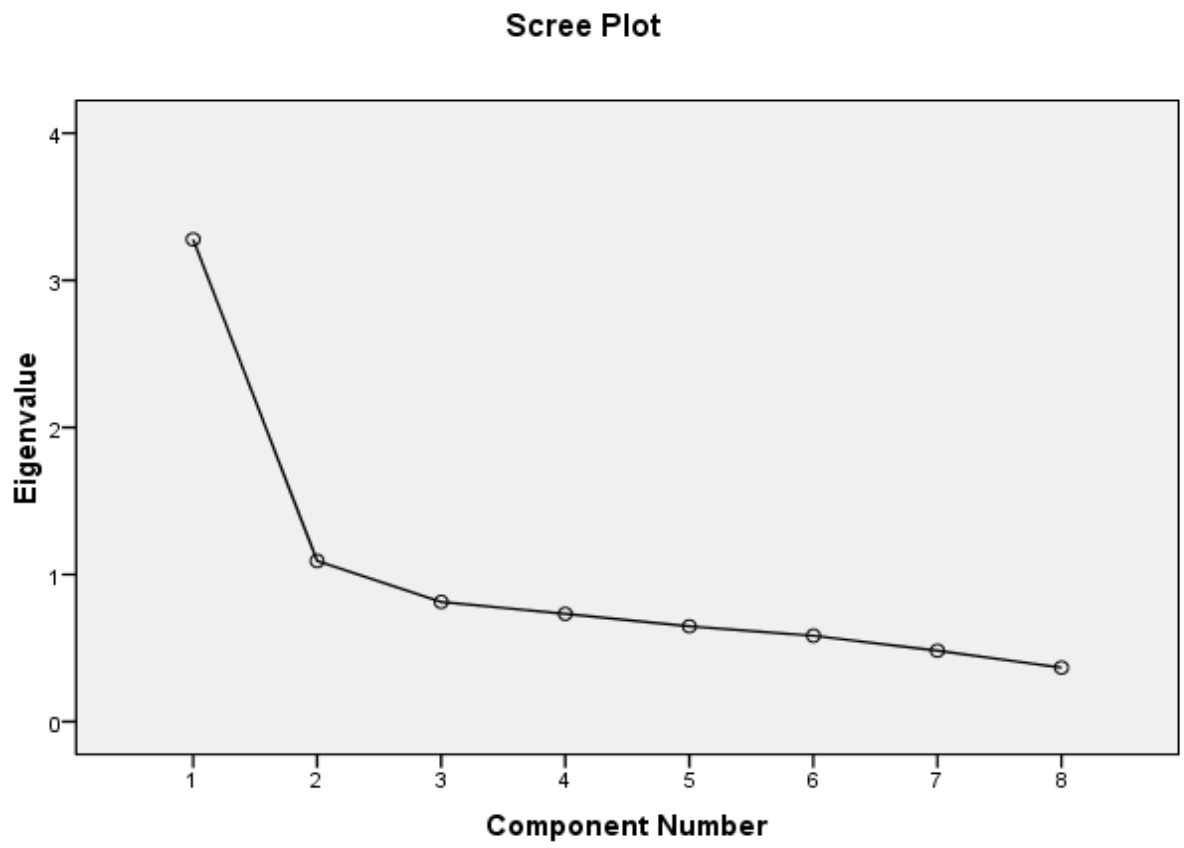
Based on the result of PCA, the author could not specify a model that comprised of all 8 items of SQ8-3. Problem with 8 items PCA included: a) few items were found having cross loading across different factors; b) component having items from mixed factors. Component one that was exceptionally defined by few items having two themes; respect and culture suggesting further investigation for content validation as wording of these items were very similar. For example, item 5 (*SQ8_3.5: I feel staff respect people's culture*) that measure culture and item 5 *(SQ8_3.2: I feel the program respects me)* that measure respect were much closer in wording. These two items might be difficult to differentiate by the participants. In fact, a person may easily mix these two because both phrases "staff *staff respect people's culture*" and "*program respects me*" could be perceived as one theme; "respect" by the . Thus, cultural respect as a whole could be perceived as the respect of a service. Component 2 grouped two items of the outcome items, which is clearly an outcome factor. Therefore, a two factor solutions could be suggested for SQ8-3.

4.4.6 Factor Structure for SQ8-3for Females

A total of 217 femaleparticipants were counted for SQ8_3 with a class interval of 95. Initial correlation of the component matrix revealed the presence of a large number of components having coefficient value larger than .30 (see table 34). A Kaiser-Mayer-Olkin value of .867 exceeded the recommendation value of .60 (Kaiser 1970) and the Bartlett's test of sphericity (Bartlett, 1954) reached statistical significance at P≤ .001, supporting the factorability of the correlation matrix. A two factors solution was found for SQ8-3 having eigenvalues greater than one; 3.27 and 1.09 explaining 54.63% of the variance. Inspection of the scree plot revealed a clear break after the second component (see figure 8).

Figure 8

Scree Plot showing principal component analysis with Varimax rotation of SQ8-3 for Female



Items loading .50 and above were included for interpretations. Variables having eigenvalues less than .25 in loading were not included in the interpretation. To aid in the interpretation of the two components, Varimax factor rotation was performed. Table 35 shows the factor loadings of the scale items. Items SQ8-3.1, SQ8-3.2, SQ8-3.7 and SQ8-3.8 has a cross loading of approximately .30 or over. Thus, these items were identified as defective. Factor 1 included a total of two items and factor 2 included two items. Two of the outcome items loaded strongly on component 1, which is identifiably an outcome factor. One of the respect items and one of the culture items loaded more strongly onto component 2.

Based on the result of PCA, the author could not specify a model that comprised of all 8 items of SQ8-3 for female participants. Even though a 2 factor solution was found based on the PCA of SQ8-3 for female participants, it is difficult to define a model for this one. The problem with 8 items PCA included: a) half items were found having cross loading across different factors; b) component having items from mixed factors.

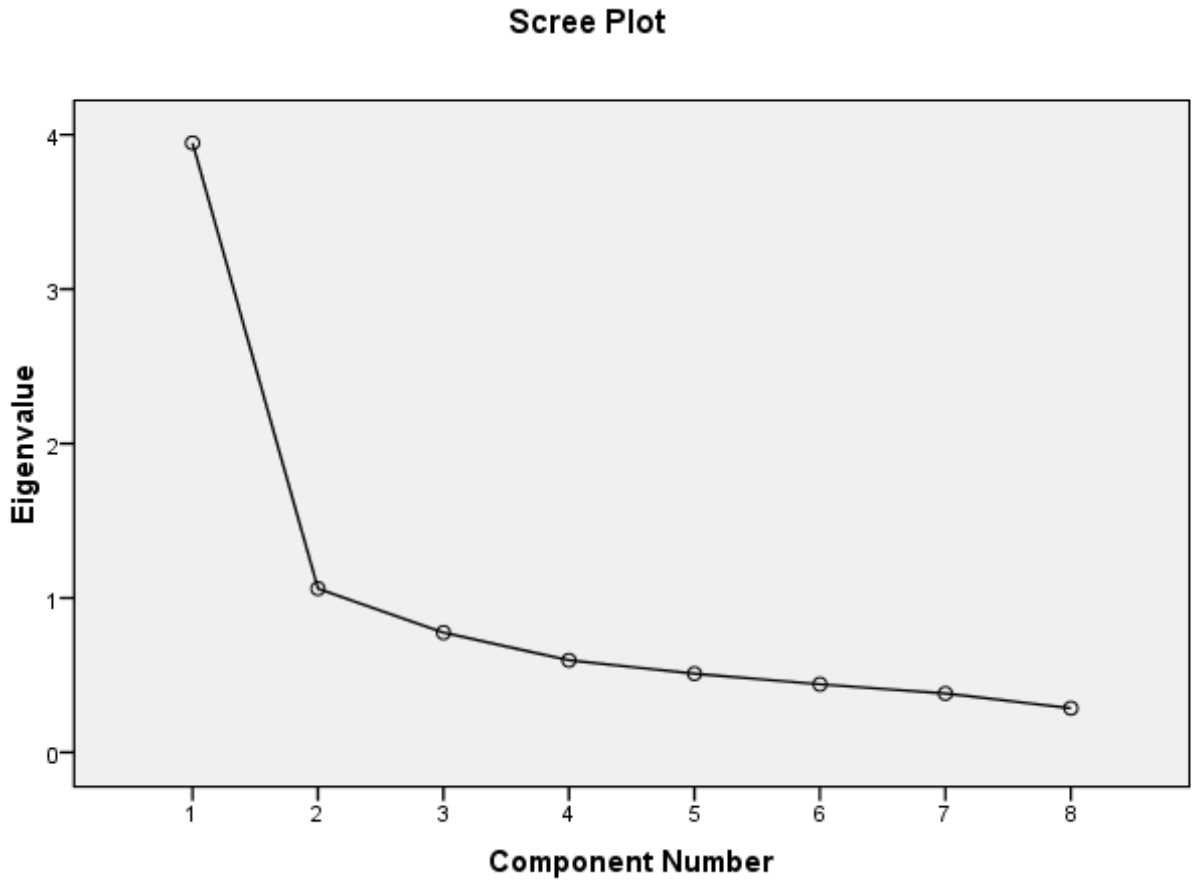
4.4.7 Factor structure for SQ8-3for Males

A total of 151 female participants were counted for SQ8-3 with a class interval of 95. Initial correlation of the component matrix revealed the presence of a large number of components having coefficient values larger than .30 (see table 36). A Kaiser-Mayer-Olkin value of .867 exceeded the recommendation value of .60 (Kaiser 1970) and the Bartlett's test of sphericity (Bartlett, 1954) reached statistical significance at $P \leq .001$, supporting the factorability of the correlation matrix. A two factor solution was found for SQ8-3 having eigenvalues greater

than one; 3.95 and 1.06 explaining 62.59% of the variance. Inspection of the scree plot revealed a clear break after the second component (see figure 9).

Figure 9

Scree Plot showing principal component analysis with Varimax rotation of SQ8-3 for Male



Items loading .50 and above were included for interpretations. Variables having eigenvalues less than .25 in loading were not included in the interpretation. To aid in the interpretation of the two components, Varimax factor rotation was performed. Table 37 shows the factor loadings of the scale items. Items SQ8-3.1, SQ8-3.4, SQ8-3.7 and SQ8-3.8 has a cross loading of approximately .30 or over. Thus, these items were identified as defective. Both factor 1 and factor 2 included two items each. One of the respect items and one of the culture items

loaded more strongly onto component 1.Two of the outcome items loaded strongly on component 2, which is identifiably an outcome factor.

Based on the result of PCA, the author could not specify a model that comprised of all 8 items of SQ8-3 for male participants. Even though a 2 factor solution was found based on the PCA of SQ8-3 for male participants, it is difficult to define a model for this one. Problems with 8 items PCA included: a) half items were found having cross loading across different factors, b) component having items from mixed factors.

