Virginia HEALS

Caring Collaboration, Empowering Families

The Virginia Victimization Screen[1] Pilot and Evaluation Report

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[1] Following the conclusion of the pilot phase, the Virginia Victimization Screen (VVS) was re-named the Screening for Experiences and Strengths (SEAS), and the Linking Systems of Care Project (LSC) was re-named Virginia HEALS All future references to SEAS and Virginia HEALS model stem from the VVS pilot and the LSC project.

Acknowledgements

Linking Systems of Care (LSC) project staff and all who participated on the research team would like to thank the many individuals, agencies, and organizations that contributed to the development, piloting, and evaluation of the Virginia Victimization Screen (VVS). First and foremost, we would like to acknowledge the 17 local agencies and organizations (Appendix A) throughout the Commonwealth of Virginia that participated in the pilot. Service providers from a variety of child-serving systems in the Cities of Alexandria, Charlottesville, Newport News, Hampton and Richmond, and the Counties of Albemarle, Henrico, and Washington, devoted time, energy, and resources to participate in not only administering the VVS to children, youth, and caregivers, but also in trainings, site visits, and focus groups critical to a successful pilot and evaluation of the screening tool.

The pilot and evaluation of the VVS took place over the course of more than 3.5 years, during which LSC project staff, in various positions and roles, made instrumental contributions to the development, training, and pilot of the VVS. Specifically, we would like to express gratitude to Jenna Foster, Monique Williams, Calvin Nunnally, Anna Cody, Kim Barbarji, Stacie Vecchietti, Chidimma "Chidi" Uche, and also to Virginia's LSC Project Director, Nancy Fowler.

The LSC Project is supported by funding from the U.S. Department of Justice, Office of Justice Programs, Office for Victims of Crime. In addition to providing direct support to Virginia and other demonstration states, this funding also supported invaluable training and technical assistance by the National Council of Juvenile and Family Court Judges (NCJFCJ) as well as guidance from child trauma experts who were on the project's National Steering Committee or other partner groups. Including in these advisors were: Isaiah Pickens, Ph.D., a Licensed Clinical Psychologist, who contributed both on site and virtually to the development of the VVS; Lisa Conradi, Psy.D. and Director of Clinical Operations at the Chadwick Center for Children and Families at Rady Children's Hospital, who developed and facilitated training on trauma-informed screening for two of the three waves of pilot sites; and Jane Halladay Goldman, Ph.D., Service Systems Program Director at the National Center for Child Traumatic Stress Network, who provided key recommendations for final modifications to the VVS prior to statewide rollout. We would also like to acknowledge Hunter Hurst, IV, Senior Research Associate with NCJFCJ, who supported LSC project staff in compiling information for and assisting in the writing of this report.

For a project this lengthy, dozens of people contributed to the development, piloting, and/or evaluation of the VVS. A Screening Tool Committee (workgroup), made up of an array of front-line service providers from a variety of systems convened for a year to provide input and feedback on the VVS's domains and questions, and the LSC's Training Committee provided input on the creation of the training manual and module. Research Assistants from Virginia Commonwealth University's Psychology Department collected and helped analyze data and

compile reports from and of the various pilot sites. Finally, we acknowledge those who served on the Virginia LSC Partner Agency Team, who offered ongoing insight and constructive feedback into the development and piloting of the VVS and their valuable leadership to the LSC project as a whole. (See Appendix B for the full list of Contributors.)

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Executive Summary

Linking Systems of Care (LSC) is a seven-year demonstration project implemented to help service providers better identify traumatic experiences among children, youth and young adults and respond with a continuum of services that can help to address the long-term consequences of exposure to abuse and crime. The project is funded by the United States Department of Justice, Office of Justice Programs, Office for Victim of Crime (OVC).

Launched in January 2015, Virginia was selected to be one of two state-level demonstration sites, with two additional state sites joining the project in 2018. State demonstration sites were tasked with bringing together all relevant child-serving systems and professionals to establish a coordinated approach that would ensure that every child entering these systems is screened for victimization and trauma, provided coordinated and comprehensive services to address their needs, and that policies and practices are established to sustain the project long-term.

This report presents findings from an evaluation of the Virginia LSC project's development and implementation of a screening instrument, the Virginia Victimization Screen (VVS), and pilot implementation in three different regions of the state.

Primary Activities

Virginia's LSC project's work around screening for victimization and trauma was organized into three distinct phases: 1) a 15-month planning phase during which the primary objective was to research evidence-based approaches to screening and determine an approach for Virginia; 2) a 3-year pilot phase that ended in March 2020, during which the VVS, screening procedures, and response and referral practices were developed and tested; and 3) a sustainability phase during which the VVS, along with a toolkit of resources to support the LSC model of service delivery, was rolled out to child, youth, and family service providers statewide. OVC funding support for the project ends in March of 2021.

Evaluation Methods

The evaluation methods examined in this report and its supporting appendices included quantitative and qualitative approaches. Project staff collected focus group data from professionals involved in implementing the VVS and contracted with Virginia Commonwealth University (VCU) to analyze that data and to conduct a descriptive data analysis of screening results and service referral information. VCU also conducted tests of internal validity for the emerging VVS and helped to advise improvements during each phase.

Key Evaluation Findings and Recommendations

A summary of evaluation findings is presented below and supported in greater detail within the report narrative:

- The development of the VVS was preceded by a national search for existing screening approaches intended for young victims from early childhood (under age 6) through teen years and into young adulthood. A good fit for the LSC project's goals was not found. Through consultation with leading experts and with support from the project's national Steering Committee, the VVS was developed.
- The VVS was piloted across a diverse range of communities within Virginia, including a mixture of both urban, suburban, and rural communities. The pilots involved a variety of settings that provide services to children,youth, and families and the VVS has promise for being implemented in these settings.
- The VVS training was effective at increasing service providers' perceived ability to administer the screening and their knowledge about childhood victimization.
- Given the breadth of communities and local partner agencies, the project encountered some challenges. However, there was wide support for the VVS among those implementing the tool, even when they encountered challenges in their particular environment.
- Overall, 230 screens were administered during the pilot phases of the project; and with ongoing feedback from the project's evaluation process led by VCU, the VVS was modified and improved. The VVS received broad support among those working directly with children and youth during the pilot, despite some feedback about the awkwardness of asking specific types of questions.
- The pilot helped both the screen administrators and the people being screened understand that there are ways to help people who have experienced bad things.
- VCU determined that the VVS is serving its intended function to identify young victims and link them to services, and responses to VVS items during the pilot phases were determined to be internally coherent.

