A Pathway to Justice, Healing, and Hope - Addressing Polyvictimization in a Family Justice Center Setting

An Applied Book of Lessons Learned

ALLIANCE for HOPE INTERNATIONAL

Table of Contents

Chapter 1

Introduction: A Pathway to Justice, Healing, and Hope - Addressing Polyvictimization in a Family Justice Center Setting

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CHAPTER 1: Introduction to A Pathway to Justice, Healing, and Hope - Addressing Polyvictimization in a Family Justice Center Setting

In 2016, the United States Department of Justice Office for Victims of Crime (OVC) launched a national demonstration initiative designed to enhance the capacity of Family Justice Centers (FJCs or Centers) to identify and address polyvictimization among its clients. This Demonstration Initiative (Initiative) recognizes the strength of the FJC model to offer comprehensive, co-located, community-wide responses to victims of domestic violence and their children. The Initiative also recognizes that many survivors and their children seeking services at an FJC have likely experienced multiple types of violence, victimization, and trauma across their lifespans. For some survivors, this may be in the form of historical oppression, community violence, sexual abuse, human trafficking, or other forms of victimization and adverse life experiences. It may include prior victimizations that they have never reported or even disclosed to anyone for a variety of complex and multifaceted reasons or traumatic experiences that they themselves have not previously identified as victimizations. Yet the effects of these traumas are buried deep within them, only serving to further compound the trauma brought on by the current experiences of victimization for which they have reached out and sought help. Finally, the Initiative recognizes that individuals who have had cumulative exposure to unmitigated trauma may be at greater risk for future victimization and/or other adverse health effects during their lifetime.

OVC is dedicated to improving the national response to crime victims and to breaking down the silos that create barriers to a survivor's safety, empowerment, and self-determination. The Polyvictimization Demonstration Initiative was envisioned by OVC as a unique opportunity to create a test environment for more effectively serving polyvictims. What might it look like to offer services that address both the immediate needs of a Family Justice Center client, based on their presenting victimization, as well as offer advocacy, counseling, or other forms of programming and/or support to holistically serve survivors and mitigate past trauma? How can one's experience as a polyvictim be approached in a way that is empowering and not retraumatizing for the survivor? How might the children of Family Justice Center clients be served in a more holistic way? What organizational changes might need to occur within a Family Justice Center to effectively address polyvictimization? What other partners may need to be engaged to support a more holistic healing process? Might we be able to help to change the course of a polyvictim's life, setting them on a more solid pathway from pain to justice, healing, and hope? The Polyvictimization Demonstration Initiative sought to explore these questions.

OVC's FY 2016 Demonstration Initiative, A Pathway to Justice, Healing, and Hope: Addressing Polyvictimization in a Family Justice Center Setting, challenged Family Justice Centers to expand services and create cohesive communities of support for polyvictims healing from a lifetime of adversity. This Demonstration Initiative was one of a series of national initiatives undertaken in response to OVC's Vision 21 Initiative and the recommendations put forth in the Vision 21: Transforming Victim Services Final Report. Through the Initiative, a Polyvictimization Assessment Tool (Assessment Tool) was developed, validated, and pilot tested for use, with the goal of identifying polyvictims, identifying additional services needed,

and building capacity in FJCs to serve polyvictims in a more holistic manner. The following chapters will document the implementation of this transformative Initiative in the various Centers; share the process of developing the Assessment Tool; analyze the challenges, lessons learned, and data collected throughout the three years; and offer recommendations and tips for success. The objective is to help other communities, and specifically Family Justice Centers, identify how they can better address and serve the needs of polyvictims and ultimately transform the way they provide services to survivors. Through this applied book, Alliance for HOPE International challenges FJC communities to learn about polyvictimization, evaluate how their agencies can holistically address the lived experiences of survivors, and develop hope-centered communities and partnerships to support them in breaking the cycle of violence.

OVC and Vision 21

OVC, a component of the Office of Justice Programs within the U.S. Department of Justice, is dedicated to enhancing the nation's capacity to assist crime victims and providing leadership in changing policies and practices to promote justice and healing for all victims of crime. In 2010, OVC launched the Vision 21: Transforming Victim Services (Vision 21) Initiative with the goal of expanding the vision and impact of the crime victim assistance field and permanently transforming the way victims of crime are treated throughout the country. For over 18 months, OVC led a comprehensive national effort to examine the framework of the victim assistance field in the United States, identifying promising practices, and exploring new and existing challenges. Polyvictimization was identified during this process as a critical issue to be addressed and recognized the field's need to enhance its capacity to serve victims who present with multiple victimizations.

In 2013, OVC released the Vision 21: Transforming Victim Services Final Report (Final Report), a culmination of the Vision 21 Initiative that presented a comprehensive set of recommendations to support strategic change in victim services nationwide. The Final Report was a call to action for the crime victim assistance field and became a strategic roadmap for OVC in the design, development, and implementation of many of its programs going forward. Among its many findings, the Final Report talked about the need to "cast a wide net" to connect with other fields that intersect with victim assistance and acknowledged "the inherent conflict" between responding to a specialized type of victimization and responding to the holistic needs of a victim, including and beyond the presenting victimization. OVC's Polyvictimization Demonstration Initiative tackles these issues head-on. For more on the Vision 21 Initiative, please see OVC's Final Report.

The Importance of Addressing Polyvictimization

Polyvictimization describes the collective impact of trauma and victimization on an individual. Some of the leading researchers and thought leaders in the trauma field - David Finkelhor, Richard Ormrod, Heather Turner, and Sherry L. Hamby - identified a cluster of four circumstances that function as pathways to polyvictimization: living in a violent family, living in a distressed and chaotic family, living in a violent neighborhood, and having pre-existing psychological symptoms (Finkelhor et al., 2011). According to Finkelhor, Ormrod, and Turner (2007), polyvictims can be categorized as low polyvictims with four to six victimizations, and as high polyvictims with seven or more victimizations. When assessing for polyvictimization, the

time period of victimization can range from within the past year to over the course of a lifetime. This variation has created significant differences in research methods and analyses, but similar negative health and life difficulties have been documented for polyvictims, regardless of the time period utilized when screening for trauma.

Polyvictimization impacts survivors on multiple levels including mental health, behavioral and physical wellbeing, increased possibility of life adversities, and increased chances of future victimizations. A study conducted between December 2002 and February 2003 by Finkelhor, Ormrod, and Turner identified polyvictimization as a key predictor of trauma symptoms such as clinical rage, clinical anxiety, and depressive symptoms; thus significantly affecting and impacting survivors' mental health (2007, p. 16). Furthermore, the cumulative impact on mental health, particularly in children, is evident showing "a relatively linear increase in symptoms with each additional form of victimization experienced" (Finkelhor, Ormrod, & Turner, 2010, p. 325).