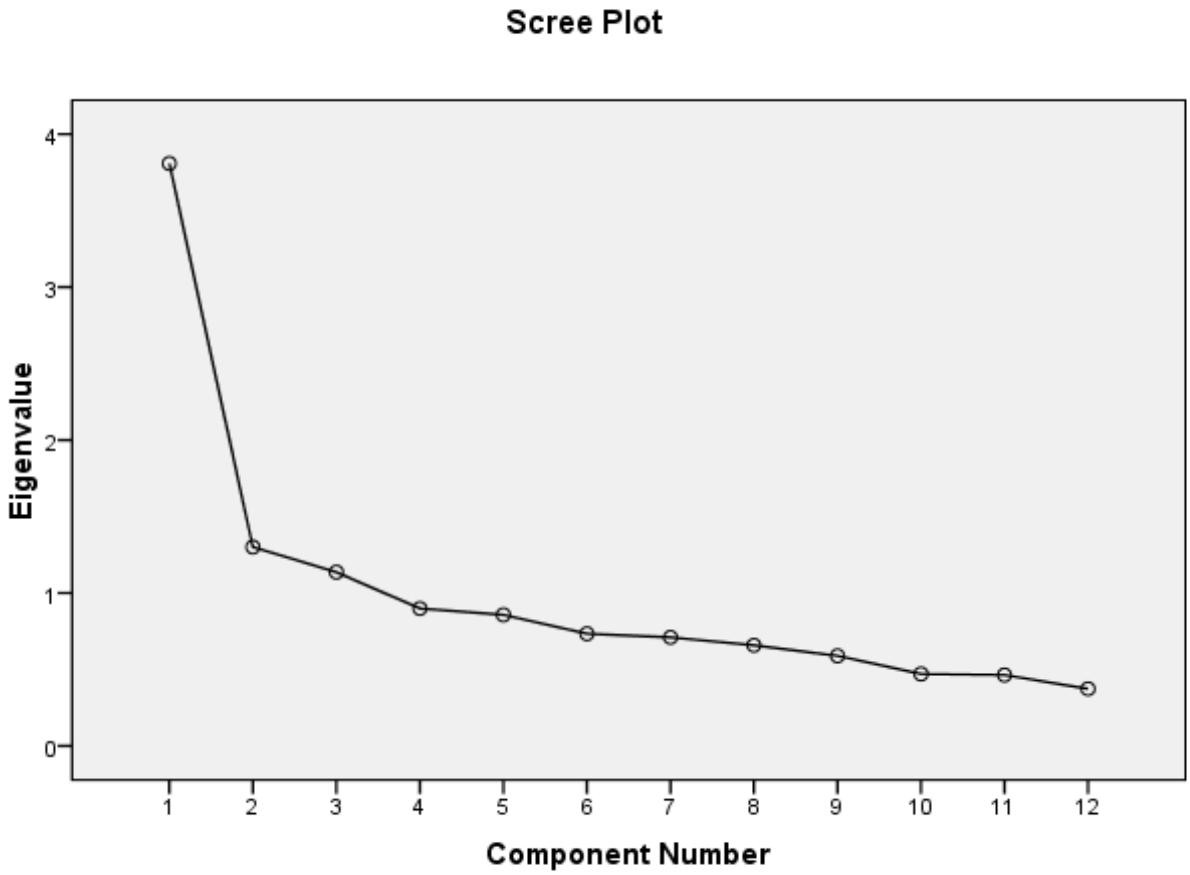
4.4.8 Factor structure for SQ12-3

A total of 320 participants were counted for SQ12-3 with a class interval of 95. Initial correlation of the component matrix revealed the presence of a fair number of components having coefficient value larger than .30 (see table 28). A Kaiser-Mayer-Olkin value of .810 exceeded the recommendation value of .60 (Kaiser 1970) and the Bartlett's test of sphericity (Bartlett, 1954) reached statistical significance at $P \leq .001$, supporting the factorability of the correlation matrix. A three factors solution was found for SQ12-3 having eigenvalues greater than one; 3.81, 1.30 and 1.14 explaining 52.04% of the variance. Inspection of the scree plot revealed a clear break after the third component (see figure 5). Items loading .50 and above were included for interpretations. Variables having eigenvalues less than .25 in loading were not included in interpretation. To aid in the interpretation of the three components, Varimax factor rotation was performed. Table 29 shows the factor loadings of the scale items. Items SQ12-3.4, SQ12-3.8 and SQ12-3.11 has a cross loading of over .30. Thus, these items were identified as defective. Factor 1, included a total of four items, factor 2 included three and factor 3 included three items. All the three of the outcome items and one of the empowerment items loaded more

strongly onto component 1. The three culture items loaded strongly on component 2, which is identifiably a culture factor. The three respect items loaded strongly onto component 3, which is clearly a respect factor. Although item 4, which measures respect, had a cross loading of over .30 with component 1 , that violated the item inclusion criteria of this study, suggesting refinement of this item.

Figure 5

Scree Plot showing principal component analysis with Varimax rotation of SQ12-3



Based on the result of PCA, the author could not specify a model that comprised of all 12 items of SQ12-3. Problems with 12 items PCA included: a) few items were found having cross loading across different factors, b) component having items from mixed factors. Although,

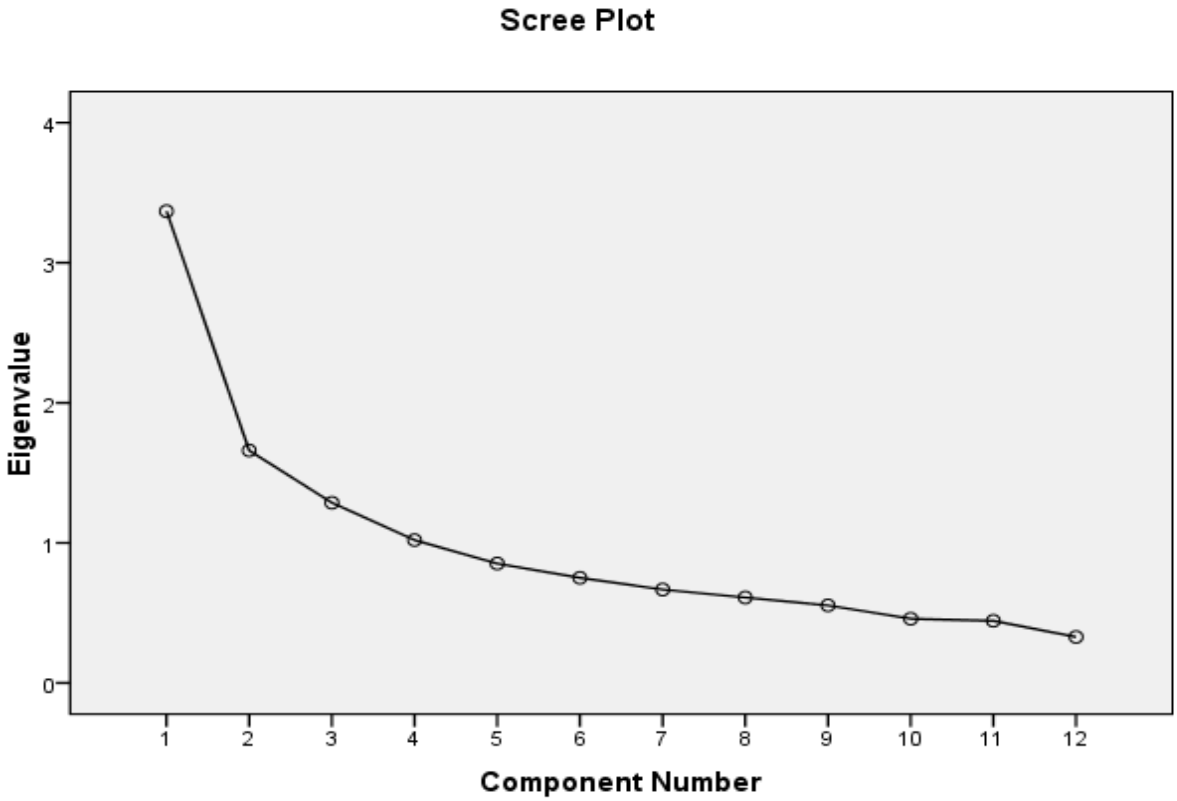
component 1 that was exceptionally defined by few items having two themes; outcome and empowerment, wording of these items were very similar. For example, item (*SQ12-5.10: I have felt staff help me to plan my own goals*) that measure empowerment and item 12and item 5*(SQ12-5.12: The (program) influenced how I do some things, SQ12-5.5: While in the program, I learned helpful things)* that measure outcome were much closer in taking steps. These three items gives what to do, how to do and the effective action of the first two (what to do, how to do). The items are all about goal setting-action taking-outcome. Thus, the item of empowerment could be perceived as the item of outcome. Component 2 grouped three culture items, which is clearly a culture factor. However, item 6 (SQ12-3.6: *I felt that my culture was treated with respect in the program*) has a cross loading nearly .30 with respect factor. Thus, these items need to be used cautiously. Although, item SQ12-3.2, SQ12-3.4 and SQ12-3.7 grouped together which is clearly a respect factor, item SQ12-3.4 has a cross loading above .30 with component 1. Thus, this items needs to be used cautiously. Therefore, a three factor solution is suggested for SQ12-3.

4.4.9 Factor structure for SQ12-3 for Females

A total of 147female participants were counted for SQ12-3 with a class interval of 95. Initial correlation of the component matrix revealed the presence of a fair number of components having coefficient value larger than .30 (see table 38). A Kaiser-Mayer-Olkin value of .810 exceeded the recommendation value of .60 (Kaiser 1970) and the Bartlett's test of sphericity (Bartlett, 1954) reached statistical significance at $P \leq .001$, supporting the factorability of the correlation matrix. A four factors solution was found for SQ12-3 having eigenvalues greater than one; 3.37, 1.66, 1.29 and 1.02 explaining 61.13% of the variance. Inspection of the scree plot revealed a clear break after the fourth component (see figure 10).

Figure 10

Scree Plot showing principal component analysis with Varimax rotation of SQ12-3 for Female



Items loading .50 and above were included for interpretations. Variables having eigenvalues less than .25 in loading were not included in interpretation. To aid in the interpretation of the three components, Varimax factor rotation was performed. Table 39 shows the factor loadings of the scale items. Items SQ12-3.3, SQ12-3.4, SQ12-3.6, SQ12-3.11 and SQ12-3.12 has a cross loading of over .30. Thus, these items were identified as defective. Factor one, included a total of two items, factor 2 included three, factor 3 included two items, and factor 4 included one item. Two of the three culture items loaded more strongly onto component 1. Two of the three outcome items and one empowerment item loaded strongly on component 2.

Two of the three respect items loaded strongly on component 3. Only one empowerment item loaded on component 4.