Recommendations for advancing the VVS are organized under the topics of ongoing training to support statewide implementation, evidence supporting statewide implementation, and next steps required to advance the research supporting the screening instrument.

Training

Recommendation 1: Continue ongoing VVS training to address the needs of those implementing the instrument in a manner that is responsive to their agency roles and culture.

Recommendation 2: Improve the training to address the needs of screeners who lack a specific background in behavioral health.

Recommendation 3: Consider expanding the core training to include a component on cultural diversity.

Statewide Implementation

Recommendation 4: The VVS should be implemented across the Commonwealth with support to organize continuous feedback for refining the screening tool and procedures for administering it.

Recommendation 5: Refine the Spanish language version of the VVS to consider informal and formal communication styles.[2]

Recommendation 6: Expand translation of the VVS into additional languages commonly spoken in Virginia.

Research

Recommendation 7: Two to three years into statewide implementation, seek support for continuing to advance the research supporting the reliability and validity of the VVS and assessing whether VVS guided intervention and referral leads to better outcomes for youth. Focus future research on settings where the VVS is in wide use and focus research activities with data support from that agency sector.

[2] This recommendation has been incorporated, as the Spanish version has been re-translated since the conclusion of the pilot.

Linking Systems of Care Project and Virginia Victimization Screen Rebranding

Focus group and monthly site visit feedback from service providers administering the Virginia Victimization Screen (VVS) to children, youth, and caregivers during each of the three waves of the pilot consistently indicated a preference for re-naming the tool. According to providers, using the "victimization" term made it challenging to introduce the screening tool and did not promote a strengths-based approach. Discussions around potential new names indicated a preference to also avoid the word "trauma" for the same reasons. In light of these considerations and noting that the screening tool includes a domain to identify protective factors, following the third and final wave of the pilot, project staff renamed the screening tool the **Screening for Experiences and Strengths (SEAS)**.

At the same time, project staff determined that it would be timely to rename and create a new brand and visual identity for the Linking Systems of Care (LSC) project, as LSC is specifically tied to the name of the Federal grant, which ends in March 2021. Project staff worked with a branding firm and gathered input from a diverse group of stakeholders to select a name, logo, and tagline that would reflect the overarching goal of linking systems of care and also highlight family engagement and empowerment, primary themes embedded in Virginia's work and model of service delivery. The LSC Project in Illinois, one of the three other state demonstration sites, branded their project Illinois HEALS (**H**elping **E**veryone **A**ccess **L**inked **S**ervices), and the Virginia team decided to use this name as a base, with the addition of a state-specific tagline. Moving forward, the LSC project in the Commonwealth of Virginia will be referred to as **Virginia HEALS, "Caring Collaboration, Empowering Families."**

Virginia HEALS

Caring Collaboration, Empowering Families

Background

Linking Systems of Care (LSC) for Children and Youth is a statewide demonstration project funded by the United States Department of Justice, Office of Justice Programs, Office for Victims of Crime. The goal of the project is to identify children and youth who have had crimes committed against them and to address the potential serious and long-lasting consequences of exposure to crime. The project gives Virginia, along with three other states, an opportunity to collaboratively create, strengthen, and improve the coordination of services provided by the many child and youth-serving systems to ensure that:

1. children are screened for victimization;
2. children, youth and families are provided comprehensive and coordinated services to fully address their needs; and
3. policies and practices are established to sustain this approach long-term.

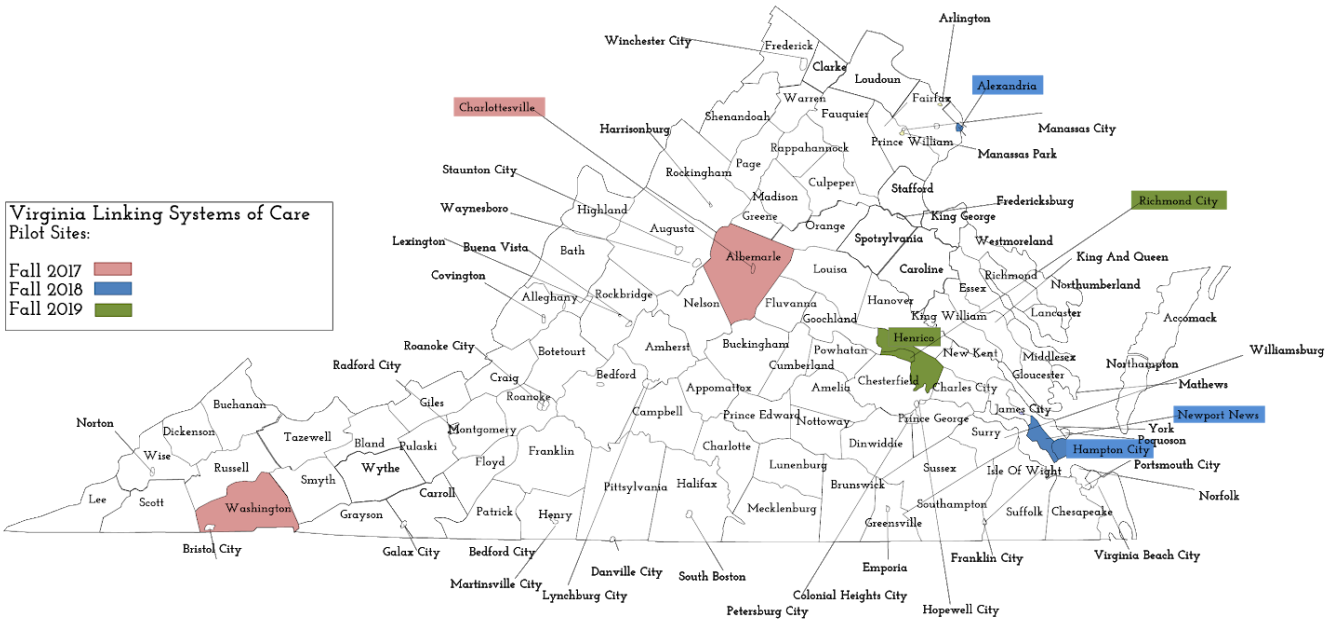
During the first 15 months, the project's designated "planning phase," a number of evaluation activities, including a statewide Stakeholder Survey and five Cross-Systems Mapping Events, were undertaken to obtain information from front line service providers on current screening and assessment practices of children and youth, the training associated with these screening and assessment tools, and inter-agency collaboration. The more than 1,550 front line service providers that participated in these activities represented a variety of systems (child welfare, advocacy, juvenile justice, criminal justice, education, behavioral health, and public health) and reported utilizing over 50 different screening and assessment tools, not routinely receiving training on how to administer these tools or assessments, and supporting the development of a brief screening tool that that could be used by and across their systems.