The cumulative impact of trauma and victimization can result in reactive behaviors. According to a study conducted by the Administrative Office of the Courts' Center for Families, Children, and the Courts, exposure to trauma in children can result in "increased aggression, poor social skills, an inability to moderate emotional responses, attachment problems, and an increase in risk-taking behaviors and impulsivity" (2014, p. 7). Although this report is focused on children, it demonstrates that the implications of trauma can start in childhood and, if not properly addressed, can continue to impact behavior into adulthood. Research also shows that survivors with high Adverse Childhood Experiences (ACEs) scores have higher rates of smoking, alcoholism, and intravenous drug use when compared to adults and adolescents with low ACEs scores (Felitti et al. 1998 p. 249 - 254). Furthermore, people with high ACEs have higher risks of impaired worker performance, teen pregnancy, sexually transmitted infections, and high-risk sexual behavior, all of which may contribute to complications and life adversities later faced. Finally, research shows that the cycle of violence in the life of a polyvictim may result in an inadequate support system and that healthy peer relationships are connected to mental health wellbeing (Turner, Shattuck, Finkelhor, & Hamby, 2015, p. 4 - 5).

While clients walking into agencies may share the most recent incident that brought them in for services, many do not disclose other traumas. This often creates gaps in understanding and context for service providers, consequently leaving survivors vulnerable to other types of victimizations and needs. Studies on polyvictimization show that individuals who have been exposed to one form of victimization have an increased risk of experiencing additional victimizations, and often more severe victimizations, throughout their lifetimes (Pilnik, & Kendall, 2012, p. 8; Finkelhor, Turner, Hamby, & Ormrod, 2011, p. 2).

Because traumatic experiences are not idiosyncratic but fluid and interconnected, screening for polyvictimization reveals more forms of trauma, allowing staff to provide additional comprehensive and integrated services through their partner agencies. This is especially critical for clients who may visit an agency once and not return. By focusing solely on one form of victimization, providers may be amplifying its impact without accounting for other forms of trauma that interact and co-occur to create negative outcomes for clients (Finkelhor, Ormrod, & Turner, 2010, p. 323). More significantly in the context of serving survivors in agencies, studies reveal that including polyvictimization in assessments, "either eliminated or greatly reduced the predictive power of individual types of victimization" (Finkelhor, Ormrod, & Turner, 2007, p. 16).

Why Family Justice Centers?

From the 2002 opening of the first Family Justice Center in San Diego, to the expansion of the Family Justice Center movement across the country and around the world, FJCs have fundamentally transformed the approach to responding to survivors of domestic violence and their children. Family Justice Centers are rooted in the history of the domestic violence movement, informed by the voices of survivors, and built around a community-wide commitment to survivor safety and empowerment. Family Justice Centers place the survivor at the center of the service delivery response, offering comprehensive, wraparound, trauma-informed services in one location to best meet the unique needs of each survivor. Many FJCs have already expanded their services to address the often co-occurring crimes of sexual assault, child abuse, human trafficking, and more. Additionally, Family Justice Centers have a history of multi-agency collaboration and in-depth community strategic planning to create a shared vision for responding to the complex needs of survivors and their children. The synergetic nature of assessing for polyvictimization in the context of co-location not only provides positive outcomes for survivors, but also results in conversations and collaborative efforts that build relationships and trust between partners, improve professional development, and further inform best practices in collaboration. Family Justice Centers, by design, offer a safe and supportive community for survivors, whether they are seeking immediate crisis intervention and/or long-term support in their healing journey. It is for all of these reasons that OVC saw the Family Justice Center model as a unique framework for piloting an initiative to address polyvictimization, possibly leading to a new frontier of victim service delivery. The Family Justice Center framework is ideal for utilizing polyvictimization assessments to address the multilayered and complex nature of trauma and adopting a holistic, integrated approach to providing services that meet the immediate and long-term needs of survivors, while mitigating future risk factors for victimization.

Family Justice Centers and the Polyvictimization Framework

At its outset, the Polyvictimization Demonstration Initiative sought to examine service delivery models and create meaningful changes to the way Family Justice Centers and other co-located multidisciplinary organizations respond to survivors of cumulative trauma. Grounded in the six key principles of trauma-informed care, the science of hope, and the Family Justice Center Guiding Principles, the Polyvictimization Demonstration Initiative has produced real change in the way participating FJCs engage clients and transform service delivery to help polyvictims heal.

However, there was a clear gap in existing literature on polyvictimization. Most of the research on this topic was conducted with children and very little polyvictimization work was practiced with adults. This created a unique opportunity for the Initiative to better understand polyvictimization in the life of adult survivors and find ways to better address their needs in Family Justice Centers. Understanding the documented impact of polyvictimization, both emotional and physical, discussed above the six participating Centers and Alliance for HOPE International wanted to ensure an in-depth assessment and response for survivors. Therefore, for the purposes of the Initiative, it was critical Centers assessed for both lifetime victimization and victimizations occurring within the year prior to the client first arriving at the Centers for services. Additionally, because of the clear physical manifestation of trauma symptomology

among polyvictimization, the Initiative also aimed to assess for both symptomology and traumatic experiences in order to understand and provide adequate services to clients. Center staff understood that there would be many clients who may be experiencing latent and long-term symptoms of trauma without having previously connected their mental and physiological ailments with the adversities they had experienced. By assessing for these various factors, the Initiative hoped to identify how many FJC clients are polyvictims and apply this knowledge to tailor and guide service delivery. While advancing evidence-based practices was a key component of the Demonstration Initiative, the ultimate goal was to ensure that polyvictims receive the best services to support them in their journeys towards justice, hope, and healing.

What is a Demonstration Initiative?

OVC's Polyvictimization Initiative was designed as a national scope demonstration initiative, a funding approach used to test a promising practice and/or an innovative idea in an effort to learn from the communities involved and ultimately share lessons learned with the broader crime victims services field. OVC's national scope demonstration initiatives typically target a small number of communities, or in this case, Family Justice Centers and Multi-Agency Centers, with funding and comprehensive training and technical assistance (TA) in order to document the strategies, challenges, and successes of the project sites. OVC's demonstration initiatives also typically include a research and evaluation component in an effort to evaluate the process and expand the body of evidence-based practices. These initiatives are highly collaborative and involve a significant level of involvement from OVC staff in the oversight and management of an initiative, working very closely with the competitively selected national technical assistance provider and pilot sites to shape and guide the direction of the initiative.

Each site contributed a chapter documenting their processes and lessons learned in order to demonstrate the nuances and complexities of implementing a polyvictimization framework in a variety of organizational structures and communities. Their accounts of the Polyvictimization Demonstration Initiative can be found in Chapter 5 - 10 of this Applied Book.