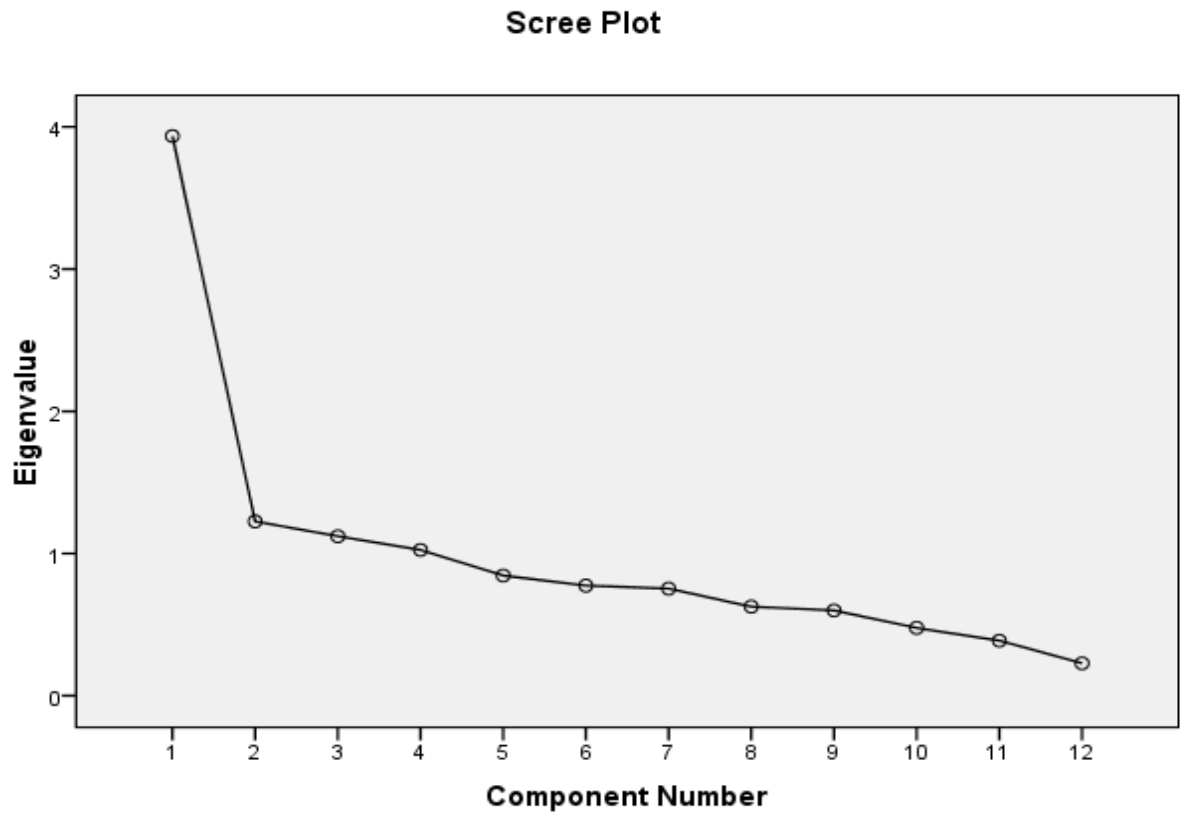
Based on the results of PCA, the author could not specify a model that comprised of all 12 items of SQ12-3. Surprisingly, four factors were found for female participants. Problems with 12 items PCA included: a) few items were found having cross loading across different factors, b) component having items from mixed factors. Although, component 1 that was primarily loaded on the three culture items, item 6 had found defective having cross loading over .30 with empowerment. Thus, two items were included in component 1.Component 2 was defined by three items having two themes; outcome and empowerment. It seems to the author that the wording of these items were very similar. For example, item (*SQ12-3.10: I have felt staff help me to plan my own goals*) that measure empowerment and item 12 and item 5 *(SQ12-3.12: The (program) influenced how I do some things, SQ12-3.5: While in the program, I learned helpful things)* that measure outcome were much closer in taking steps. These three items gives participants what to do, how to do and the effective action of the first two (what to do, how to do). The items are all about goal setting- action taking-outcome. Thus, the item of empowerment could be perceived as the item of outcome. Although item 3 that measure outcome were loaded in component 2, this item was found having cross loading over .30 with empowerment. Thus, this item was not included in component 2. Although, item 4 was found having loading over .50, this item was found having cross loading with 2 different themes; outcome and empowerment. Therefore, this item is identified as a clear defective one. Although, component 4, which is empowerment factor, loaded two items of empowerment having loading over .50, item number 11 was found having cross loading over .30. Therefore, this component was found with only one item.

4.4.10 Factor structure for SQ12-3for Males

A total of 174 male participants were counted for SQ12-3 with a class interval of 95. Initial correlation of the component matrix revealed the presence of a fair number of components having coefficient value larger than .30 (see table 40). A Kaiser-Mayer-Olkin value of .810 exceeded the recommendation value of .60 (Kaiser 1970) and the Bartlett's test of sphericity (Bartlett, 1954) reached statistical significance at P≤ .001, supporting the factorability of the correlation matrix. A four factors solution was found for SQ12-3 having eigenvalues greater than one; 3.94, 1.23, 1.12 and 1.03 explaining 60.90% of the variance. Inspection of the scree plot revealed a clear break after the fourth component (see figure 11).

Figure 11

Scree Plot showing principal component analysis with Varimax rotation of SQ12-3 for male



Items loading .50 and above were included for interpretations. Variables having eigenvalues less than .25 in loading were not included in interpretation. To aid in the interpretation of the three components, Varimax factor rotation was performed. Table 41 shows the factor loadings of the scale items. Items SQ12-3.4, SQ12-3.6, SQ12-3.7 and SQ12-3.8, SQ12-3.9 and SQ12-3.10 has a cross loading of over .30. Thus, these items were identified as defective. Factor one, included a total of three items, factor 2 included one, factor 3 included one items and factor 4 included one item. Two of the three outcome items and one empowerment item loaded strongly on component 1. One of the three culture items loaded onto component 2. One of the three respect items loaded on component 3. One outcome item loaded on component 4.

Based on the result of PCA, the author could not specify a model that comprised of all 12 items of SQ12-3.Problems with 12 items PCA included: a) few items were found having cross loading across different factors: b) component having items from mixed factors. Even though, four factors were found for male participants, there were three factors having only one item.

4.5 Reliability

The reliability of the Service Questionnaire scale for each version was assessed in two ways. First, this was calculated using all scale items of each version. Second, internal consistency was then calculated for each of the four subscales (respect, culture, empowerment and outcome) of SQ12-5 and SQ12-3. Cronbach's alpha for each version of Service Questionnaire are shown in tables 42-44. Cronbach's alpha for each of the instruments suggest high internal consistency. Cronbach's alpha for the scales were .884 for SQ12-5, .792 for SQ12-3, .812 for SQ8-3 and .637 for SQ4-3. In my study, Cronbach alpha for four subscales were

measured for SQ12-5, SQ12-3, and SQ8-3 versions. Cronbach's alpha for four subscales of SQ12-5 were .611 for respect, .795 for culture, .743 for empowerment and .795 for outcome. Cronbach's alpha for four subscales of SQ12-3 were .620 for respect, .701 for culture, .546 for empowerment, .532 for empowerment. Cronbach's alpha for four subscales of SQ8-3 were .689 for respect, .625 for outcome, .649 for empowerment and .497 for culture This result indicates a moderate to high level of internal consistency of each subscale of SQ12-5 and SQ12-3.

Table 24

Inter Item Correlation matrix for Service Questionnaire 12-5,KMO= .910

Factor Measures	1	2r	3	4	5	6	7r	8	9	10	11	12
SQ12-5.1: *I feel that (program) has supported my contact with my culture as much as possible./I feel that my therapist/clinician has been sensitive to my values and beliefs*	1	.252	.294	.504	.380	.587	.317	.440	.560	.454	.417	.337
SQ12-5.2r: *I have felt that (program) staff did **not** respect me.*		1	.069	.232	.169	.229	.540	.175	.177	.167	.143	.111
SQ12-5.3:Since starting the (program), I feel better about myself			1	.471	.478	.385	.102	.387	.334	.439	.439	.479
Sq12-5.4: I have felt appreciated and valued by staff of program I have felt appreciated and valued by my therapist				1	.486	.580	.285	.477	.488	.473	.477	.417
Sq12-5.5: While in the (program), I learned helpful things					1	.488	.205	.411	.418	.476	.492	.519
SQ 12-5.6: I felt that my culture was treated with respect in the (program)./I have felt that my values and beliefs were treated with respect in the (program).						1	.306	.445	.554	.486	.456	.337
*Sq12-5.7r: I have felt that staff do**not** pay attention to what is important to me. /I have felt that my therapist/clinician does **not** pay attention to what is important to me.*							1	.267	.298	.235	.237	.173
Sq12-5.8: I feel I have the opportunity to make my own choices								1	.542	.534	.486	.370
Sq12-5.9: I feel culture is important in the (program)./I have felt my values and beliefs are important in my sessions at the (program).									1	.512	.476	.392
Sq12-5.10I have felt staff help me to plan my own goals										1	.674	.468
Sq12-5.11 Staff have helped me to learn where to get help when I want it I feel my therapist/clinician has helped me to learn where to get help when I want it											1	.523
Sq12-5.12 The (program) influenced how I do some things												1

Table 25

Exploratory Factor Analysis of Service Questionnaire items (SQ12-5) Varimax Rotated Factor loadings for the two FactorsSolution

Items	Factor 1	Factor 2
*(*SQ12-5.1): *I feel that (program) has supported my contact with my culture as much as possible./I feel that my therapist/clinician has been sensitive to my values and beliefs*	**.584**	.426
SQ12-5.2r: *I have felt that (program) staff did **not** respect me.*		**.830**
SQ12-5.3:Since starting the (program), I feel better about myself	**.706**	
Sq12-5.4: I have felt appreciated and valued by staff of program *I have felt appreciated and valued by my therapist*	**.694**	.290
Sq12-5.5: While in the (program), I learned helpful things	**.720**	
SQ 12-5.6: I felt that my culture was treated with respect in the (program). /I have felt that my values and beliefs were treated with respect in the (program).	**.668**	.354
*Sq12-5.7r: I have felt that staff does **not** pay attention to what is important to me. /I have felt that my therapist/clinician does **not** pay attention to what is important to me.*		**.828**
Sq12-5.8: I feel I have the opportunity to make my own choices	**.666**	
Sq12-5.9: I feel culture is important in the (program). /I have felt my values and beliefs are important in my sessions at the (program).	**.667**	.315
Sq12-5.10I have felt staff help me to plan my own goals	**.764**	
Sq12-5.11 Staff have helped me to learn where to get help when I want it *I feel my therapist/clinician has helped me to learn where to get help when I want it*	**.767**	
Sq12-5.12 The (program) influenced how I do some things	**.713**	

Table 26

Inter Item Correlation matrix for Service Questionnaire 8-3, KMO= .867

Factor Measures	1	2r	3	4	5	6	7r	8
SQ8-3.1: I feel that (program) has supported my contact with my culture	1	.301	.251	.323	.335	.307	.343	.370
SQ8-3.2:I feel the program respects me		1	.299	.553	.441	.299	.466	.437
SQ8-3.3: Since starting the program, I feel better about myself			1	.305	.165	.463	.634	.312
SQ8-3.4: I feel staff care about what is important to me				1	.446	.308	.469	.510
SQ8-3.5: I feel staff respect people's culture					1	.247	.307	.334
SQ8-3.6: While in the program I learned things that will help me						1	.403	.369
SQ8-3.7: The staff help me do the things that are important to me							1	.478
SQ8-3.8: The staff help me to keep on trying								1

Table 27

Exploratory Factor Analysis of Service Questionnaire items (SQ8-3) Varimax Rotated Factor loadings for the two Factors Solution