LSC project staff first convened a multi-disciplinary workgroup (Screening Tool Committee) in July 2015, which collected and reviewed numerous existing evidence-informed screening tools and assessments for child victimization and trauma (e.g. Child Trauma Screening Questionnaire, Child Stress Disorder Checklist), focusing specifically on questions, constructs, and measures of trauma symptomatology. Unable to find an existing brief screening tool that covered a wide array of victimization types and that could be used by front line service providers in any/all child-serving systems, the workgroup decided to proceed with developing, piloting, evaluating, and implementing one in the Commonwealth.

The Screening Tool Committee spent over 12 months developing the Virginia Victimization Screen (VVS), which was then approved for piloting by the LSC's state leadership group, the Partner Agency Team (PAT), in July 2016. Simultaneously, project staff, with input from a Training Committee, developed a training manual and module for those who would be administering the VVS. As the project moved into the next phase, the VVS was piloted in three waves (cohorts) of service providers from across a variety of systems and demographically diverse communities. Pilot communities included: Charlottesville/Albemarle

and Washington County (Wave 1); Alexandria and Newport News/Hampton (Wave 2); and the Greater Richmond Region (Wave 3). Providers in each community administered the VVS to children, youth, and their caregivers for a six-month period.

Figure 1: Map of Pilot Site Localities



The Virginia Department of Social Services, the lead agency under which the LSC project is housed, deferred to the Institutional Review Board (IRB) at Virginia Commonwealth University (VCU) to review and approve the research proposal and protocol; and Dr. Jared Keely, Principal Investigator and research partner in the Psychology Department, conducted the analysis of the qualitative and quantitative data regarding the screening tool and the accompanying training manual and module that was developed and provided in person to screen administrators. The Virginia Department of Juvenile Justice has its own review board, the Human Rights and Research Committee, which reviewed and approved a separate research proposal and protocol for local Court Service Unit participation in the pilot, with analysis of that data also being performed by the VCU Psychology Department. This report is a compilation of data and findings from all three of the pilot site waves.

Development of the Screening Tool

Key Terms and Domains

Prior to crafting the content of the VVS, it was necessary to agree on the scope of the screening tool and the definitions of key terms that would provide structure for its development:

- Participation in Extracurricular Activities: Any activity outside of school and/or work in which a child/youth participates as a positive outlet (i.e., sports, choir, youth groups, volunteering)
- General Feelings of Fear: Any activity and/or observation of an activity that places one in a heightened sense of danger.
- Action-Need for Help: Any activity and/or observation that places someone in need of emergency assistance from law enforcement, first responders, or other trusted adults.
- Exposure/Community Violence: Exposure to intentional acts of interpersonal violence committed in public areas by individuals who are not intimately related to the victim.
- Threatened by a Deadly Weapon: Any act or threat including a weapon that can be used to physically harm, mutilate, or kill someone.
- Emotional Bullying: Any act including isolation, verbal assault, humiliation, intimidation, or any other treatment which may diminish the sense of identity, dignity, and self-worth.
- Safety Needs: Any activity that may restrict someone from accessing basic health and safety needs such as medications, bathing, toileting, etc.
- Physical Bullying: Any act when a person uses overt bodily acts to gain power over peers. Physical bullying can include kicking, punching, hitting or other physical attacks.
- Physical Assault/Abuse: Any intentional act that causes another person to fear that they are about to suffer physical harm. This construct recognizes that placing another person in fear of imminent bodily harm is itself an act deserving of punishment, even if the victim of the assault is not physically harmed.
- Sexual Assault/Abuse: Any type of sexual contact or behavior that occurs without the explicit consent of the recipient. Falling under the definition of sexual assault are sexual activities such as forced sexual intercourse, forcible sodomy, child molestation, incest, fondling, and attempted rape.
- Sexual Assault/Abuse-Human Trafficking: The recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery. It also refers to sex trafficking in which a commercial sex act is induced by force, fraud or coercion.

After the key terms were identified and defined, based on a review of comparable tools, two primary domains of **Identification of Victimization** and **Reactions to Victimization** were identified. Based on input from the workgroup and other stakeholders, a third primary domain, **Protective Factors**, was identified to more effectively promote and support resilience and a strengths-based approach. Throughout the iterations and modifications to the tool, these three primary domains remained constant.

Content Validity

Content validity refers to how well a test covers the domain of behavior which it is intended to measure. A standard method for assessing content validity involves judgments by subject matter experts (SMEs) with expertise in the content of the instrument. The expert panel provides information on the representativeness and clarity of each item on the instrument, determines whether the instrument is measuring what it is supposed to, and provides suggestions as to how to improve the instrument[3] Over the course of more than a year, a panel of researchers and experts from Virginia and across the country created the VVS. That process, as it relates to the test's content validity, is detailed in this section.

The aforementioned workgroup that LSC project staff convened to develop the tool included experienced professionals from child welfare, public health, juvenile justice, public health, early childhood development, and advocacy systems and included those working at both the local and the state level in both front line service workers and leadership positions. LSC staff and the workgroup also routinely received input and guidance on developing the structure of the tool and its questions and constructs from national technical assistance providers at the National Council of Juvenile and Family Court Judges (NCJFCJ) as well as Dr. Isaiah Pickens, a national expert in childhood trauma who participated on the LSC project's National Steering Committee. The PAT, the project's state-level leadership team, was also engaged in the development and review processes for the VVS, having provided feedback on it and voting affirmatively to approve its use prior to being finalized for piloting.