The Six Demonstration Sites and the Technical Assistance Provider

When developing innovative and best practices for service provision to polyvictims, it was imperative for the Initiative to create a response that was both comprehensive enough to be replicated on a national level, and versatile enough to address the specific needs of communities. The Centers chosen for this Initiative serve rural, urban, and suburban communities with a wide variety of histories, population sizes, and demographics encompassing various languages, religions, cultures, ethnic backgrounds, and immigration histories.

The diversity in capacity, clientele, and service models of the six competitively selected sites allowed a polyvictimization framework to develop in a manner that became adaptable to a variety of program structures. Both Family Justice and Multi-Agency Centers successfully implemented procedures developed during the Initiative, as did crisis-oriented Centers and organizations with a stronger emphasis on long-term case management. Additionally, pilot testing revealed community-specific adversities impacting survivors at each site that subsequently resulted in a service provision framework responsive to a wide breadth of trauma and symptomology.

The selected sites also benefited from the existing strong leadership necessary to sustain momentum throughout the three years of the Initiative and implement the organizational changes identified for developing a trauma-informed and hope-centered approach to addressing polyvictimization. Skilled Center directors and designated project managers for the Initiative were able to create leaders at all levels of the sites and build capacity and confidence.

Each Center has a dedicated chapter, written by their team, where they share more about their community, their process, the challenges and successes they had with the polyvictimization framework in their Family Justice Center. These chapters will help provide others who are interested in applying the polyvictimization framework, with context and additional information so that they are able to find Centers who best match their community.

Meet the Participating Family Justice Centers:

Sojourner Family Peace Center – Milwaukee, WI

Sojourner, founded in 1975, opened the Family Peace Center (FPC) in collaboration with the Children's Hospital of Wisconsin (CHW) in 2015. Sojourner and CHW formed a unique partnership to better serve families impacted by family violence. The Center provides services to clients through its 14 onsite partners, seven visiting partners, and five offsite partners. The Center is led by Carmen Pitre, the President and CEO, and operates as a nonprofit. The Demonstration Initiative was led and implemented by Tristan Gross, Erin Schubert, and other key leadership staff in the Center. Partners serve on committees which guide the critical work of the FPC. The Center is housed in a 75,000 square foot standalone campus facility. The Sojourner Family Peace Center is guided by the mission, "to transform lives impacted by domestic violence" (Sojourner Family Peace Center, 2019).

New Orleans Family Justice Center – New Orleans, LA

The New Orleans Family Justice Center (NOFJC) was established in 2007. It is located in a 25,000 square foot shared facility and operates as an independent 501(c)3 under the leadership of Director Mary Claire Landry. The Center currently has 10 onsite partners and 20+ offsite partners, with 75 full-time professionals onsite. The Demonstration Initiative was led and implemented by Eva Lessinger and other key leadership staff in the Center. Their mission is: "New Orleans Family Justice Center Alliance is a partnership of agencies dedicated to ending family violence, child abuse, sexual assault, and stalking through prevention and coordinated responses by providing comprehensive, client-centered empowerment services in a single location" ("Who We Are - New Orleans Family Justice Center" 2019).

Queens Family Justice Center – New York, NY

The Queens Family Justice Center (QFJC) was established in 2008. The Center has 20 onsite and 25 offsite partners, with 103 professionals located onsite. The QFJC is led by Susan Jacob, the Executive Director of the Center, and operates under the Mayor's Office to End Domestic and Gender-Based Violence. The Center is housed in a 16,000 square foot standalone facility. The Demonstration Initiative was led and implemented by Susan Jacobs, Jennifer DeCarli, and other key leadership staff in the Center. The QFJC is guided by the mission that, "the New York Family Justice Centers (FJCs) provide comprehensive civil legal,

counseling, and supportive services for survivors of intimate partner violence, elder abuse, and sex trafficking. Located in all five boroughs, the FJCs are safe, caring environments that provide one-stop services and support. Key city agencies, community, social, and civil legal service providers, and District Attorney's Offices are located onsite at the FJCs to make it easier for survivors to get help" ("Family Justice Centers - ENDGBV" 2019).

The Family Justice Center Sonoma County – Sonoma, CA

The Family Justice Center Sonoma County (FJSC) was established in 2011. The Center is headed by Michelle Carstensen, the Executive Director, and operates as a unit of local government (County Office). The FJSC has 15 onsite partners and 29 offsite partners. The FJC has 55 professionals onsite who are housed in a 20,000 square foot standalone facility. The Demonstration Initiative was led and implemented by Diane Traversi, Kelsey Price, and other key leadership staff in the Center. The Center is guided by the mission, "The Family Justice Center Sonoma County empowers family violence victims to live free from violence and abuse by providing comprehensive services, centered on and around the victim through a single point of access. Building on strong inter-agency collaboration, we protect the vulnerable, stop the violence, and restore hope" ("Family Justice Center Sonoma County" 2019).

Stanislaus Family Justice Center – Stanislaus, CA

The Stanislaus Family Justice Center (SFJC) was opened November 1, 2010. The Center offers hope and healing for survivors of domestic violence, sexual assault, child abuse, and elder abuse. The SFJC has eight onsite partners and seven offsite partners. The Center is headed by Lisa Mantarro Moore, the interim Executive Director, and has 30 professionals onsite. The Center is housed in a 9,600 square foot standalone facility. The Demonstration Initiative was led and implemented by Carol Shipley, Romero Davis, Arleen Hernandez, and other key leadership staff in the Center. The SFJC operates as an independent 501(c)3 and is guided by the mission statement, "The Stanislaus Family Justice Center offers victims and survivors a path to safety and hope through compassion and coordinated services" (Stanislaus Family Justice Center, 2019).

Family Safety Center – Tulsa, OK

The Family Safety Center (FSC) in Tulsa, Oklahoma was established in 2006. The FSC has 13 onsite and 20 offsite partners. The Center is headed by Suzann Stewart, the Executive Director, and operates as a nonprofit. The Center has 50 professionals onsite who are housed in a 15,000 square foot City Building within the Courts' facility. The Demonstration Initiative was led and implemented by Janine Collier and other key leadership staff in the Center. The mission of the Family Safety Center is to "provide one location that effectively combines civil, criminal, health, and social services for victims of family violence" ("About Us - Family Safety Center" 2019).