Items	Factor 1	Factor 2
SQ8-3.1: I feel that (program) has supported my contact with my culture	.491	.325
SQ8-3.2:I feel the program respects me	**.749**	
SQ8-3.3: Since starting the program, I feel better about myself		**.822**
SQ8-3.4: I feel staff care about what is important to me	**.766**	
SQ8-3.5: I feel staff respect people's culture	**.771**	
SQ8-3.6: While in the program I learned things that will help me		**.790**
SQ8-3.7: The staff help me do the things that are important to me	.533	.505
SQ8-3.8: The staff help me to keep on trying	.598	.423

Table 28

Inter Item Correlation matrix for Service Questionnaire 12-3, KMO= .810

Factor Measures	1	2r	3	4	5	6	7r	8	9	10	11	12
SQ12-3.1: *I feel that (program) has supported my contact with my culture as much as possible./I feel that my therapist/clinician has been sensitive to my values and beliefs*	1	.002	.162	.190	.310	.521	.164	.215	.383	.100	.180	.254
SQ12-3.2r: *I have felt that (program) staff did **not** respect me.*		1	.092	.307	.154	.192	.430	.240	.182	.161	.213	.129
SQ12-5.3:Since starting the (program), I feel better about myself			1	.226	.350	.206	.236	.304	.267	.263	.374	.320
Sq12-3.4: I have felt appreciated and valued by staff of program *I have felt appreciated and valued by my therapist*				1	.335	.387	.331	.300	.200	.267	.373	.161
Sq12-3.5: While in the (program), I learned helpful things					1	.273	.168	.304	.192	.367	.251	.232
SQ 12-3.6: I felt that my culture was treated with respect in the (program). /I have felt that my values and beliefs were treated with respect in the (program).						1	.265	.296	.409	.223	.309	.226
*Sq12-3.7r: I have felt that staffs do **not** pay attention to what is important to me. /I have felt that my therapist/clinician does **not** pay attention to what is important to me.*							1	.228	.220	.198	.293	.163
Sq12-3.8: I feel I have the opportunity to make my own choices								1	.203	.184	.415	.169
Sq12-3.9: I feel culture is important in the (program). /I have felt my values and beliefs are important in my sessions at the (program).									1	.235	.236	.235
Sq12-3.10 I have felt staff help me to plan my own goals										1	.330	.222
Sq12-3.11 Staff have helped me to learn where to get help when I want it/I feel my therapist/clinician has helped me to learn where to get help when I want it											1	.298
Sq12-3.12 The (program) influenced how I do some things												1

Table 29

Exploratory Factor Analysis of Service Questionnaire items (SQ12-3) for all ,Varimax Rotated Factor loadings for the three Factors Solution

Items	Factor 1	Factor 2	Factor 3
SQ12-3.1: I feel that (program) has supported my contact with my culture as much as possible./I feel that my therapist/clinician has been sensitive to my values and beliefs		**.855**	
SQ12-3.2r: I have felt that (program) staff did not respect me.			**.821**
SQ12-3.3:Since starting the (program), I feel better about myself	**.729**		
Sq12-3.4: I have felt appreciated and valued by staff of program *I have felt appreciated and valued by my therapist*	.323		**.558**
Sq12-3.5: While in the (program), I learned helpful things	**.622**		
SQ 12-3.6: I felt that my culture was treated with respect in the (program). /I have felt that my values and beliefs were treated with respect in the (program).		**.756**	.281
Sq12-3.7r: I have felt that staff does not pay attention to what is important to me. /I have felt that my therapist/clinician does not pay attention to what is important to me.			**.731**
Sq12-3.8: I feel I have the opportunity to make my own choices	.453		.352
Sq12-3.9: I feel culture is important in the (program). /I have felt my values and beliefs are important in my sessions at the (program).		**.642**	
Sq12-3.10 I have felt staff help me to plan my own goals	**.625**		
Sq12-3.11 Staff have helped me to learn where to get help when I want it *I feel my therapist/clinician has helped me to learn where to get help when I want it*	**.610**		.347
Sq12-3.12 The (program) influenced how I do some things	**.538**		

Table 30

Inter Item Correlation matrix for Service Questionnaire 12-5 (Female), KMO= .910

Factor Measures	1	2r	3	4	5	6	7r	8	9	10	11	12
SQ12-5.1: *I feel that (program) has supported my contact with my culture as much as possible./I feel that my therapist/clinician has been sensitive to my values and beliefs*	1	.265	.313	.526	.452	.609	.305	.454	.531	.467	.450	.376
SQ12-5.2r: *I have felt that (program) staff did **not** respect me.*		1	.080	.201	.164	.220	.510	.133	.226	.144	.101	.115
SQ12-5.3:Since starting the (program), I feel better about myself			1	.509	.506	.391	.099	.422	.364	.434	.407	.485
Sq12-5.4: I have felt appreciated and valued by staff of program I have felt appreciated and valued by my therapist				1	.552	.593	.264	.524	.520	.493	.490	.441
Sq12-5.5: While in the (program), I learned helpful things					1	.550	.197	.468	.450	.487	.505	.554
SQ 12-5.6: I felt that my culture was treated with respect in the (program). /I have felt that my values and beliefs were treated with respect in the (program).						1	.320	.500	.574	.517	.467	.405
*Sq12-5.7r: I have felt that staff do**not** pay attention to what is important to me. /I have felt that my therapist/clinician does **not** pay attention to what is important to me.*							1	.261	.350	.233	.236	.162
Sq12-5.8: I feel I have the opportunity to make my own choices								1	.565	.559	.523	.420
Sq12-5.9: I feel culture is important in the (program)./I have felt my values and beliefs are important in my sessions at the (program).									1	.526	.481	.416
Sq12-5.10 I have felt staff help me to plan my own goals										1	.661	.465
Sq12-5.11 Staff have helped me to learn where to get help when I want it I feel my therapist/clinician has helped me to learn where to get help when I want it											1	.513
Sq12-5.12 The (program) influenced how I do some things												1

Table 31

Exploratory Factor Analysis of Service Questionnaire items (SQ12-5) for female ,Varimax Rotated Factor loadings for the two Factors Solution

Items	Factor 1	Factor 2
SQ12-5.1: I feel that (program) has supported my contact with my culture as much as possible./I feel that my therapist/clinician has been sensitive to my values and beliefs	**.614**	.400
SQ12-5.2r: I have felt that (program) staff did not respect me.		**.831**
SQ12-5.3:Since starting the (program), I feel better about myself	**.700**	
Sq12-5.4: I have felt appreciated and valued by staff of program *I have felt appreciated and valued by my therapist*	**.737**	
Sq12-5.5: While in the (program), I learned helpful things	**.756**	
SQ 12-5.6: I felt that my culture was treated with respect in the (program). /I have felt that my values and beliefs were treated with respect in the (program).	**.697**	.344
Sq12-5.7r: I have felt that staff does not pay attention to what is important to me. /I have felt that my therapist/clinician does not pay attention to what is important to me.		**.826**
Sq12-5.8: I feel I have the opportunity to make my own choices	**.720**	
Sq12-5.9: I feel culture is important in the (program). /I have felt my values and beliefs are important in my sessions at the (program).	**.665**	.365
Sq12-5.10 I have felt staff help me to plan my own goals	**.760**	
Sq12-5.11 Staff have helped me to learn where to get help when I want it *I feel my therapist/clinician has helped me to learn where to get help when I want it*	**.757**	
Sq12-5.12 The (program) influenced how I do some things	**.716**	

Table 32

Inter Item Correlation matrix for Service Questionnaire SQ12-5 (Male), KMO= .879

Factor Measures	1	2r	3	4	5	6	7r	8	9	10	11	12
SQ12-5.1: *I feel that (program) has supported my contact with my culture as much as possible./I feel that my therapist/clinician has been sensitive to my values and beliefs*	1	.201	.265	.463	.265	.531	.290	.394	.565	.395	.353	.280
SQ12-5.2r: *I have felt that (program) staff did **not** respect me.*		1.00	.051	.250	.163	.204	.566	.201	.071	.147	.172	.093
SQ12-5.3:Since starting the (program), I feel better about myself			1.00	.421	.424	.378	.069	.310	.313	.473	.518	.471
Sq12-5.4: I have felt appreciated and valued by staff of program I have felt appreciated and valued by my therapist				1.00	.360	.566	.293	.385	.413	.421	.444	.370
Sq12-5.5: While in the (program), I learned helpful things					1.00	.392	.208	.302	.352	.452	.462	.444
SQ 12-5.6: I felt that my culture was treated with respect in the (program). /I have felt that my values and beliefs were treated with respect in the (program).						1.00	.253	.341	.509	.418	.426	.337
*Sq12-5.7r: I have felt that staff do**not** pay attention to what is important to me. /I have felt that my therapist/clinician does **not** pay attention to what is important to me.*							1.00	.221	.199	.182	.207	.176
Sq12-5.8: I feel I have the opportunity to make my own choices								1.00	.501	.481	.410	.276
Sq12-5.9: I feel culture is important in the (program)./I have felt my values and beliefs are important in my sessions at the (program).									1.00	.446	.442	.359
Sq12-5.10 I have felt staff help me to plan my own goals										1.00	.688	.480
Sq12-5.11 Staff have helped me to learn where to get help when I want it I feel my therapist/clinician has helped me to learn where to get help when I want it											1.00	.543
Sq12-5.12 The (program) influenced how I do some things												1.00

Table 33

Exploratory Factor Analysis of Service Questionnaire items (SQ12-5) for male ,Varimax Rotated Factor loadings for the three Factors Solution

Items	Factor 1	Factor 2	Factor 3
SQ12-5.1: I feel that (program) has supported my contact with my culture as much as possible./I feel that my therapist/clinician has been sensitive to my values and beliefs		**.816**	
SQ12-5.2r: I have felt that (program) staff did <u>not</u> respect me.			**.885**
SQ12-5.3:Since starting the (program), I feel better about myself	**.742**		
Sq12-5.4: I have felt appreciated and valued by staff of program I have felt appreciated and valued by my therapist	.385	**.567**	
Sq12-5.5: While in the (program), I learned helpful things	**.675**		
SQ 12-5.6: I felt that my culture was treated with respect in the (program). /I have felt that my values and beliefs were treated with respect in the (program).	.306	**.688**	
Sq12-5.7r: I have felt that staff does <u>not</u> pay attention to what is important to me. /I have felt that my therapist/clinician does <u>not</u> pay attention to what is important to me.			**.843**
Sq12-5.8: I feel I have the opportunity to make my own choices	.294	**.593**	
Sq12-5.9: I feel culture is important in the (program). /I have felt my values and beliefs are important in my sessions at the (program).		**.793**	
Sq12-5.10 I have felt staff help me to plan my own goals	**.694**	.386	
Sq12-5.11 Staff have helped me to learn where to get help when I want it I feel my therapist/clinician has helped me to learn where to get help when I want it	**.762**	.312	
Sq12-5.12 The (program) influenced how I do some things	**.755**		

Table 34

Inter Item Correlation matrix for Service Questionnaire 8-3 (female participants), KMO= .833