Following the second wave of pilots and largely based upon an analysis of qualitative data from 14 focus groups, changes were made to the screening tool to make the language more age and developmentally appropriate, reduce or remove duplicative or unnecessary questions, and to make the tool more brief and user-friendly. Feedback and assistance in making these changes was solicited and obtained from the LSC project's Stakeholder Advisory Group, which included front line workers in child advocacy programs, behavioral health, and school counseling.

Final modifications were made after the third wave of pilots. These changes were also based on focus group feedback as well as the recommendations of Dr. Jane Halladay Goldman, child trauma expert at the National Child Traumatic Stress Network, to clarify and simplify the wording of four questions around sexual assault/abuse and sex trafficking.

Description of the Screening Tool

The VVS is available in three age-specific versions, 0 to 6 years old (to be administered to parents and caregivers), 7 to 12 years old, and 13 to 21 years old. The language employed in each version varies slightly to reflect phrases that are age and developmentally appropriate.

[3] Bunch, J., Mayer. J. & McKay, P. (2020). *The Montana Experiences and Expressions Screener Validation Report*. Missoula, MT: University of Montana, Criminal Justice Research Group.

Front-line service workers are to perform the screenings, as the tool was not developed for children, youth, and/or caregivers to self-administer. The overall structure and content is the same across the three versions, with the three primary domains being **Identifying Victimization, Possible Reactions to Trauma**, and **Protective Factors,** and two additional domains to obtain **Demographic Information** and encourage **Rapport Building**.

The VVS's **Demographic Information** domain (Part A) (Fig. 2) collects information about which agency or organization is administering the screen, the date that the screening occurs, and the start and end time of the screening. It also collects information about the child or youth's age, gender, race/ethnicity, and preferred language. No personally identifiable information is collected. Following this domain, there are also questions to indicate whether a caregiver or parent is present as well as who is answering the questions (child/youth, parent/caregiver, or both).

Fig. 2: Part A. Demographic Information

AGE (in years): _____	RACE/ETHNICITY (Check all that apply):	PREFERRED LANGUAGE:
GENDER: ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Non-Binary	☐ Caucasian ☐ African American ☐ Asian/Pacific Islander ☐ Hispanic/Latino ☐ Native American/American Indian ☐ Middle Eastern ☐ Other:	☐ English ☐ Spanish ☐ Other: _____
These questions can be addressed to a child/youth or, for younger children, to the parent/caregiver, who answers in terms of their concerns for the child.		
Who is answering these questions? ☐ Child/Youth ☐ Parent/Caregiver ☐ Both		
Was parent or caregiver present during the session? ☐ YES ☐ NO		
Source: The Virginia Victimization Screen, Ages 7-12.		

The **Rapport Building** domain (Part B, Fig. 3) does not collect any data or information. It is included in the VVS as a reminder to those administering the screen of the importance of establishing rapport with a child/youth and/or parent/caregiver prior to asking questions that may be very difficult.

Fig. 3: Part B. Rapport Building

Part B: Rapport Building. Many of the topics brought up in the screening tool are sensitive topics and often difficult to discuss. For this reason, we strongly encourage that the interviewer ask the child or youth a few informal questions to increase their comfort level with them prior to discussing any forms of victimization. The objective of this section in the screening tool is to develop trust. You do NOT need to write down or record their answers to these questions.

Source: The Virginia Victimization Screen, Ages 7-12.

The **Identifying Victimization** domain (Part C, Fig. 4) begins with suggested wording for introducing the screening tool, with specific emphasis on explaining assent, which is the right of the child or youth to skip any questions they don't feel comfortable answering, or to stop the screening at any time. The 14 items included on this domain fall into the following categories: community violence, weapon exposure, neglect, threat, physical abuse, and sexual abuse. For a "yes" response to any of these questions, two additional questions are asked.ne identifies if the event happened in the last thirty days and the other identifies if it was perpetrated by a family member or caregiver. Both of these items are included to better assess for risk factors and the need to make a mandatory report to Child Protective Services. For each yes in this section, a point is calculated.

Fig. 4: Part C. Identifying Victimization

Part C. Identifying Victimization. We are interested in learning about your life experiences. Sometimes very scary or upsetting things happen to people. These scary or upsetting things may be done by people you know and love. I am going to ask you some questions today to find out if any scary or upsetting things have happened to you. If you feel uncomfortable answering these questions, you can also tell me you want to stop. The information you share with me is completely voluntary. If you do NOT want to answer a question, just say 'skip'.

☐ *Check if you read the statement above.*

Item	FOLLOW-UP QUESTIONS: If YES, ask "has it happened in the last 30 days?" If it occurred in the last 30 days, score as 2. If any responses are YES, ask "has it has occurred from a caregiver/family member?"	Answer Choices: S = Skip 0 = No 1 = Yes 2 = Yes within 30 days	Answer Choices: Perpetrated by Caregiver/ Family Member? (0 = No; 1= Yes)
1.	Have you ever been in a place where you saw or heard:		
a.	Physical fighting between neighbors or people at school?		
b.	Physical fighting between family members?		
c.	Gun shots? (where you may have been in danger)		
d.	Someone taking or stealing something by force?		
2.	Has anyone ever:		
a.	Used a gun, knife, or other weapon against you?		
b.	Used a gun, knife, or any other weapon against anyone else you were hanging out with?		
c.	Kept food or medicine from you that you needed?		
d.	Said that they would hurt you or someone you care about?		
e.	Teased, bullied or harassed you in person or online?		
f.	Pushed, slapped, thrown something at or hurt you in some way?		
g.	Taken pictures or videos of you naked?		

h.	Touched your private parts with any part of their body?		
i.	Asked or forced you to touch their private parts with any part of your body?		
j.	Offered to give you money, food or other things for them to touch or see your private parts or for you to touch or see theirs?		
	Total Score: *(If total score equals ZERO, skip Part D. Go directly to Part E.)*		
Source: The Virginia Victimization Screen, Ages 7-12,			

The domain, **Reactions to Possible Victimization** (Part D, Fig. 5), measures various signs and symptoms of trauma and Post-Traumatic Stress Disorder. The section includes 8 items that assess for trouble eating, sleeping, or concentrating, fearfulness, anxiety, depression, and threats of harm to self or others. This section also includes items that assess the degree to which these symptoms impact the youth at school, home, work (if applicable) and relationships. The items are measured using a Likert scale ranging from "Never" to "Always," to assess for risk. Three additional items in this section address threats of harm to self or others. These questions ask if a child or youth has "ever" had these thoughts.