Meet the Polyvictimization Initiative National Technical Assistance Provider:

Alliance for HOPE International - San Diego, CA

Alliance for Hope International (the Alliance) was selected to serve as the national TA provider for the Initiative. The Alliance is one of the leading systems and social change organizations in

the country focused on creating innovative, collaborative, trauma-informed, and hope-centered approaches to meeting the needs of survivors of domestic violence, sexual assault, child abuse, elder abuse, and human trafficking. The Alliance serves as a clearinghouse, research center, technical assistance provider, and national membership organization for Family Justice Centers and Multi-Agency Centers in the United States. Based on the comprehensive vision for the delivery of TA put forward for the Initiative, the Alliance was selected for the innovative collaborations entered into to expand the bandwidth of subject matter expertise available for the pilot sites, and for the National Advisory Team of nationally renowned experts in the areas of trauma, community violence, and the science of hope.

The Alliance's TA Team played a central role in the implementation of the Initiative, establishing a framework for the rollout of the Initiative and providing structure, guidance, and expert consultation throughout all three years.

Overview Year 1 of the Demonstration Initiative:

A key priority during the launch of the Initiative was ensuring all sites had the foundational understanding and application of the trauma-informed care principles necessary to expand their frameworks to include polyvictimization. To this end, Learning Exchange Teams (LETs) were established at each site consisting of project coordinators, researchers, frontline staff, and Center directors. The Alliance, OVC, and the LETs conducted 96 conference calls and 12 webinars during the first year that called upon field-renowned experts to provide specialized training and helped foster a fundamental understanding of polyvictimization, the existing literature and research on the subject. This also provided the opportunity to dive deep into understanding, integrating, and building capacity around implementing trauma-informed approaches and best practices in all of the Centers. A Kickoff Orientation meeting was held in April 2017 and provided the opportunity for an in-person learning exchange among demonstration sites, experts, and stakeholders, as well as the creation of a shared language around polyvictimization. The engagement and relationship building across sites created a system in which they could directly assist one another with organizational changes, new procedures, and training approaches.

During the first year, OVC and the Alliance conducted two day site visits to each Center in order to document strengths, challenges, and training needs; make recommendations to be adopted prior to the implementation of the Assessment Tool and over the course of the Demonstration Initiative; and benchmark current processes and protocols. The TA team also conducted focus groups with survivors who received services at three of the six Centers in order to gain a candid, firsthand understanding of any gaps in service provision and client perception of the polyvictimization framework. Using the information collected during site visits, the Alliance developed detailed profiles of each Center that evaluated their intake process and examined their service flow and range of onsite partners. Within six months of the site visits, all six sites had implemented significant changes to their procedures – primarily concerning intake – and expanded onsite services to reflect a more holistic, client-centered model of healing.

One of the Polyvictimization Demonstration Initiative's most notable Year 1 accomplishments was the development of the Polyvictimization Assessment Tool (Assessment Tool) used during pilot testing. This version of the Assessment Tool was designed to screen for lifetime victimization and trauma in clients and identify symptomology that clients may have

experienced or continue to experience as a result of these unmitigated traumas. Chapter 2 will go into more detail about the process for developing the initial Assessment Tool, including the intensive literature review conducted, the systematic review of the Tool involving all of the sites, and the robust conversations that took place during this process.

Overview Year 2 of the Demonstration Initiative:

Throughout Year 2, the Alliance, its partners, and the six sites prepared for pilot testing of the Assessment Tool by finalizing agreements on implementation, conducting mock interviews with frontline staff, and gathering information about which questions may be difficult for frontline staff to ask survivors. Pilot testing of the Assessment Tool was designed to accomplish the following goals:

1. Identify the various types of victimizations that impact survivors coming into Family Justice Centers;
2. Identify additional partners/services that Centers may need to bring onsite;
3. Help survivors connect victimizations with present physical, mental, and emotional symptoms; and
4. Allow for a deeper connection between intake staff and survivors by educating, normalizing, and contextualizing the lived experience of survivors.

Sites piloted the Assessment Tool for a three month period, during which the Alliance provided frequent technical assistance directly to frontline staff through one-on-one video conference calls, mock intakes, and regular and intentional debriefs. Simultaneously, sites and their partners engaged in in-depth conversations about representative sample sizes, confidentiality, and informed consent - all evidence that embedding research partners from the beginning of this Initiative had begun to shift conversations and frameworks in Centers. During pilot testing, partners and leadership agreed to validate or dismiss ideas and theories about the impact this Assessment Tool would have on clients. In particular, the researchers focused on analyzing assumptions frontline staff had prior to pilot testing that the Assessment Tool would be too invasive and triggering for clients.

In June 2018, pilot testing of the Assessment Tool was completed. The University of Oklahoma, the Alliance's research partner in the Initiative, analyzed 197 Assessment Tools completed during pilot testing for national data, while sites analyzed their local data. The sites met in July to revise, edit, and create updated protocols for implementing the Assessment Tool based on their findings, challenges, and lessons learned from pilot testing. In addition to quantitative findings around prevalence, the qualitative findings revealed that the Assessment Tool is best used retrospectively rather than during the meeting with clients; that the Assessment Tool should not be used with clients currently in crisis or clients being victimized for the first time in their lives; and that the Assessment Tool should be used conversationally with clients rather than being read verbatim or used as a checklist.

The final version of the Assessment Tool was finalized following an in-person Learning Exchange Team meeting in September 2018, which resulted in pivotal conversations around the purpose and use of the Assessment Tool. Though the Alliance cooperatively built the Assessment Tool with all sites and requested input and feedback at all steps of the process, frontline staff and leadership at the six Centers felt that the length of the Assessment Tool

made it difficult to administer in its entirety while still providing existing services for survivors. As a result, the Alliance disseminated a survey asking stakeholders their opinion of every aspect of the Assessment Tool, including instructions, questions, answer options, language options, etc. The results of the survey, in conjunction with a series of LET calls prior to the September meeting, led to the development of the final Polyvictimization Assessment Tool and a realization of the need to create an abbreviated instrument for Centers to use when discerning which clients would benefit from using the Assessment Tool. Due to the varying structures, staff, and partners at each of the Centers, it was agreed that sites would have the option to develop their own Screeners, along with parameters that would indicate how clients would be further assessed with the final version of the Assessment Tool. Other adaptations included shortening the length of the Assessment Tool; loosening parameters around the administration of the Assessment Tool – for example, when Centers could complete the Assessment Tool; adding additional answer choices the user could select; and translating the Assessment Tool into Russian and Spanish in order to streamline the process for bilingual frontline staff. Chapter 3 will go into more detail about the evolution of the Assessment Tool: From Screener to Assessment.