Factor Measures	1	2r	3	4	5	6	7r	8
SQ8-3.1: I feel that (program) has supported my contact with my culture	1	.353	.186	.211	.255	.242	.288	.283
SQ8-3.2:I feel the program respects me		1	.317	.595	.455	.318	.412	.442
SQ8-3.3: Since starting the program, I feel better about myself			1	.209	.195	.345	.353	.304
SQ8-3.4: I feel staff care about what is important to me				1	.431	.158	.313	.356
SQ8-3.5: I feel staff respect people's culture					1	.201	.285	.229
SQ8-3.6: While in the program I learned things that will help me						1	.365	.346
SQ8-3.7: The staff help me do the things that are important to me							1	.485
SQ8-3.8: The staff help me to keep on trying								1

Table 35

Exploratory Factor Analysis of Service Questionnaire items SQ8-3 for female Varimax Rotated Factor loadings for the two Factors Solution

Items	Factor 1	Factor 2
SQ8-3.1: I feel that (program) has supported my contact with my culture	.393	.355
SQ8-3.2:I feel the program respects me	.367	**.753**
SQ8-3.3: Since starting the program, I feel better about myself	**.688**	
SQ8-3.4: I feel staff care about what is important to me		**.829**
SQ8-3.5: I feel staff respect people's culture		**.750**
SQ8-3.6: While in the program I learned things that will help me	**.755**	
SQ8-3.7: The staff help me do the things that are important to me	**.677**	.306
SQ8-3.8: The staff help me to keep on trying	**.629**	.344

Table 36

Inter Item Correlation matrix for Service Questionnaire 8-3 (Male participants), KMO= .835

Factor Measures	1	2r	3	4	5	6	7r	8
SQ8-3.1: I feel that (program) has supported my contact with my culture	1	.291	.351	.466	.447	.399	.421	.493
SQ8-3.2:I feel the program respects me		1	.312	.515	.427	.281	.514	.420
SQ8-3.3: Since starting the program, I feel better about myself			1	.416	.136	.621	.387	.337
SQ8-3.4: I feel staff care about what is important to me				1	.449	.427	.598	.608
SQ8-3.5: I feel staff respect people's culture					1	.283	.319	.412
SQ8-3.6: While in the program I learned things that will help me						1	.436	.436
SQ8-3.7: The staff help me do the things that are important to me							1	.466
SQ8-3.8: The staff help me to keep on trying								1

Table 37

Exploratory Factor Analysis of Service Questionnaire items SQ8-3 for male Varimax Rotated Factor loadings for the two Factors Solution

Items	Factor 1	Factor 2
SQ8-3.1: I feel that (program) has supported my contact with my culture	**.601**	.343
SQ8-3.2:I feel the program respects me	**.708**	
SQ8-3.3: Since starting the program, I feel better about myself		**.886**
SQ8-3.4: I feel staff care about what is important to me	**.731**	.379
SQ8-3.5: I feel staff respect people's culture	**.795**	
SQ8-3.6: While in the program I learned things that will help me		**.822**
SQ8-3.7: The staff help me do the things that are important to me	**.611**	.433
SQ8-3.8: The staff help me to keep on trying	**.684**	.344

Table 38

Inter Item Correlation matrix for Service Questionnaire 12-3 for female participants, KMO= .733

Factor Measures	1	2r	3	4	5	6	7r	8	9	10	11	12
SQ12-3.1: *I feel that (program) has supported my contact with my culture as much as possible./I feel that my therapist/clinician has been sensitive to my values and beliefs*	1	-.009	.069	.116	.318	.460	.125	.113	.471	.152	.039	.225
SQ12-3.2r: *I have felt that (program) staff did **not** respect me.*		1	-.007	.331	.193	.057	.465	.136	.115	.070	.263	.099
SQ12-5.3:Since starting the (program), I feel better about myself			1	.248	.317	.107	.141	.249	.120	.340	.282	.174
Sq12-3.4: I have felt appreciated and valued by staff of program I have felt appreciated and valued by my therapist				1	.451	.245	.355	.261	.137	.205	.435	.087
Sq12-3.5: While in the (program), I learned helpful things					1	.184	.160	.175	.221	.390	.211	.281
SQ 12-3.6: I felt that my culture was treated with respect in the (program). /I have felt that my values and beliefs were treated with respect in the (program).						1	.114	.300	.432	.135	.223	.236
*Sq12-3.7r: I have felt that staffs do **not** pay attention to what is important to me. /I have felt that my therapist/clinician does **not** pay attention to what is important to me.*							1	.194	.143	.151	.287	.046
Sq12-3.8: I feel I have the opportunity to make my own choices								1	.145	.217	.373	.081
Sq12-3.9: I feel culture is important in the (program). /I have felt my values and beliefs are important in my sessions at the (program).									1	.170	.060	.264
Sq12-3.10 I have felt staff help me to plan my own goals										1	.333	.226
Sq12-3.11 Staff have helped me to learn where to get help when I want it/I feel my therapist/clinician has helped me to learn where to get help when I want it											1	.208
Sq12-3.12 The (program) influenced how I do some things												1

Table 39

Exploratory Factor Analysis of Service Questionnaire items (SQ12-3) for female participants, Varimax Rotated Factor loadings for the four Factors Solution

Items	Factor 1	Factor 2	Factor 3	Factor 4
SQ12-3.1: I feel that (program) has supported my contact with my culture as much as possible./I feel that my therapist/clinician has been sensitive to my values and beliefs	**.807**			
SQ12-3.2r: I have felt that (program) staff did <u>not</u> respect me.			**.833**	
SQ12-3.3:Since starting the (program), I feel better about myself		**.540**		.495
Sq12-3.4: I have felt appreciated and valued by staff of program I have felt appreciated and valued by my therapist		.388	**.584**	.289
Sq12-3.5: While in the (program), I learned helpful things		**.754**	.298	
SQ 12-3.6: I felt that my culture was treated with respect in the (program). /I have felt that my values and beliefs were treated with respect in the (program).	**.699**			.391
Sq12-3.7r: I have felt that staff does <u>not</u> pay attention to what is important to me. /I have felt that my therapist/clinician does <u>not</u> pay attention to what is important to me.			**.751**	
Sq12-3.8: I feel I have the opportunity to make my own choices				**.788**
Sq12-3.9: I feel culture is important in the (program). /I have felt my values and beliefs are important in my sessions at the (program).	**.799**			
Sq12-3.10 I have felt staff help me to plan my own goals		**.687**		.288
Sq12-3.11 Staff have helped me to learn where to get help when I want it I feel my therapist/clinician has helped me to learn where to get help when I want it		.255	.254	**.684**
Sq12-3.12 The (program) influenced how I do some things	.305	**.527**		

Table 40

Inter Item Correlation matrix for Service Questionnaire 12-3 for male participants, KMO= .740

Factor Measures	1	2r	3	4	5	6	7r	8	9	10	11	12
SQ12-3.1: *I feel that (program) has supported my contact with my culture as much as possible./I feel that my therapist/clinician has been sensitive to my values and beliefs*	1	-.010	.216	.249	.325	.598	.206	.357	.313	.042	.248	.270
SQ12-3.2r: *I have felt that (program) staff did **not** respect me.*		1	.153	.324	.131	.310	.402	.328	.262	.258	.174	.175
SQ12-5.3:Since starting the (program), I feel better about myself			1	.176	.319	.233	.317	.329	.353	.179	.392	.351
Sq12-3.4: I have felt appreciated and valued by staff of program *I have felt appreciated and valued by my therapist*				1	.200	.422	.258	.292	.251	.252	.287	.159
Sq12-3.5: While in the (program), I learned helpful things					1	.255	.124	.377	.184	.328	.215	.117
SQ 12-3.6: I felt that my culture was treated with respect in the (program). /I have felt that my values and beliefs were treated with respect in the (program).						1	.341	.230	.421	.222	.315	.168
*Sq12-3.7r: I have felt that staffs do **not** pay attention to what is important to me. /I have felt that my therapist/clinician does **not** pay attention to what is important to me.*							1	.255	.307	.212	.278	.244
Sq12-3.8: I feel I have the opportunity to make my own choices								1	.322	.141	.439	.224
Sq12-3.9: I feel culture is important in the (program). /I have felt my values and beliefs are important in my sessions at the (program).									1	.220	.351	.195
Sq12-3.10 I have felt staff help me to plan my own goals										1	.274	.179
Sq12-3.11 Staff have helped me to learn where to get help when I want it/I feel my therapist/clinician has helped me to learn where to get help when I want it											1	.306
Sq12-3.12 The (program) influenced how I do some things												1

Table 41

Exploratory Factor Analysis of Service Questionnaire items (SQ12-3) for male ,Varimax Rotated Factor loadings for the four Factors Solutions

Items	Factor 1	Factor 2	Factor 3	Factor 4
SQ12-3.1: I feel that (program) has supported my contact with my culture as much as possible./I feel that my therapist/clinician has been sensitive to my values and beliefs		**.868**		
SQ12-3.2r: I have felt that (program) staff did not respect me.			**.818**	
SQ12-3.3:Since starting the (program), I feel better about myself	**.752**			
Sq12-3.4: I have felt appreciated and valued by staff of program *I have felt appreciated and valued by my therapist*		.413	**.517**	
Sq12-3.5: While in the (program), I learned helpful things				**.806**
SQ 12-3.6: I felt that my culture was treated with respect in the (program). /I have felt that my values and beliefs were treated with respect in the (program).		**.793**	.364	
Sq12-3.7r: I have felt that staff does not pay attention to what is important to me. /I have felt that my therapist/clinician does not pay attention to what is important to me.	.388		**.617**	
Sq12-3.8: I feel I have the opportunity to make my own choices	**.467**			.373
Sq12-3.9: I feel culture is important in the (program). /I have felt my values and beliefs are important in my sessions at the (program).	.392	.407	.328	
Sq12-3.10 I have felt staff help me to plan my own goals			.393	**.676**
Sq12-3.11 Staff have helped me to learn where to get help when I want it *I feel my therapist/clinician has helped me to learn where to get help when I want it*	**.612**			
Sq12-3.12 The (program) influenced how I do some things	**.716**			

Table 42

Item loading on each factor, corrected item total subscale correlation, and Cronbach's alpha if item deleted from subscale for SQ12-5, Cronbach's alpha=.884

Factor Measures	Corrected item-total subscale correlation	Cronbach"s alpha if item deleted from subscale
Respect (3 items) Cronbach's alpha=.611		
*SQ12-5.2r: I have felt that (program) staff did **not** respect me.*	.474	.440
Sq12-5.4: I have felt appreciated and valued by staff of program *I have felt appreciated and valued by my therapist*	.290	.689
*Sq12-5.7r: I have felt that staff do**not** pay attention to what is important to me. /I have felt that my therapist/clinician does **not** pay attention to what is important to me.*	.514	.361
Culture(3 items) Cronbach's alpha=.795		
SQ12-5.1: I feel that (program) has supported my contact with my culture as much as possible./I feel that my therapist/clinician has been sensitive to my values and beliefs	.648	.709
SQ 12-5.6: I felt that my culture was treated with respect in the (program). /I have felt that my values and beliefs were treated with respect in the (program).	.641	.719
Sq12-5.9: I feel culture is important in the (program)./I have felt my values and beliefs are important in my sessions at the (program).	.626	.735
Empowerment (3 items) Cronbach's alpha=.743		
Sq12-5.5: While in the (program), I learned helpful things	.583	.643
Sq12-5.12 The (program) influenced how I do some things	.574	.652
SQ12-5.3:Since starting the (program), I feel better about myself	.551	.681
Outcome(3 items) Cronbach's alpha=.795		
Sq12-5.8: I feel I have the opportunity to make my own choices	.557	.803
Sq12-5.10 I have felt staff help me to plan my own goals	.698	.658
Sq12-5.11 Staff have helped me to learn where to get help when I want it *I feel my therapist/clinician has helped me to learn where to get help when I want it*	.666	.691