Fig. 5: Part D. Reactions to Possible Victimization

Part D. Reactions to Possible Victimization. The events listed above can be difficult to handle. Please tell us how often you have experienced any of the following feelings as a result of the experiences you just described and to what degree these feelings have impacted the way you deal with life.

Item	SCREENING QUESTIONS:	Answer Choices: Skip Never Rarely Sometimes Often Always
3.	Based on what you just told me, how often have you:	
a.	Had a hard time paying attention or concentrating?	
b.	Had trouble sleeping/soothing?	
c.	Felt on the lookout for danger?	
d.	Felt sad or down?	
e.	Felt upset, like you wanted to scream or hit someone?	
f.	Not wanted to eat or wanted to eat more than usual?	
g.	Found yourself wanting to be left alone more than usual?	
h.	Used drugs or alcohol?	
4.	How often have any of these issues made your life difficult:	
a.	At school?	
b.	At home?	
c.	With others?	
		Answer Choices: Skip No Yes
5.	Have you ever:	
a.	Tried to hurt yourself?*	
b.	Tried to hurt others?*	
c.	Felt like you wanted to stop living?*	

Source: The Virginia Victimization Screen, Ages 7-12..

Six items are included in the **Protective Factors** domain (Part E) (Fig. 6) to a) identify and build upon existing supports that a child or youth has in their life and b) promote a strengths-based approach in the concluding section of the VVS. The items in this section assess whether a child or

youth feels supported by family members (including extended family), friends, teachers or coaches, mentors, and their faith community. Even if a child or youth answers "No" to all sections in the Identifying Victimization domain, the administrator will still ask them the questions on the Protective Factors domain.

Fig. 6: Part E: Protective Factors

Part E. Protective Factors. Sometimes people around us can help us when we feel sad, upset, or having a problem. Please tell us more about which people in your life help and support you.

		Answer Choices: Skip	No	Yes	N/A
6.	Do you feel strong support from:				
a.	Parents or the people who take care of you?				
b.	Extended family? Aunts, uncles, cousins, etc.?				
c.	Friends or their families?				
d.	Teachers, coaches or other adults at school?				
e.	Mentor or someone who teaches you new things?				
f.	Church, mosque, or temple?				

Source: The Virginia Victimization Screen, Ages 7-12

The **Scoring Reminders Section** of the VVS is not directive. It does not indicate that a certain score requires a specific response, nor does it suggest that a specific referral be made. Every child or youth's experience with, and reactions to, trauma is unique; and, therefore, post-screening steps should be based on identified needs, any services or support that may have already been accessed and utilized, their level of support and protective factors, etc. The exception is for high-risk situations. Guidance is provided to assess the need for crisis intervention in cases where a child or youth has expressed thoughts of harm to self or others and to make mandatory reports in cases of abuse or neglect by a family member or caregiver. Reminders are designed to promote a child and family-centered approach in assessing all of the results in determining referral and response.

Description of Pilot Sites

A total of 114 service providers from 17 agencies and organizations participated in one of the three waves of the VVS pilot. Pilot community selection for each wave was made based on their region of the state, a balance of urban, rural, and suburban representation, as well as capacity and buy-in from agency and organization leadership. Each locality considered for the pilot opportunity was required to have a team approach that included participation from three to five different child-serving "systems". Participants of the three pilot waves represented both public agencies and community-based organizations in child welfare (local departments of human/social services), victim advocacy (child advocacy centers, domestic violence programs), public health (teen wellness center), juvenile justice (Court Services Units), and behavioral health (therapeutic day treatment, crisis stabilization) systems (Appendix A).

Project staff provided a full-day of live training, facilitated by at least two LSC project staff, to all participants on both how to obtain required guardian consent and child/youth assent to participate

in research and how to administer the VVS. Training included lecture, discussion, and role play. Pre and post-surveys were administered to all participants to evaluate the training. Following the full-day training, participants were provided with a training manual to use as a reference throughout the pilot. Per VCU's IRB requirements, any service provider administering the VVS was required to complete this training.

Project staff learned from Wave One pilot sites that many of the barriers to administering the screen were based on concerns that screening would re-traumatize children and youth. Therefore, additional training to address these concerns was provided to those participating in waves two and three. Lisa Conradi, Director of Clinical Operations at the Chadwick Center for Children and Families and national expert in the field of child trauma, facilitated this full-day training session, which included instruction and discussion on how to create a psychologically safe environment that supports youth and families within a trauma-informed system of care framework, how to respond to trauma disclosures, and secondary trauma.

During the six-month data collection period for each wave of pilots, LSC project staff also made monthly technical assistance site visits with each participating agency or organization, where they discussed how the pilot was going and addressed questions and challenges around administering the screen, required consent and assent, scoring, and/or data collection. Additional technical assistance was provided both on site and by phone or email, as requested.

Mid-way through and immediately following the conclusion of each wave of pilot sites, focus groups were held, facilitated by current and former project staff who were not directly involved with the pilots. Questions and discussion during the focus groups centered around the experiences using the VVS with children, youth, and families, including successes, challenges, and suggestions for improvement, as well as how well the training and technical assistance prepared them to administer the VVS.