Overview Year 3 of the Demonstration Initiative:

With renewed buy-in and excitement about the Assessment Tool, as well as increased transparency and engagement, sites and researchers began final implementation in January of 2019. The Alliance continued hosting site-wide conference calls for researches, LETs, and frontline staff, as well as individual check-in calls with sites to discuss progress and address any ongoing difficulties. The Alliance also visited each site during final implementation to document the significant progress achieved over the course of three years and observe intakes and the administration of the Assessment Tool. Centers had effectively identified the most ideal points in service delivery during which to administer the Assessment Tool and frontline staff exhibited increased comfort with the content of both event and symptomology questions. Once this working knowledge of polyvictimization and the Assessment Tool solidified, sites were able to broaden the context of the framework to include hope theory during the final months of the Initiative. During the spring of 2019, Centers hosted Dr. Chan Hellman, PhD, Director of the Hope Research Center, to conduct a one-day hope theory training that delved further into the role of hope in the lives of both clients and service providers. As a result, sites engaged in conversations around how to integrate hope theory into service delivery, and some Centers began administering the Hope Scale in conjunction with the Assessment Tool in order to gain a more holistic perspective of their clients while helping survivors acknowledge their own goals and strengths.

Between May and August of 2019, site researchers collected and analyzed the data from final implementation, submitted their findings to the national database, and shared their data with the other LETs. The site-specific findings around event and symptom prevalence provided illuminating information about the most pervasive adversities facing each Center's client population. While much of the prevalence data shared commonalities across sites, there were several significant variations that, unsurprisingly, reflected the most significant issues facing each site's community at large. More information on site-specific data can be found in Chapters 5 - 10. On a national level, the data provided significant insight into the prevalence of polyvictimization and the correlation between events and symptoms, while also revealing how

the adjustments to the Assessment Tool between pilot testing and final implementation contributed to more efficient information gathering and impacted the service delivery models at each of the Centers.

During Year 3, most Centers were able to make final decisions around various operational aspects of the Assessment Tool - particularly regarding the Screeners. Some sites fully embraced their Screeners and found them to be very effective in mitigating capacity issues, while others proceeded with sole use of the full Assessment Tool after identifying that most of their clients were indeed polyvictims. In either case, however, the ultimate result was an increased sense of ownership over the process and adaptability of the framework to each Center's clientele and staff structure.

The Year 3 visits and the site profiles illustrated the profound effect the Initiative had on Centers beyond just the use of the Assessment Tool. These changes included expanded conversations around vicarious trauma and burnout among frontline staff, renewed interest in adhering to trauma-informed care approaches and maintaining trauma-informed organizations, and prioritization of having holistic healing services onsite. The Initiative also challenged assumptions held by Family Justice Centers around how services should be provided to survivors, with final implementation of the Polyvictimization Assessment Tool demonstrating a marked shift towards a framework that prioritizes long-term case management and relationship building. Centers established stronger protocols around frequent follow-up with clients, created more case management positions, and moved toward a "generalist" model of advocacy, wherein advocates were trained to identify trauma beyond interpersonal violence and can help clients process the mind-body connection of their symptoms without being licensed clinicians.

A Final Note:

The writing of this book was a highly collaborative effort involving the leaders and frontline staff from all of the participating Centers, the entire Alliance TA team, and the research team from the University of Oklahoma. Most importantly, it was informed by the many survivors who willingly participated in this special initiative. The remaining chapters will go into much more detail about the process, the collaborative efforts, the difficult conversations had, the challenges addressed, and the benefits derived as a result of the transformation that has taken place in each of the participating Centers to more holistically address polyvictims. It is to all Family Justice Center clients who are survivors of complex trauma that this book is dedicated.

Chapter 2

The Systematic Literature Review

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CHAPTER 2: Introduction – The Systematic Literature Review

A core deliverable of the Polyvictimization Demonstration Initiative was the creation of a Polyvictimization Assessment Tool (Assessment Tool). As outlined by OVC and Vision 21, the screening or assessment tool should be designed to screen for lifetime victimization and trauma in clients. Before diving into development of the Assessment Tool, the Alliance, supported by OU, began with an intensive literature review of 199 articles and tools that focused on traumatic events and symptomology, 30 of which became the building blocks for the Assessment Tool. A systematic review was then conducted with strong engagement from the demonstration sites. This process not only produced the first version of the Assessment Tool, but also led to robust dialogues and conclusions on the use of the Assessment Tool, its purpose, and the principles that should guide its use.

Trauma refers to, "experiences that cause intense physical and psychological stress reactions" (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014, p. xix). Trauma can result from a single event, a series of events, or circumstances that are perceived as harmful or threatening which have continuing negative effects on a person's overall wellbeing (SAMHSA, 2014). The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) defines trauma as an exposure where an individual person is exposed "to actual or threatened death, serious injury, or sexual violence" (American Psychiatric Association, 2013, p. 271). Trauma is not only comprised of experienced events, it is also the negative feelings that are associated with the event, which can vary between individuals experiencing the same event (SAMHSA, 2014). For example, both natural disasters and abuse/neglect can lead to trauma. Trauma can be co-occurring (with other disorders), cumulative (over time), and complex (multiple), especially when a caregiver is involved. Felitti et al.'s (1998) ACE study helped to understand trauma, but with a focus on children, and by examining events that have been considered as potentially traumatic. "Polyvictimization refers to the experience of multiple victimizations of different kinds, such as sexual abuse, physical abuse, bullying, and exposure to family violence, not just multiple episodes of the same kind of victimization" (Turner, Hamby, & Banyard, 2013, p. 2). Finkelhor, Ormrod, & Turner (2007) found that "polyvictimization was a powerful predictor of trauma symptoms" (p. 16).

Hopper, Bassuk, & Olivet (2010) explain trauma-informed care as a "strengths-based framework that is grounded in an understanding of and responsiveness to the impact of the trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment" (p. 131). Trauma-informed care suggests understanding trauma on a broad scale and anticipating common stress reactions and responses to traumatic triggers (SAMHSA, 2014). While other systematic reviews of trauma screening measures have been published, few examine utilization during the intake process or are concerned with trauma-informed care specifically for use within the context of polyvictimization.

Objective

This systematic review describes screening instruments which could potentially be utilized in the Family Justice Center framework. The screening instruments reviewed ranged from asking if someone has suffered from trauma or helping to identify if certain experienced life events were traumatic (Vandervort, 2015). Keeping in mind that "trauma refers both to exposure to a potentially traumatic event and the impact of that exposure on the individual's behavioral and emotional functioning" (Vandervort, 2015, para. 9) and that trauma "creates a sense of fear, helplessness, or horror, and overwhelms a person's resources for coping" (Hopper, Bassuk, & Olivet, 2010, p. 131) the tools analyzed included questions that address both of these components.

The review sought to answer the following question: what is an appropriate trauma-informed tool to assess for polyvictimization in a Family Justice Center? The American Psychological Association (2014) explains that although the terms screening and assessment are often used interchangeably they are not synonymous. Screening is typically concise and limited in scope and can be administered by clinical support staff or even self-administered. Additionally, screenings are not meant to diagnose a specific condition or disorder (APA, 2014). Assessments are comprehensive and are often administered by a clinician to aid in diagnosis and/or treatment planning (APA, 2014).