Table 43

Item loading on each factor, corrected item total subscale correlation, and Cronbach's alpha if item deleted from subscale for SQ12-3, Cronbach's alpha=.792

Factor Measures	Corrected item-total subscale correlation	Cronbach"s alpha if item deleted from subscale
Respect (3 items) Cronbach's alpha=.620		
*SQ12_3.2r: I have felt that (program) staff did **not** respect me.*	.458	.480
Sq12_3.4: I have felt appreciated and valued by staff of program *I have felt appreciated and valued by my therapist*	.381	.596
*Sq12_3.7r: I have felt that staff do**not** pay attention to what is important to me. /I have felt that my therapist/clinician does **not** pay attention to what is important to me.*	.483	.454
Culture (3 items) Cronbach's alpha=.701		
SQ12_3.1: I feel that (program) has supported my contact with my culture as much as possible./I feel that my therapist/clinician has been sensitive to my values and beliefs	.533	.589
SQ 12_3.6: I felt that my culture was treated with respect in the (program). /I have felt that my values and beliefs were treated with respect in the (program).	.568	.559
Sq12_3.9: I feel culture is important in the (program)./I have felt my values and beliefs are important in my sessions at the (program).	.466	.687
Empowerment (3 items) Cronbach's alpha=.546		
Sq12_3.5: While in the (program), I learned helpful things	.359	.458
Sq12_3.12 The (program) influenced how I do some things	.340	.480
SQ12_3.3:Since starting the (program), I feel better about myself	.389	.391
Outcome (3 items) Cronbach's alpha=.532		
Sq12_3.8: I feel I have the opportunity to make my own choices	.333	.453
Sq12_3.10 I have felt staff help me to plan my own goals	.285	.558
Sq12_3.11 Staff have helped me to learn where to get help when I want it *I feel my therapist/clinician has helped me to learn where to get help when I want it*	.439	.290

Table 44

Item loading on each factor, corrected item total correlation, and Cronbach's alpha if item deleted from subscale for SQ8-3, Cronbach's alpha=.812[26]

Factor Measures	Corrected item-total subscale correlation	Cronbach"s alpha if item deleted from subscale
SQ8-3.1: I feel that (program) has supported my contact with my culture	.465	.802
SQ8-3.2:I feel the program respects me	.587	.788
SQ8-3.3: Since starting the program, I feel better about myself	.455	.805
SQ8-3.4: I feel staff care about what is important to me	.610	.781
SQ8-3.5: I feel staff respect people's culture	.460	.800
SQ8-3.6: While in the program I learned things that will help me	.523	.792
SQ8-3.7: The staff help me do the things that are important to me	.602	.780
SQ8-3.8: The staff help me to keep on trying	.603	.780

[26] Item total subscale correlations were not performed because each subscale measured by two items only.

Chapter Five

Discussion

The main purpose of the study was to assess the reliability and validity of New Direction's Service Questionnaire (SQ). The Service Questionnaire is a self-reported questionnaire package comprising of demographic information and items seeking to assess the experience of service recipients by measuring respect, culture, empowerment and outcome. There are four versions of the Service Questionnaire: SQ12-5, SQ8-3, SQ4-3 and SQ12-3 comprising of 12 items, 8 items and 4 items (with 5 and 3 response options depending on the version). The study used data gathered from the Service Questionnaire that was to 2,269 service recipients from 2012 to 2016.

The qualitative interviews conducted with New Directions staffs sought to understand the intention and uses of the Service Questionnaire. Several themes emerged from these interviews: intention of the questionnaire, reasons for continuation, meeting the purposes of the organization, the usefulness of the data; and refinement for improvement. The interviews corroborated that the main purpose of using and adapting the Service Questionnaire was to assess the value of the New Directions and to obtain feedback from service recipients about the services at both programmatic and agency level. The second themereferred that the reason of continuation of using the Service Questionnairewas to adjust services based on the feedback from service recipients. The third theme addressed that although the Service Questionnaire measures some values of the organization it is not holistic enough; because interviewees considered that close ended questions limit the collection of possibly more in depth information about the person-centered services. The fourth theme suggested two main reasons of using data collected by the Service Questionnaires: for funding applications and to make decisions to improve the quality of

services. The final theme suggested some changes and refinements of Service Questionnaire. First, that a few more domains, such as sense of belonging, relationships, communication, and self-advocacy would be important to measure and could be added to the Service Questionnaire. Nonetheless, there was some doubt among some interviewees whether the Service Questionnaire was measuring what it was supposed to measure. The quantitative aspect of the study sought to address this issue.

Univariate analyses explored the socio-demographic distribution of participantsrelated to different service areas at New Directions. Different distribution patterns of service recipients showed differences in rating services areas at New Directions. Thus, it could be noted that there are differences among different gender, age groups, duration in program, times client seen therapist/counselor in how participants perceive service areas. For example, transgender participants perceived service areas somewhat differently compare to male and female. Younger participants also perceive service areas slightly differently compare to older service recipients. Bivariate analysis explored the association between different socio-demographic variables and service areas care recipients received at New Directions. The results of the bivariate analysis revealed that, in New Directions, female service recipients were somewhat more likely to feel respected, empowered and culturally respected compared to male. It is important to note that this result was only true for participants who were provided SQ12-5.

No association between gender and service areas was found forparticipantswho were administered SQ12-3. The association between gender and service area for recipients who were administered SQ 8-3 revealed that female participants were slightly more likely to feel respected than male.

For SQ12-5, seniors were more likely to feel respected, empowered, culturally respected and outcome the services were also met more expectedly by them than younger service recipients. Similar results were found for care recipients who were provided SQ8-3 given that younger care recipients were slightly less likely to feel empowered and outcome the services were also met less than expected. However, no significant association was found between age and the remaining two domains (respect and culture) of SQ8-3. For SQ12-3, adults aged 17 to 30 years were slightly less likely to feel empowered, culturally respected and outcome the services were also met less expectedly by them compared to the remaining (youth and seniors). Similarly, study finds out a significant association between patient's demographic characteristics and both dependent and independent variables (Beach et al., 2005).

The association between time in program and service areas revealed that care recipients that answered SQ12-5 and received services for more than three months were slightly more likely to feel culturally respected and empowered compared to the service recipients who got services for less than four months. However, no statistically significant association was found between time in program and service domains of those who were administered SQ12-3. Care recipients that answered SQ8-3 who got services for more than three months were slightly more likely to feel respected and culturally respected compared to the participants who got services for less than four months.

For care recipients that were administered SQ12-5 and SQ12-3, no significant association was found between time client seeing therapist/counselor and services areas. Although for care recipients that were administered SQ8-3 there was a statistically significant association between the number of time client seeing therapist/counselor and service areas for empowerment and

outcome, this finding should be considered with caution as most of the care recipients visited their therapist/counselor the highest number of times.

Factor structures for each of the different versions of the Service Questionnaire were presented separately in the results chapter. Different factor structures were found for scales with different items and response options. However, overall a similar factor structures were found for each version of the questionnaire when comparing between the original items and the transformed worded items. This finding suggests that there was no effect of the reversed worded items on the construct of the present scales.

The factor structure for each version of Service Questionnaire suggests different factor solution. For example, outcome items and empowerment items clearly combined together clearly when the factor was extracted using data for all care recipients that answered SQ12-5. This combination was also the same for female care recipients administered SQ12-5. This result was not significantly different for SQ12-5's males. Consequently, a most parsimonious three factor solution comprising of 11 items define three factorability of SQ12-5 well. Eliminating one item from this would not affect much in the reliability. The reliability of this 11 item scale is .885, which shows good reliability of theSQ12-5 scale.

Factor structures of SQ8-3 suggest a two factor solution comprising of five items measuring respect and outcome. It was evident that one item that was measuring cultural respect combined with the rest of the two respect items and made factor 1. The wording of respect and cultural respect were similar. This finding suggests that it would be worthwhile to investigate the content validity of cultural respect items to make sure individuals can differentiate these items from the respect items. Eliminating one item would not affect much in terms of reliability. The reliability of this five items scale was .749, which shows good reliability of the SQ8-3 scale.

Factor structures of SQ12-3 revealed a three to four factors solution. Three factor solutions were found from the extraction of all participants' data and four factor solutions was found from the data for females only. Four factors solution for males was ambiguous revealing minimal significance of this result. Therefore, a three factor solutions comprising of 10 items was suggested for SQ12-3. This three factors solution was made considering difficulty in application of the Service Questionnaire separately for females. The three factor solutions measure respect, culture and outcome. Two empowerment items were omitted from the solutions and one empowerment item was merged into outcome factor. Eliminating one item from this would not affect much in terms of reliability. The reliability of the 10 items scale is .736, which shows good reliability of the SQ12-3 scale.

From the reliability analysis, it could be said that there is a good reliability for each of the domains of SQ12-5. The reliability of the outcome domain for SQ12-5 is .795. Steine, Finset&Laerum (2001) conduct a reliability analysis of outcome domain using data of a primary health care patient and found .80 alpha values. This result supports the result of my study. However, comparatively a low alpha value (.532) is found for SQ12-3.

Different factor structures were found when comparisons were done on the basis of gender. Differences were seen between males and females only. Due to small sample sizes (below 100), transgender participantswere not counted in the comparison. It is noted from the factorability of different genders that factor structures of males and females are different. Therefore, separate versions of questionnaire for both male and female could be a solution for this. Adaptation of the scales considering the gender differences could be another solution.

It could be suggested that a three factor model was the most reasonable solution for SQ12 regardless of their response options. It is revealed from the factor solutions for SQ12 with both three and five response options that empowerment items were closer to outcome items. It would seem that they grouped together because the wording of the items and content which were very similar to each other. This finding suggests further investigation of the content validity of empowerment measures.This result was not surprising as empowerment is measured on the basis of information accessibility, available resources and skills developed by the service recipients (Wowra&Mccarter, 1999; Castelein et al, 2008). In addition, empowerment was also identified as a predictor of different health care outcome (Castelein et al., 2008). The Service Questionnaire also measures outcome and empowerment using items containing such predictors.These definitions supported the factorability of our study suggesting one component solution for both empowerment and outcome.

It is important to note that item 4 for SQ12 with both 5 and 3 response options was supposed to measure respect have shared loading with other domains. Thus, this item was identified as defective and further refinement is suggested.Even though the floor-ceiling effect was not measured; the higher mean score indicates a possibility of having ceiling effect of the present data.