Descriptive Summary of VVS Results Across Sites

Demographic Information

A total of 230 children and youth were screened across the three pilot waves (Wave 1 = 72, Wave 2 = 91, Wave 3 = 67). Demographic information on participating children and youth is presented in Figure 7.[4]

Fig. 7: Demographic Information for Virginia Victimization Screens

Total screens completed	230

	0-6	7-12	13-21
age group	100 (43.5%)	42 (18.6%)	88 (38.3%)

	Caucasian	African American	Asian/ Pacific Islander	Hispanic/ Latinx	American Indian	Middle Eastern	Multiple	Not Reported
race and ethnicity	55 (23.9%)	111 (48.3%)	3 (1.3%)	38 (16.5%)	3 (1.3%)	4 (1.7%)	11 (4.9%)	5 (2.2%)

	Female	Male	Transgender, Female	Transgender, Male	Non-Binary	Unspecified
gender	118 (51.3%)	103 (4.8%)	1 (0.4%)	0	1 (0.4%)	7 (3.0%)

	Child/ Youth	Parent/ Caregiver	Both
respondent	101 (43.9%)	112 (48.7%)	10 (4.3%)

[4] Because the child advocacy center, which administered a large percentage of the screenings, had a routine practice of interviewing the child with the non-offending caretaker, the number of VVSs in the 0-6 age range (the version used when interviewing a parent or caregiver) is skewed.

Victimization Types

As noted above, the VVS gathers information on six types of victimization, along with whether it was perpetrated by a family member. The table below illustrates the incidence of each type of victimization across all three waves. Note that the total number of types of victimization does not equal the total, as many children and youth had experienced multiple forms for victimization. Community violence was by far the most common form of victimization, and nearly half of the children and youth included in the study had experienced at least one form of victimization perpetrated by a family member. Over three-quarters (76.1%) of children and youth in the study reported experiencing at least one form of victimization.

Fig. 8: Victimization Types	
Community violence	136 (59.1%)
Weapon exposure	34 (14.8%)
Neglect	12 (5.2%)
Threat	79 (34.3%)
Physical	50 (21.7%)
Sexual	51 (22.2%)
Family Member Perpetration	93 (40.4%)

Protective Factors

The VVS gathered information on the protective factors upon which each child and youth could rely, presented in the table below. The version of the VVS used in Wave 3 also included a question about protective factors associated with religious affiliation, which was endorsed by 47.8% of that sample.

Fig. 9: Protective Factors				
Parents/ Caregivers	Extended Family	Friends	Teachers/ Coaches	Mentor
210 (91.3%)	186 (80.9%)	161 (70.0%)	148 (64.3%)	69 (30.0%)

Across all three waves of pilot study, a total of 98 interventions were offered to screened children, youth, and their families, and a total of 56 referrals were made to other agencies. Of the 98 interventions, 59 (60.2%) were accepted by the child/youth and family. Of the 59 referrals, 47 (83.9%) were accepted. The most common reason for declining additional services was that the child was already receiving services, either from the current agency or elsewhere.

There were some differences across the waves in the agency types piloting the VVS that impacted the nature of the results. The children and youth in Wave 1 were more likely to be Caucasian than for either Waves 2 or 3, which were more likely to be African American or Hispanic/Latinx. This distribution matches the general racial and ethnic demographic makeup of the regions represented in the three waves. Because of the agencies included, each wave had a different distribution of age

ranges. Wave 1 included mostly children in the youngest age range (0-6), Wave 2 had relatively few children in the middle age range (7-12), and Wave 3 had few children in the youngest age range (0-6). The types of victimization varied across the waves as well. Wave 1 children were more likely to experience neglect, threat, and sexual victimization. Wave 3 participants were the most likely to have experienced community violence. Rates of most types of victimization were lower in Wave 2.

Findings

Quantitative Findings

To examine the internal validity of the screening items, we used each victimization type from Part C to predict symptoms and impairment reported in Part D. ***All measures of symptom or impairment were significantly associated with one or more forms of victimization, and each type of victimization predicted at least one form of psychological impact.*** The individual pattern of prediction varied by wave of the study, which likely had to do with the specific makeup of the sample in each.

Wave 1. In the first pilot wave, exposure to a weapon was a predictor of every form of psychological impact measured by the VVS. This wave included the largest number of young children, and so weapon exposure may have had a more prominent psychological impact on children that age versus older youth. Exposure to a weapon was a significant predictor of difficulty attending or concentrating (item 3a; β = .25, p < .05), having difficulty sleeping or self-soothing (item 3b; β = .35, p < .01), frequent feelings of anger or irritability (item 3e; β = .35, p < .01), lack of appetite (item 3f; β = .32, p < .05), social withdrawal (item 3g; β = .28, p < .05), experiencing difficulty at school (item 4a; β = .41, p < .01), experiencing difficulty at home (item 4b; β = .55, p < .001). Having a heightened sense of danger (item 3c) was associated with having been exposed to a weapon (β = .46, p < .001) and physical assault (β = .32, p < .01). Feelings of depression (item 3d) was predicted by both weapon exposure (β = .51, p < .001) and neglect (β = .34, p < .01). Both weapon exposure (β = .40, p < .01) and sexual abuse (β = .27, p < .05) were associated with experiencing trouble with relationships (item 4c).

Wave 2. For the second pilot wave, associations between individual forms of violence and psychological outcomes were weaker, even though in combination they produced statistically significant predictions. This pattern is likely due to fewer children and youth in this sample having experienced a form of victimization. Community violence approached being a significant predictor of difficulty sleeping or self- soothing (item 3b; β = .24, p = .051) and was a significant predictor of feelings of anger or irritability (item 3e; β = .29, p < .05), and experiencing difficulty in relationships (item 4c; β = .27, p < .05). Neglect (β = .26, p < .05) was associated with a lack of appetite (item 3f).

Wave 3. The pattern of association in Wave 3 was the most complete, likely due to the children and youth in this sample having the widest range of exposure to victimization. Exposure to a threat (β = .29, p < .05) and community violence (β = .23, p < .05) were both significant predictors of difficulty attending or concentrating (item 3a). Experiencing neglect was associated with more difficulty sleeping or self-soothing (item 3b; β = .29, p < .05) and a higher sense of perceived danger (item 3c;

β = .41, p < .01). Feelings of depression (item 3d) were predicted by threat (β = .38, p < .001), community violence (β = .26, p < .05) and sexual abuse (β = .23, p < .05). Having experienced threat (β = .24, p < .05) or community violence (β = .40, p < .01) were associated with more frequent feelings of anger or irritability (item 3e). Threat (β = .33, p < .01) was also associated with a lack of appetite (item 3f). Feelings of social withdrawal (item 3g) were predicted by exposure to community violence (β = .28, p < .05), threat (β = .24, p < .05), and physical assault (β = .26, p < .05). Interestingly, exposure to weapons was associated with lower levels of social withdrawal (β = -.37, p < .01). Both threat (β = .25, p < .05) and community violence (β = .29, p < .05) predicted experiencing difficulty at school (item 4a). In contrast, home difficulties (item 4b) were predicted by neglect (β = .38, p < .001), community violence (β = .34, p < .01), and sexual abuse (β = .25, p < .05). Last, community violence (β = .31, p < .05) and neglect (β = .34, p < .01) were associated with problems with relationships (item 4c).