Although demeaning and difficult, victimization does not always lead to traumatic stress, but can still end/pause a person's usual goal-oriented thinking/pursuits and "can rob people of their hope" (Snyder, 2002, p. 264). The National Child Traumatic Stress Network (NCTSN) (n.d.) explains that complex trauma describes both the exposure to and the long-term impact of multiple traumatic events. Children who witnessed violence against family and/or friends have lower hope than their counterparts that had not witnessed similar acts (Snyder, 2002). Complex trauma involves traumatic stressors that are prolonged or repeated, involve harm, neglect, or abandonment by caregiver, and occur during developmentally sensitive periods of life (Courtois & Ford, 2014).

Methods

After the review question was framed, relevant work was identified by conducting a full systematic search that began after a strategy was developed to include additional terms for:

- polyvictimization (polyvictim, victim, victimization, treatment for polyvictimization abuse, neglect, survivor, coping, resiliency and client);
- types of trauma (chronic, sustained, cumulative, multiple, repeated, co-occurring, complex, traumatic events, potentially traumatic events);
- adverse childhood experiences;
- trauma symptoms;
- post-traumatic stress disorder (PTSD);
- community violence;
- treatment for trauma;

- mitigating trauma;
- trauma-informed care and trauma-informed practice;
- screening (measuring symptomology, trauma screening, intake, and assessment), and;
- tools (long term case management, building community, measures, instrument, and scale).

The databases searched included EBSCO Collection and (selecting all databases) JSTOR. Google Scholar was utilized to obtain instruments and articles and other "grey literature" like conference presentations, governmental and institutional reports, research sites, etc. that led to direct correspondence with authors to obtain other instruments and journal articles (Page, 2008, p. 173).

For an article or tool to be included in this review it needed to either screen for or examine multiple victimizations and/or traumas. Whereas some groups (Cochrane Collaboration and Campbell Collaboration) are interested in extremely focused literature searches, Page (2008) notes that these methods are not as easily conducted outside of the medical field because of the "wide range of possible databases to examine and... much looser terminology usage within the literature" (p. 172). This review followed Page's (2008) recommendations to "identify the depth and breadth of knowledge" in this area (p. 178). The search produced 198 results (77 articles and 121 tools).

Inclusion/Exclusion Criteria and Critical Appraisal

Due to the extensive number of tools found it was important to develop criteria to help narrow down the review so that the six demonstration sites and their partners could review them. To that end, the University of Oklahoma and the Alliance, based on feedback from the six Centers, created the following criteria: 1) the tool must be something that could be used with adults; 2) had to include multiple victimizations; 3) the tool could be administered by others than only mental health professionals; and, 4) could not take longer than an hour to administer and/or be longer than 45 questions long. Based on these requirements, this review eliminated 44 tools that were concerned exclusively with children, which left 77 measures for review. An additional 47 instruments were excluded (11 were modifications or alternate versions of tools already included in the review and 17 where copies of the tool itself could not be obtained); six tools were removed because they had over 45 questions or took longer than an hour to administer; and finally, 13 tools did not measure multiple victimizations or events. This left a total of 30 tools (12 dealing with symptomology, 12 concerned with events, and six that are a mix of symptomology and events) appropriate for recommendation and review by the six demonstration sites and their partners (see Appendix 1 for decision tree).

Conceptually, systematic reviews assess quality of included articles based upon methodological criteria (e.g., reliability, validity, experimental use, non-experimental design) the criteria for quality in this review was informed by the target goal of implementation as an intake tool utilized in Family Justice Centers. The criteria listed above and the authors' definition, of the instrument either being a screening or assessment, was also listed as well as

brief pro/con notes about possible utilization in the Family Justice Center model (see Appendix 2 for a table showing examined criteria).

Results

Below are the 30 instruments that met the inclusion criteria. These measures were classified into three categories: symptomology tool (12), events tool (12), and tools with a mixture of symptom and event screening and/or assessment (six).

Symptomology Tools

Breslau Screening. This measure, developed by Breslau and associates (1999), is a short screening scale for the Diagnostic and Statistical Manual of Mental Disorders fourth edition (DSM-IV) post-traumatic stress disorder (PTSD), which is also known as the Short Screening Scale for PTSD. The seven-symptom screening scale is comprised of five avoidance and numbing items and two hyperarousal items to measure lifetime history of PTSD in respondents exposed to traumatic events. Yes or no options are given for each question where the number of yes responses are added to compute the overall score. The authors suggest a cutoff score of four or more for the best positive or negative predictive value.

Cumulative Trauma Disorder Scale (CTD). Kira et. al (2012) developed the Cumulative Trauma Disorder Scale (CTD) as a mental health screening tool for populations that experience multiple traumatization (e.g., refugees, prisoners, minorities, torture survivors). The authors sought to identify and measure symptom profiles instead of looking for a single diagnosis. The measure is comprised of 16-items with a five-point Likert-type response format (0 = does not apply; 4 = very much present). Scores range from a low of zero to a high of 64 with higher scores reflecting higher symptoms of trauma.

Impact of Event Scale-Revised (IES-R). The original 15-item Impact of Event Scale (IES; Horowitz, Wilner, & Alvarez, 1979) screened for two subscales (*intrusion* and *avoidance*) in which seven items measured intrusive symptoms (e.g., intrusive thoughts, feelings and imagery) and eight items measured avoidance symptoms (e.g., numbing, avoidance of feelings, situations, and ideas) and was designed to "yield sub-scores for intrusive and avoidance experiences" (p. 217). The revised version of the Impact of Event Scale (IES-R; Weiss & Marmar, 1997) adds six additional items to the original measure to assess for the hyperarousal (in congruence with cluster *D* in the DSM-IV) and another single item to measure dissociative reactions (e.g., flashbacks). The IES-R is comprised of 22 items with a five-point Likert-type response format (0 = not at all; 4 = extremely). Scores range from a low of zero to a high of 88 with subscales provided to measure avoidance, intrusion, and hyperarousal.

Los Angeles Symptom Checklist (LASC). The Los Angeles Symptom Checklist (LASC) was designed by King, King, Leskin, & Foy (1995) as a self-report measure of PTSD and associated features for use with various trauma groups. This 43-item measure had been utilized for over a decade in both the diagnosis and study of PTSD under various names including *PTSD symptom checklist* before the authors published their psychometric findings. Foy, Wood, King, King, & Resnick (1997) reworded 24 items to create a modified version of the instrument for use with adolescent populations. Both versions allow for the scoring of a 17-

item PTSD index that corresponds to Criteria B, C, and D symptom categories of the DSM-IV in addition to (and within) the 43-item full-scale index which provides a severity score for PTSD. Items are rated on a five-point Likert-type scale with responses ranging from 0 (not a problem) to 4 (extreme problem). Scores range from a low of zero to a high of 172 with an additional subscale provided to measure depression.