The main limitation of the study was that the validation involved three different versions of the Service Questionnaire. These versions were developed in order to increase the applicability of the tool among different population groups having different physical, intellectual and mental health issues. However, the tool did not include some important demographic variables such as ethnicity, health condition, employment and economic status, marital status and education.

Respect, culture, empowerment and outcome are important constructs in health care field. This study has provided psychometric support of the Service Questionnaire used by New Directions to measure these four domains. Although there are many organizations that measure different indicators of quality of services, to my knowledge, there is no organization that brings all of these four domains; respect, culture, empowerment and outcome under the same tool. New directions took that steps and my research aimed to validate the tool.

The Service Questionnaire tool developed by New Directions included items that focus on measuring general respect and values of a client. Both of these ideas are supported by the definition of respect by Darwall's "recognition respect", Health Council of Canada's "general respect" and Beach, Duggan, Cassel, & Geller's "respect for persons" and "respect for autonomy" (Darwall, 1977, Health Council of Canada, 2012 &Beach, Duggan, Cassel, & Geller 2007).The current study tool seeks to measure both types of respect.

The current study tool measures the cultural humility and responsiveness of the care recipients. According to Tervalon& Murray-Garcia (1998) cultural humility refers to the self-reflection of service providers, where they may understand the imbalance in the power dynamics between care providers' and recipients' cultures and apply this knowledge for the improvement of quality health and social services. Cultural humility is the integral part and a new perspective of a culturally competent healthcare (Ahmed et al., 2018). Bramesfeld et al., (2007) state that cultural responsiveness is a part and parcel of a culturally competent health care where responsiveness means ensuring a service that connects the service recipients to their culturalvalues and norms. Therefore, it could be said that the Service Questionnaire seeks to measure both characteristics (humility and responsiveness) of a culturally competent health service which validates the culture factor.

Empowerment items of the Service Questionnaire scale seek to measure participant's involvement to make their own choice, and the program's support to help them reach their goals. Both of these ideas are supported by the definition of empowerment (Shebib, 2019 & Power, 2003). Shebib (2019) states that empowerment is a process of helping care recipients to identify their own strengths and capabilities in order to meet the goals of taking control and making change in their life. Power (2003) defined empowerment as a strategic help that gives care recipients an opportunity and strength to make their own decisions so that they can take control over their lives. The current study tool seeks to measure both criteria of empowerment.

The Service Questionnaire seeks tomeasure outcome based on the participant's changes in skills and knowledge (e.g., learning helpful things), behavior, and emotion (e.g., feeling better about one's self). Similarly, Steine (2001) measured outcome of the service recipient based on the characteristics such as information, communication, emotional experience, expectation and coping skills. Therefore, it could be said that the present study's measurement criteria of outcome is valid.

The literature review supports the present study's measurement criteria of factors including respect, culture, empowerment and outcome. However, the structural construct revealed from factor analysis of the current study suggests that the Service Questionnaire measures three components. Therefore it could be summarized from the current study that the current Service Questionnaire tool partially supports its original construct.

5.1 Conclusion and Recommendations

Respect, culture, empowerment and outcome are important factors for quality health and social care. However, to my knowledge no study that has been conducted in an aim to measure such factors by a single scale. New Directions had taken such steps in order to improve their quality of services. This study opens an eye to the organization like New Directions that development of a multivariable scale with a few items is possibly a good example considering the complex population groups (e.g. different age, gender, cognitive abilities). The valid and reliable instrument could potentially now be used by other organizations like New Directions to measure such factors with a single scale. The study findings can be of assistance to adjust services that seek to improve the lives of individuals of different groups of age, gender, life circumstances, that receive services in New Directions. Adding some demographic variables such as education, marital status and so on can enrich the quality of the scale and broaden the areas requires by providers and organizations. Additionally, this scale may assist organizations to identify the predicators of quality care for the participants with complex mental and physical health issues.

Based on the result and discussion, the recommendations are that some items of this tool be refined. Additionally,items that measure self-advocacy, sense of belongings and communication and relationship be added to the tool, as well as some open ended questions.

This study contributes to the present knowledge on validation of a questionnaire measuring respect, culture, empowerment and outcome. Future research on the scale could focus in further investigation on the content validity of the present scale.

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Appendix 1

NEW DIRECTIONS

Service Questionnaire (SQ4) 3

PROGRAM NAME Program SPSS Number

DATE: _____ **How old are you?** _____ **Gender:** ☐1 male ☐2 female ☐3 transgender

How long have you been in the ____program?

☐ less than 1 month ☐ 1 to 3 months ☐ 4 to 6 months ☐ 7 months to 1 year ☐ more than 1 year

Please choose the answer that best applies to you.
There is no right or wrong answer.

	Disagree	Neither Agree nor Disagree	Agree
1. I feel the ___program respects me.			
2. While in the ___program, I learned things that will help me.			
3. Staff help me to make my own choices.			
4. Staff care about my culture (values, beliefs, traditions).			

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Appendix 2

NEW DIRECTIONS

Service Questionnaire (SQ8) 2

PROGRAM NAME SPSS Program Number

DATE: _____ How old are you? _____ Gender: ☐1 male ☐2 female ☐3 transgender

How long have you been in the _____ program?

☐ less than 1 month ☐ 1 to 3 months ☐ 4 to 6 months ☐ 7 months to 1 year ☐ more than 1 year

Please choose the answer that best applies to you.
There is no right or wrong answer.

	Disagree	Neither Agree nor Disagree	Agree
1. I feel that _____ has supported my contact with my culture.			
2. I feel the _____ program respects me.			
3. Since starting the _____ program, I feel better about myself.			
4. I feel staff care about what is important to me.			
5. I feel staff respect people's culture (values, beliefs, traditions).			
6. While in the _____program, I learned things that will help me.			
7. The staff help me do the things (activities) that are important to me.			
8. The staff help me to make my own choices.			

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Appendix 3

NEW DIRECTIONS

Service Questionnaire (SQ12-III) 4

PROGRAM NAME Program SPSS Number

DATE: _____ **How old are you?** _____ **Gender:** ☐1 male ☐2 female ☐3 transgender

How long have you been in the ____program?

☐ less than 1 month ☐ 1 to 3 months ☐ 4 to 6 months ☐ 7 months to 1 year ☐ more than 1 year

For the following statements, please select the answer that best applies to you. There is no right or wrong answer.

	Disagree	Neither Agree nor Disagree	Agree
1. I feel that ____ has supported my contact with my culture (values, beliefs, traditions) as much as possible.	☹	😐	☺
2. I have felt that _____ staff did **not** respect me.	☹	😐	☺
3. Since starting the _____ program I feel better about myself.	☹	😐	☺
4. I have felt appreciated and valued by staff of the _____program.	☹	😐	☺
5. While in the _____program, I have learned helpful things.	☹	😐	☺
6. I have felt that my culture (values, beliefs, traditions) was treated with respect in the _____program.	☹	😐	☺
7. I have felt that staff do **not** pay attention to what is important to me.	☹	😐	☺
8. I feel I have opportunities to make my own choices.	☹	😐	☺
9. I have felt culture is important in the _____program.	☹	😐	☺
10. I have felt staff help me to plan my own goals.	☹	😐	☺
11. Staff have helped me to learn where to get help when I want it.	☹	😐	☺
12. The _____program has influenced how I do some things.	☹	😐	☺

Revised January 2013

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Appendix 4

NEW DIRECTIONS

Service Questionnaire (SQ12-V) 1

PROGRAM NAME Program SPSS Number

DATE: _____ How old are you? _____ Gender: ☐1 male ☐2 female ☐3 transgender

How long have you been in the ____program?

☐ less than 1 month ☐ 1 to 3 months ☐ 4 to 6 months ☐ 7 months to 1 year ☐ more than 1 year

For the following statements, please select the answer that best applies to you. There is no right or wrong answer.	1 Disagree Strongly	2 Disagree a little	3 Neither Agree nor disagree	4 Agree a little	5 Agree Strongly
1. I feel that _____has supported my contact with my culture (values, beliefs, traditions) as much as possible.	1	2	3	4	5
2. I have felt that _____staff did **not** respect me.	1	2	3	4	5
3. Since starting the _____program I feel better about myself.	1	2	3	4	5
4. I have felt appreciated and valued by staff of the _____program.	1	2	3	4	5
5. While in the _____program, I have learned helpful things.	1	2	3	4	5
6. I have felt that my culture (values, beliefs, traditions) was treated with respect in the _____program.	1	2	3	4	5
7. I have felt that staff do **not** pay attention to what is important to me.	1	2	3	4	5
8. I feel I have the opportunity to make my own choices.	1	2	3	4	5
9. I have felt culture is important in the _____program.	1	2	3	4	5
10. I have felt staff help me to plan my own goals.	1	2	3	4	5
11. Staff have helped me to learn where to get help when I want it.	1	2	3	4	5
12. The _____program has influenced how I do some things.	1	2	3	4	5

Revised January 2013

ASL ☐ Video ☐

Appendix 5

Service Questionnaire Guidelines

The Service Questionnaires are meant to give all participants the opportunity to provide feedback on the service that they receive at New Directions. It is meant to inform programs of strengths and weaknesses in their delivery of service, as reported by the participants. All programs must offer the questionnaire to participants; participants have a choice to respond or not.

The Service Questionnaire measures 4 factors: ***respect*** (to the person and the issues of concern to the person), ***outcome*** (benefits of participation in the program, such as skills and knowledge, changes in behaviour, changes in emotional well-being), ***empowerment*** (person's sense of having a say in how the program provided support), and ***culture*** (person's experience of respect and support for his or her culture).

Reporting

Reports based on the Service Questionnaire will be produced annually. Reports will be based on the period between the first day in January and the last day in December. A report collapsed across all programs for an overall agency report for New Directions will be produced. This agency report will be written in February/March annually.

Frequency of administration

How often the Service Questionnaire is administered to participants is determined by individual programs, but it is to be administered at least once per year (see Program Service Questionnaire Administration Schedule). Administration of the Service Questionnaire is meant to be a routine task within the natural flow of the program, and should therefore occur at some point within the program where it makes sense and would be easy to remember and administer (e.g., with follow up, during graduation preparation, in the process of discharge, etc.).

Which Service Questionnaire version to use

Please use the most recent and updated Service Questionnaires for your program; do not use older versions. The most recent were revised **January 2013.** Service Questionnaires revised prior to this have some questions that have been changed on the most recent SQ's.

There are two types of Service Questionnaire: Program and Counsellor. There are four versions for each type: 12-5 item, 12-3 item, 8-item, and 4-item version. The versions vary in terms of the number of questions (12, 8, or 4), the number of response options (5 options or 3 options), and the use of visual support (smiley faces) for response:

These can be found in your programs' shared folders:

Z drive → Evaluation Committee I or II → *Program Folder* → Evaluation Tools Templates → Service Questionnaires → Service Questionnaires Program Versions or Counsellor Services or Care Provider Versions (if your program has sub programs, you will see these folders with SQ's for each sub program).
There you will find all of the SQ's: SQ4, SQ8, SQ12-III, SQ12-V (Revised January 2013).