Across the three pilot waves, there is evidence that the forms of victimization measured by the VVS are meaningfully associated with psychological impacts for children and youth, as they would be expected to be. The nature of that association seems to vary by age, race, or other sociocultural factors. Nonetheless, the VVS is meaningfully selecting individuals who are experiencing problems that warrant additional intervention or treatment.

Qualitative findings

An element of the mix-methods screener evaluation design included focus groups for each of the three pilot waves. Results were summarized by VCU for each wave (see reports for each wave in Appendix C). This section provides a summary of focus group themes across waves 2 and 3 piloting where the question format was consistent and focused more specifically on comfort level utilizing the VVS and effectiveness of the training that was provided. National technical assistance providers from NCJFCJ reviewed VCU interim reports and findings and analyzed transcripts from 12 focus groups in qualitative analysis software (NVivo) for the purpose of confirming primary themes across both phases for an overall summary.

Focus group participants included staff who were directly involved in piloting the VVS with children and youth. Wave 1 focus groups were conducted in the fall of 2017 and questions addressed organizational collaboration, referral procedures, and cross training experiences. The question format changed for focus groups conducted in the subsequent 2 waves to address participants' experiences administering the VVS, training that was received to administer the screening process, response and referral procedures, and how the participants engaged families during the pilot.

The process for participating in the VVS pilot was the most frequently discussed theme during the focus groups. The process for explaining and obtaining informed consent/assent to participate in research required screeners to devote considerable time to administer. Focus group participants indicated that the process was detailed and overwhelming for some participants. For example, some screeners indicated that the amount of time needed to cover informed consent required an entire session or appointment. Participants continued by explaining that, if the parents/caregivers consented and the child/youth assented to the process and signed the required forms, they had to schedule another time with the family to administer the VVS.

Terms used to describe the consent process included: intense, invasive, too long, overwhelming and complex. Some focus group participants described a requirement to build strong personal rapport with clients prior to introducing discussions of the VVS and its status as a pilot research project. The care required to successfully administer the informed consent process caused some service providers to question whether they were qualified to administer the VVS, with some continuing to participate in the pilot project (participating in monthly site visits, etc.) but declining to administer the screen. They described needing training and technical assistance to overcome these challenges. Suggestions included a script for administering the informed consent process that covered the primary concerns but is more conversational and more comfortable to introduce to families.

Additional barriers for administering the screen included observations that the environment for administering a screen impacted the ability to apply it. For example, multiple respondents described the awkwardness of administering the screen in a school setting, where emotional reactions may be experienced by the participant, putting them in a vulnerable state of mind and then having to return to a classroom setting. Participants raising concerns frequently offered solutions. For example, one focus group participant described using patience in scheduling the procedure and mindfulness of the timing and setting for administering the VVS.

The second most prominent theme had to do with specific suggestions about the VVS and specific VVS questions. The number and scope of questions contained within the VVS was considered unwieldy by some. Focus group participants also raised concerns over the risk the screening might pose for re-traumatizing young victims and explained the danger this risk presents for providing a truly trauma-informed response and ready access to supportive services.

There was variation in this theme based on the agency in which the participants work. Some had substantial barriers to services that increased concern about re-traumatizing participants, such as service gaps or lengthy waiting lists. Respondents from other systems did not. Suggestions for improvement included having access to resource directories that have profiles for the eligible referral types. Some participants also expressed concern about lacking a background in mental health treatment and not knowing what the appropriate response to trauma being identified by a participant may be. Others expressed concerns about how to administer the screening questions to children and young people with cognitive delays or mental health challenges that cause them to be non-verbal, such as autism spectrum disorders. In these situations, screeners had to explain or, as they described, “unpack words” in the VVS in a manner that additional training could support.

Specific items were identified as frequently causing confusion, such as using the term “street fights” in the item to identify/screen for community violence. Focus group participants also had specific observations about VVS questions. Items regarding sexual experiences were more detailed than other experiences, and participants expressed tolerance, if not frustration, in that there were four separate questions regarding sexual experiences. A Spanish version of the VVS is available, but participants indicated difficulty for some Spanish-speaking clients understanding the questions as they were translated. The use of formal Spanish in contrast to informal Spanish was identified as a possible source of this confusion. Participants also expressed challenges with administering the VVS to parents and caregivers of children younger than 6 years due to a lack of resources for response and

referral and some concern that teenage participants might not be answering truthfully. The title of the VVS and language around the term victim and victimization was also a concern for some focus group participants and in conflict with their training or agency policies. Finally, some focus group participants indicated that the process helped parents and caregivers to learn that the trauma they faced as children was not normal, leading to questions about how to best support them with an adult version of the VVS, or, at minimum, receive training on how to support adult caretakers as potential survivors of trauma.

Training was the third frequently discussed theme. The training provided to implement the VVS was mostly well received and either rated as great or generally helpful. Resource mapping activities were considered useful by many participants. However, there were suggestions to provide follow up training or extend the training to manage cultural diversity and to coach screeners on how to respond to difficult experiences they may hear and how to structure the screening process to allow participants to process their emotions. The VVS training received high positive feedback, but focus group participants had suggestions for future improvements, including tailoring the training to be responsive to the type of setting the VVS will be administered within (e.g., school, community program, court services unit). The training should also more clearly outline who is eligible to administer the screen and what children and youth are eligible to be screened. Some focus group participants did not understand that any child or youth that might have suffered trauma is eligible to receive the VVS.