National Stressful Events Survey for PTSD-Short Scale (NSESSS-PTSD). The National Stressful Events Survey for PTSD-Short Scale (NSESSS-PTSD) was developed by LeBeau et al. (2014) in response to changes in classification and diagnosis of PTSD in the DSM-5. This brief self-report measure is comprised of nine items congruent with DSM-5 PTSD symptoms, is recommended for both screening and assessment, and is free from copyright restrictions. At the time of publication, the scale had not been validated in clinical samples. The authors suggest further work to determine cut-off scores, establish test-retest reliability, and to validate the scale against clinician ratings. Items are rated on a five-point Likert-type scale with responses ranging from 0 (not at all) to 4 (extremely) to assess symptomology related to events occurring during the past seven days. Scores range from a low of zero to a high of 36 with higher scores indicating greater severity of posttraumatic stress disorder.

Primary Care PTSD Screen for DSM-5 (PC-PTSD-5). The Primary Care PTSD Screen for DSM-5 (PC-PTSD-5; Prins et al., 2016) is an updated version of the Primary Care PTSD Screen (PC-PTSD; Prins et al., 2003). The original four item measure corresponded with DSM-IV PTSD diagnostic criteria and was mandated for use in Veterans Affairs (VA) and Department of Defense (DoD) clinics due to its clinical utility and diagnostic accuracy. The updated version was developed in response to revisions in DSM-5 diagnostic criteria for PTSD where an additional item was added to assess “trauma-distorted blame and guilt” (Prins et al., 2016, p. 1207). Introductory examples of potential trauma exposure are given before respondents are asked if they have “ever experienced this kind of event.” If the response is ‘yes’*,* the five PTSD symptom questions are asked whereas if the response is ‘no’*,* the screen is scored at zero and further questions are not asked. Items are rated on a *yes*/*no* format then added to compute a total score with a range from a low of zero to a high of five. The authors recommend a cut score of three for optimizing sensitivity and note that further evaluation is necessary for other populations and settings.

PTSD Checklist for DSM-5 (PCL-5). The original 17-item Posttraumatic Stress Disorder Checklist (PCL; Weathers, 2008; Weathers, Litz, Herman, Huska, & Keane, 1993) was developed in relation to the symptom criteria for PTSD in the DSM-IV. Three versions were created in which eight items were reworded for different populations: military (PCL-M), civilian (PCL-C), and specific (PCL-S) where respondents are asked questions regarding “a stressful military experience”, “a stressful experience from the past”, or “the stressful experience” respectively. A shortened version of the PCL-C is examined in more detail below. The PTSD Checklist for DSM-5 (PCL-5; Weathers et al., 2013c) is a revision of the PCL that has been updated to assess the 20 symptoms of PTSD in the DSM-5 including the three new PTSD symptoms (negative emotions, blame, and reckless or self-destructive behavior). This 20-item self-report measure rates items on a five-point Likert-type scale with responses ranging from 0 (not at all) to 4 (extremely) which asses symptomology related to problems in response to very stressful experiences that have bothered respondents during the past month. Scores range

from a low of zero to a high of 80 with higher scores indicating greater severity of posttraumatic stress disorder symptoms.

Abbreviated PTSD Checklist-civilian version (Abbreviated PCL-C). The Abbreviated PTSD Checklist-civilian version (Abbreviated PCL-C) was derived from the PCL-C by Lang and Stein (2005). Two brief (two-item and six-item) versions were created from the original 17-item measure for use as a screening tool for PTSD in primary care clinics or similar general medical settings. As mentioned above the PCL-C was written to coincide with the PTSD criteria established in the DSM-IV. Similar to the PCL-5, the Abbreviated PCL-C is a self-report measure that rates items on a five-point Likert-type scale, however it utilizes the original PCL language for responses that range from 1 (not at all) to 5 (extremely) which assess symptomology related to problems or complaints in response to "stressful life experiences" that have bothered respondents during the past month. Scores range from a low of two (for the two item measure) or six (for the six item measure) to a high of 10 (for the two-item measure) or 30 (for the six-item measure) with higher scores indicating greater severity of posttraumatic stress disorder.

Purdue PTSD questionnaire-revised (PPTSD-R). The Purdue PTSD Questionnaire-Revised (PPTSD-R) was designed by Lauterbach & Vrana (1996) as a revision of the Purdue PTSD Questionnaire (PPTSD; Hartsough, 1988), which was updated to assess PTSD according to criteria in the Diagnostic and Statistical Manual of Mental Disorders third edition- revised (DSM-III-R). The original PPTSD assessed for PTSD symptomatology referenced in the Diagnostic and Statistical Manual of Mental Disorders third edition (DSM-III) for use in an assortment of populations. The PPTSD-R is a 17-item self-report measure of PTSD symptoms where respondents are asked questions about how often "reactions occurred during the previous month." The measure can be expanded to 34-items if respondents are asked to identify "how often each reaction occurred during the time" in their life when they "were most distressed by the event." The PPTSD-R rated items on a five-point Likert-type scale (A= "not at all", E= "often") that yields subscales for Reexperiencing, Avoidance, and Arousal or can provide a Total score where higher scores indicate higher PTSD symptoms.

Short Post-Traumatic Stress Disorder Rating Interview (SPRINT). The Short Post-Traumatic Stress Disorder Rating Interview (SPRINT) was developed by Connor & Davidson (2001) as a brief PTSD- specific global scale that corresponds to the four PTSD symptom clusters of the DSM-IV (avoidance, intrusion, hyperarousal, and numbing). The SPRINT is comprised of eight items with two additional items to measure improvement, both as a percentage of feeling better and a reduction in symptomology. This measure assesses PTSD symptom severity in respondents who have survived trauma by utilizing a five-point Likert-type scale where responses range from 0 (not at all) to 4 (very much) to produce a score that ranges from a low of zero to a high of 32 with higher scores indicating worse PTSD symptomology.

Trauma Screening Questionnaire (TSQ). The Trauma Screening Questionnaire (TSQ) was derived by Brewin et al. (2002) by utilizing five arousal items and five re-experiencing items originally appearing in the PTSD Symptom Scale - Self Report (PSS-SR; Foa, Riggs, Dancu, & Rothbaum, 1993). The TSQ is a brief 10-item self-report instrument designed to screen for PTSD for use with victims of all types of trauma. This measure asks respondents to answer

“yes”/“no” questions concerning their reactions to a traumatic event that occurred at least three weeks previously in which a selection of “yes” occurs “at least twice in the past week.” The authors recommend a cut-score of six “yes” responses for prediction of a PTSD diagnosis and further recommend these respondents with positive screens to be assessed with a structured interview for PTSD.