Last review - March 2012; Sept. 2016

Appendix 6

NEW DIRECTIONS

Service Questionnaire (SQ12-5 and SQ12-3) Item Explanation Sheet

- Introduce the questionnaire with the following explanation:
  Thank you for helping us with this. We will go through each question and will put your response on this sheet (show the person the questionnaire and point to the response section). Your responses are private, so we will not write your name. There are no right or wrong answers. Anything you say will be very helpful.

- Explain the response options:
  With every question, you can say how much you agree or disagree. Your answer can go from disagree strongly all the way to agree strongly. If you are somewhere in the middle, you can say you disagree a little, neither agree nor disagree, or agree a little (point to options as you mention them).

- Read one question at a time and wait for a response, if you notice the person needs further clarification, use the explanation/examples provided.

- Be careful, as you administer the questionnaire, ***NOT TO***
  - Provide or suggest answers to the questions for the participant. You can, however, fill the demographic information for the participant (i.e., age, gender, time in program, etc.).
  - Make gestures that suggest your preference or inclination towards an answer
  - Rush the participant

	QUESTIONS	EXPLANATIONS/ EXAMPLES
1.	I feel that (program) has *supported my contact with my culture* (values, beliefs, traditions) as much as possible.	- Staff helped me think about teachings that have been passed on to me - Staff encouraged me to take part in traditions from my community that are important - Staff help me think about how things are viewed from my culture. - *For instance:* o going to a ceremony o celebrate an event or holiday o value a role model
2.	I have felt that (program) staff did *not respect me.*	*For instance:* I felt staff treated me as if I… - had no value - did not matter - did not count

Revised – March 2010; Sept. 2016

Appendix 7

SERVICE QUESTIONNAIRE- SQ12 & SQ12-V - FACTORS

Factor	Item*	Item number
Respect: Person	I have felt that (program) staff did **not** respect me.	2
	I have felt appreciated and valued by staff of program I have felt appreciated and valued by my therapist	4
Respect: Issue	I have felt that staff do **not** pay attention to what is important to me I have felt that my therapist/clinician does **not** pay attention to what is important to me.	7
Outcome: Skills and knowledge	While in the (program), I learned helpful things	5
Outcome: behaviour	The (program) influenced how I do some things	12
Outcome: emotional	Since starting the (program), I feel better about myself	3
Empowerment	I have felt staff help me to plan my own goals	10
	I feel I have the opportunity to make my own choices	8
	Staff have helped me to learn where to get help when I want it *I feel my therapist/clinician has helped me to learn where to get help when I want it*	11
Culture: Humility	I felt that my culture was treated with respect in the (program). *I have felt that my values and beliefs were treated with respect in the (program).*	6
Culture: Responsiveness	I feel that (program) has supported my contact with my culture as much as possible. *I feel that my therapist/clinician has been sensitive to my values and beliefs*	1
	I feel culture is important in the (program). *I have felt my values and beliefs are important in my sessions at the (program).*	9

SERVICE QUESTIONNAIRE- SQ8/ SQ4- FACTORS

Factor	Item*	Item number SQ8	Item number SQ4
Respect: Person	*I feel the program respects me*	2	1 *(2)*
Respect: Issue	I feel staff care about what is important to me	4	
Outcome: Skills, knowledge &/or behaviour	*While in the program I learned things that will help me*	6	2 *(6)*
Outcome: emotional	Since starting the program, I feel better about myself	3	

March 2009

Appendix 8

UNIVERSITY OF MANITOBA

Rady Faculty of Health Sciences
Max Rady College of Medicine
Department of Community Health Sciences
307 Human Ecology Bldg
Winnipeg, Manitoba
Canada R3T 2N2
Phone (204) 474-8065
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RESEARCH PARTICIPANT INFORMATION AND CONSENT FORM
Individual Interview

Title of Study: Validation of a service questionnaire tool measuring respect, empowerment, culture and outcome
Principal Investigator: Md Jahidul Islam,
Research Supervisor: Dr. Javier Mignone
Sponsor: N/A

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

Purpose of this Study

The main objective of the proposed study is to validate New Direction's Service Questionnaire tool that were developed to measure respect, empowerment, culture and outcome. Accordingly, the study will also refine the tool and make recommendations.

Selection

You are being asked to participate in this study because you are one of the staffs that are involved in developing or using the Service Questionnaires. We expect to interview a total of4-5 staff members.

Study Procedures

- The method of data collection for this study will be an individual interview (face to face).
- Participation in the study will take approximately 30 minutes
- I, the student principal investigator will ask some questions about your experience in the program.These questions will help us to better understand about the validation of the Service Questionnaires
- With your consent, the sessions will be audio-taped by digital audio recorder, and will be transcribed verbatim to ensure accurate reporting of the information that you provide.
- Your name will not be asked or revealed during the recording time.

- The digital audio-recordings files will be password protected and stored in main computer of the researcher and his supervisor before and after being transcribed. The digital audio recordings will be destroyed immediately after completing the transcriptions and the transcriptions will be destroyed within 1 year after the completion of this interview.

Risks

Risks are not more than in everyday life.

Benefits

Being a participant in the interview may not help you directly, but information gained may help other people who are taking services from different programs at New Directions.

Payment for Participation

You will receive no payment or reimbursement for any expenses related to taking part in this study.

Confidentiality

We will do everything possible to keep your personal information confidential. Your name will not be used at all in the study records unless you want to. If the results of this study are presented in a meeting, or published, we will do our best to protect confidentiality. Please note that although you will not be identified as the speaker, your words may be used to highlight a specific point.

Study Records

Only my supervisor and The Joint-Faculty Research Ethics Board (JFREB) of the University of Manitoba will have access to the study records to ensure that the study is conducted properly and according to the submitted and approved protocol.

Permission for Recording

How you want the interview to be recorded?	
☐ Yes ☐ No	I agree to be audio recorded and notes will be taken during interview
☐ Yes ☐ No	I agree that my interview will be recorded by taking notes only

Permission to Quote

We may wish to quote your words directly in reports and publications resulting from this. With regards to being quoted, please check yes or no for each of the following statements:

Researchers may publish documents that contain quotations by me under the following conditions:	
☐ Yes ☐ No	I agree to be quoted directly (my name is used).
☐ Yes ☐ No	I agree to be quoted directly if my name is not published (I remain anonymous).
☐ Yes ☐ No	I agree to be quoted directly if a made-up name (pseudonym) is used.

Dissemination

The findings of the study will be shared in the form of study report with New Directions management and staff. Moreover, the researcher may disseminate the study result in conference presentations, journal articles and report to New Direction. The researcher will publish this study as a thesis paper in MSpace at University of Manitoba websites. Only a summary report will be provided to the study at the end of the study (approximately on August 2019). They will have options to receive the report including hard copy via mail and at hand or electronic copy via email.

Voluntary Participation/Withdrawal from the Study

Your decision to take part in this study is voluntary. You may refuse to participate, or you may withdraw from the study at any time before July 31, 2019 without any negative consequences. As a staff of New Directions, your participation or discontinuance in the study will not constitute an element of your job performance. Neither this study will evaluate your job performance nor share part of your personnel record at any of these Institutions.

Questions

If any questions come up during or after the study contact the principal investigator and the study staff: Md Jahidul Islam

For questions about your rights as a research participant, you may contact The University of Manitoba, Fort Garry Campus Research Ethics Board Office at (204) 474-7122

Consent Signatures:

1. I have read all 4 pages of the consent form.
2. I have had a chance to ask questions and have received satisfactory answers to all of my questions.

3. I understand that by signing this consent form I have not waived any of my legal rights as a participant in this study.
4. I understand that my records, which may include identifying information, may be reviewed by the research supervisor of this study.
5. I understand that I may withdraw from the study at any time before 31 July 2019 and my data will be withdrawn prior to publication.
6. I understand I will be provided with a copy of the consent form for my records.
7. I agree to participate in the study.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and /or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.
The University of Manitoba may look at your research records to see that the research is being done in a safe and proper way.
This research has been approved by the Joint-Faculty Research Ethics Board (JFREB). If you have any concerns or complaints about this project you may contact any of the above-named persons or the Human Ethics Coordinator at 204-474-7122 or humanethics@umanitoba.ca. A copy of this consent form has been given to you to keep for your records and reference.

Participant's Signature _____ Date _____
Researcher's Signature _____ Date _____

Appendix 9

Research Participants Wanted

My name is Md Jahidul Islam, a graduate student in the department of Family Social Sciences, at the University of Manitoba. I am conducting a study as a requirement of my M.Sc degree. Please find attached more detailed information and a consent form. If this is something you might be interested in, or if you have any questions, do not hesitate to contact me.

Study Title: "Validation of a service questionnaire tool measuring respect, empowerment, culture and outcome".

Purpose

The purpose of this study is to validate New Direction's service questionnaire tool that has been developed to measure respect, empowerment, culture and outcome. Accordingly, the study will also refine the tools and make recommendations.

Population

The study requires 4 to 5 informants from New directions who-

- are the current employees at New Directions
- are or were involved in developing Service Questionnaire tools
- are involved in distributing the service questionnaires
- are involved in policy making positions in ensuring the quality of service at New Directions

Interview Guideline

The method of data collection for this study will be a face to face interview. This interview takes approximately 30 minutes. I, the student principal investigator, will ask some questions about your experience about the development, use and application of the Service Questionnaire tools. Your response will help us to understand in depth about the purpose of development of this tool. This understanding will help me to validate the Service Questionnaires. With your consent, the sessions will be audio-taped, and will be transcribed verbatim to ensure accurate reporting of the information that you provide. Your name will not be asked or revealed during the interviews. The digital audio-recordings files will be password protected and stored in main computer of the researcher before and after being transcribed. The digital audio recordings will be destroyed immediately after the completion of the transcriptions and the transcriptions will be destroyed within 1 year after the interview. Please be informed that your participation in this study is completely voluntary. You can refuse to participate/withdraw without any consequences.

Risks

Risks are not more than in everyday life.

Benefits

Being a participant in the interview may not help you directly, but information gained may help other people who are receiving services from different programs at New Directions.
If this is something you might be interested in, or if you have any questions, do not hesitate to contact me for further information!

Principal Investigator: Md Jahidul Islam, Department of Family Social Sciences, University of Manitoba, Manitoba, Canada R3T 2N2.
Advisor: Dr. Javier Mignone, Department of Community Health Sciences , 307 Human Ecology Bldg , Winnipeg, Manitoba, Canada R3T 2N2. Phone (204) 474-8065, Fax (204) 474-7592
Email: javier.mignone@umanitoba.ca
Note: This research is approved by Joint-Faculty Research Ethics Board, University of Manitoba. For questions about your rights as a research participant, you may contact The University of Manitoba, Fort Garry Campus Research Ethics Board Office at 204-474-7122.

Appendix 10

QUESTION GUIDE FOR STAFF INTERVIEWS

1. What was your intention when you developed the Service Questionnaire?

2. Why did you decide to develop and then continue to use the Service Questionnaire across the whole organization?

3. To what extent do you think that four domains (respect, culture, empowerment and outcome)of the Service Questionnaire meet the main purpose of the organization?

4. To what extent have you used the data from the questionnaires? How? Examples?

5. After having the service questionnaires for several years, do you think some revisions may be necessary? If so what suggestions or ideas would you have?

6. Is there anything that you want to add? Have I missed anything?