Finally, the fourth most frequent theme was related to service referrals and resources. Participants expressed a variety of specific concerns about challenges they experienced with child, youth, and family receptivity to services that have a stigma for their culture or neighborhood environment or may not be considered culturally responsive. Waiting lists for services deter the families of children and youth that the VVS indicates they need. Barriers exist for some children, youth, and families due to insurance coverage and payment for services, and challenges in helping to make sure services are started and sustained. Once again, focus group participants who identified challenges generally had suggestions for solutions, such as making warm hand-offs to service providers and following up with families and interest in sustaining resource mapping and developing provider profiles. Participants also felt like the VVS is helping to elevate these discussions and create synergy for identifying solutions. Even the most vocal critics of how the process works who provided anecdotes where a family fell out of the process indicated that the VVS was helpful in educating the families with whom they work on topics that are difficult to discuss and helping to better educate that the traumatic events the VVS covers can be pervasive in society and that there are services available to support and heal those who have experienced them.

The focus groups and the reports developed for each wave of the pilot by VCU have helped the Virginia LSC team recognize challenges and make question and procedure modifications to the VVS. Participants were highly engaged in talking about the need for screening and the challenges the experienced piloting the VVS. Training was a strength of the pilot phase, increasing the participants perceived ability to administer the process and their knowledge of identifying childhood trauma. The experience has helped elevate discussions around response and referral and the types of

supplementary training that will help to address the discomfort that some screeners and screening participants were observed to feel.

Limitations

While the VVS covers a wide spectrum of types of trauma, it focuses specifically on trauma caused by being a direct victim of and/or being exposed to crime. It is important to acknowledge that there are many other types of trauma unrelated to crime victimization (e.g., natural disasters, racism). However, in addition to the fact that funding for the LSC project is directed specifically to victims, to include/cover any and all forms of trauma would be beyond the scope of a *brief* screening tool and into the realm of a longer and more complex assessment.

Although the paper version of the VVS is available in Spanish, the electronic version of the tool is currently only available in English. Further, the VVS is not available in any other languages, which is a barrier to many providers in accessing and administering the tool. Now that the tool is no longer being piloted and all modifications have been made, translating the tool into other languages is a priority when/if funding to do so becomes available.

Practical limitations of the participating agencies in all waves of the pilot limited the kind and scope of evidence that could be gathered to support the use of the VVS. The pilot projects were reliant upon the goodwill of participating agencies donating their time and resources to screen children and youth. As such, the projects had to be shaped to fit the procedures and capabilities of participating agencies, limiting the kinds of empirical evidence available to evaluate the VVS.

Conclusions and Recommendations

The three waves of pilot study have been very informative, helping to refine the VVS as a useful evidence-informed tool for screening for crime victimization and its impact on children and youth. The process has led to a number of conclusions and recommendations.

First, the training for service providers on how to use the VVS was effective at increasing professionals' perceived ability to administer the tool and their knowledge about childhood victimization. Despite initial misgivings about asking difficult questions, particularly regarding sexual victimization, the participating professionals advocated for the applicability and utility of the VVS. (See training data for each pilot wave in Appendix C).

> ***Recommendation 1:*** As the VVS rolls out to new organizations across the Commonwealth, it will be important to continue to provide specific training on how to use the VVS. As noted in the findings above, many professionals indicated that they did not feel as though their professional background provided them with the necessary training to ask sensitive questions about victimization and trauma. Therefore, the training should continue to be an integral part of the statewide rollout process to ensure it is deployed as intended.
>
> ***Recommendation 2:*** Along the same lines, the training should include additional information for professionals who lack a background in mental health. This information is vital for

effective implementation of the VVS and likely will help the acceptability of using the VVS for service providers who feel as though they lack this background.

Recommendation 3: Those who implement the training should consider adding a cultural diversity component in the training. Given the finding that rates of victimization and their impact varied across sociodemographic groups, it would be important for service providers using the tool to understand those possible interactions.

Second, the VVS was successfully administered by a variety of service providers working in a variety of settings to children, youth, and families of different age ranges. It has promise for being adopted in new settings. The VVS served its intended function to identify children and youth in need of services as evidenced by those children being referred for interventions and other services, both within and across organizations.

Recommendation 4: It is recommended that the VVS be rolled out for use across the Commonwealth. The process of feedback and refinement of a tool is always ongoing. The developers of the tool should continue to be involved in its evaluation and improvement as new information is gathered during the roll out process.

Recommendation 5: Based on pilot site feedback, refinements to the Spanish version of the VVS have been made. Given the linguistic diversity of the Commonwealth, it is recommended that the developers of the VVS consider translation into additional languages commonly spoken in Virginia, with the recognition that they will have to perform a cost-benefit analysis of the resources needed to create a translation relative to the frequency of its use.

Third, responses on the VVS were internally coherent. Reported victimization was associated in expected ways with psychological and functional sequelae. This finding is important initial evidence that the VVS operates as expected given its intended purpose. While initial empirical investigations into the use of the VVS have been promising, additional research would help further establish its evidence base.

Recommendation 6: Pending funding and the feasibility of conducting further evaluation, it would be useful to examine the reliability of VVS administrations over time and across interviewers. Further, it would be important to establish the degree to which the scores on the VVS are associated with other existing measures of victimization, trauma and their sequelae. Future research is also needed to better assess whether identifying children and youth with the VVS for referral and intervention does lead to later improved outcomes in their well-being. Finally, given the variability in outcome across sociodemographic groups, it is important that any future work focus on specific populations where the VVS is most likely to be used.

Appendices

Appendix A
Pilot Site Agencies and Organizations

Wave One: City of Charlottesville, Albemarle County, Washington County

- 16th District Court Service Unit
- 28th District Court Service Unit
- Abuse Alternatives
- Albemarle County Department of Social Services
- Foothills Child Advocacy Center
- Shelter for Help in Emergency

Wave Two: City of Alexandria, City of Hampton, City of Newport News

- City of Alexandria Department of Community and Human Services
- Alexandria Health Department Teen Wellness Center
- Hampton Healthy Families
- Newport News Department of Human Services
- The Center for Alexandria's Children
- The Center for Child and Family Services

Wave Three: City of Richmond, Henrico County

- 13th District Court Service Unit
- Challenge Discovery Projects
- Richmond Police Department
- Sacred Heart Center
- St. Joseph's Villa

Appendix B
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