Trauma Symptom Checklist-40 (TSC-40). The Trauma Symptom Checklist-40 (TSC –40) is a revision of an earlier version of the Trauma Symptom Checklist-33 (TSC-33; Briere & Runtz, 1989) where Elliott & Briere (1992) added a subscale for *Sexual Problems*. The TSC-40 is a 40-item self-report measure of *diverse types of symptomology* in adults who have experienced trauma in childhood or as an adult. The authors note the TSC-40 is a research tool, not a clinical test, and state that it should not be used as a self-test. The TSC-40 utilizes six subscales to assess: Dissociation (six items), Anxiety (nine items), Depression (nine items), Sexual Abuse Trauma Index (seven items), Sleep Disturbance (six items), and Sexual Problems (eight items) where respondents are asked to indicate how often they have experienced symptoms “in the last two months.” Items are rated on a four-point Likert-type scale with responses ranging from 0 (never) to 3 (often) which yields a total score that ranges from a low of zero to a high of 120 with higher scores indicating greater trauma symptoms.

Event Tools

Adult Experiences Survey (AES). The Adult Experiences Survey (Mersky, Janczewski, & Nitkowski, 2018) is a 19-item self-report measure designed to assess adversity experienced in adulthood. All questions are asked in a format that refers to the respondent experiencing potentially harmful events since turning age 18. The first five questions address physical, emotional, and sexual abuse with response options never’, ‘once’, or ‘more than once’. The next ten questions assess crime victimization, incarceration, alcohol or drug abuse, mental health problems, divorce, pregnancy loss, and the death of someone very close in a “yes”/“no” response format. The final four questions concern financial problems, discrimination, food insecurity, and homelessness utilizing a five-point Likert-type scale with responses ranging from “never” to “very often”. The AES can be coded for exposure to ten potentially harmful events (e.g. physical and emotional abuse, forced sexual activity, homelessness) which are indicators of adult adversity that can be summed to calculate a cumulative risk score with a range from a low of zero to a high of ten.

Adverse Childhood Experiences (ACE). The Adverse Childhood Experiences (ACE) Survey was developed by Felitti et al. (1998) to examine health risk behaviors and disease in adulthood in relation to trauma exposure (e.g., physical, sexual, and verbal/ emotional abuse) occurring during childhood. The ACE survey was derived from questions published in measures of physical and psychological abuse (Conflict Tactics Scale; Straus & Gelles,1990) and contact sexual abuse (Wyatt, 1985) experienced during childhood. The original measure of 17 questions was comprised of seven categories: childhood psychological, physical, or sexual abuse (eight items) and exposure to substance abuse, mental illness, violent treatment of mother/ stepmother, or criminal behavior during childhood (nine items). These seven categories of childhood abuse and household dysfunction yielded an exposure score that ranged from a low of zero to a high of seven, where respondents selected a positive response in a “yes”/“no” format. The current ACE questionnaire continues to ask questions after the

introduction statement “While you were growing up, during your first 18 years of life…” but has been reworked to combine the original questions into a 10-item measure that yields a score that ranges from zero to 10 based on the number of “yes” responses, where each positive answer contributes to an overall ACE Score (Felitti et al., 1998, p. 247). Higher scores demonstrate greater exposure to traumatic events during the respondent’s first 18 years of life.

Crisis Support Scale (CSS). The Crisis Support Scale (CSS) was derived by Joseph, Andrews, Williams, & Yule (1992) which is based on the Crisis Support Instrument (CSI; Andrews & Brown, 1988; Brown, Andrews, Harris, Adler, & Bridge, 1986), a semi-structured interview that was converted to a self-report questionnaire during creation of the new measure. The CSS is a 14-item instrument which measures social support by asking seven questions twice with different wording concerning two time frames, where the first question asks about the time just after the event (Time 1) and the second question asks at the present time (Time 2). Items are rated on a seven-point Likert-type scale with responses ranging from 1 “never” to 7 “always” which yields a total crisis support score computed for each timeframe. The authors note items 11 and 12 are reverse-scored and items 13 and 14 (concerning overall satisfaction) are not included in the sum where scores range from a low of six to a high of 42 with higher scores indicating greater levels of support.

Juvenile Victimization Questionnaire: 2nd Revision- screener sum version: adult retrospective form (JVQ-R2). The Juvenile Victimization Questionnaire: 2nd Revision (JVQ – R2) is an update to the original Juvenile Victimization Questionnaire (JVC; Hamby, Finkelhor, Ormrod, & Turner, 2004) developed by Finkelhor, Hamby, Turner, & Ormrod (2011) to include multiple versions of the measure for use with youth, their caregivers, and adults in clinical, community, school, or research settings in full, abbreviated, screener, or reduced item versions. The JVQ-R2 assesses for a range of victimizations youth may experience including: maltreatment, sexual victimization, peer and sibling victimization, conventional crime, and witnessing and indirect victimization (Crimes Against Children Research Center, n.d.). The authors note the JVQ-R2 is useful in providing a comprehensive assessment of the multiple forms of victimization youth may experience which is referred to as polyvictimization by Finkelhor, Ormrod, Turner, & Hamby (2005). As mentioned above, the JVQ-R2 is available in full interview options, abbreviated interview measures, the screener sum version, and reduced item options (only 12 screening questions without follow-ups) (Crimes Against Children Research Center, n.d.).

The JVQ-R2, screener sum version: adult retrospective form is comprised of the core 34-items which examine: conventional crime, child maltreatment, peer and sibling victimization, sexual victimization, witnessing and indirect victimization in which adults are asked reworded questions concerning events that may have happened during their childhood (birth through age 17) (Crimes Against Children Research Center, n.d.). Items are rated on a “yes”/“no” format with positive responses ranging from a low of zero to a high of 34 with higher scores indicating greater victimizations/ polyvictimization.

Life Events Checklist for DSM-5 (LEC-5). The Life Events Checklist for DSM-5 (LEC-5; Weathers et al., 2013b) is an update to the original Life Events Checklist (LEC) which was developed by the National Center for Posttraumatic Stress Disorder alongside the Clinician-Administered PTSD Scale (CAPS) to diagnose PTSD in relation to DSM-IV criteria (Gray, Litz,

Hsu, & Lombardo, 2004). The LEC-5 is a 17-item self-report measure constructed as a screening tool for potentially traumatic events (PTEs) respondents may have experienced in their lifetime. Sixteen questions assess for exposure to events which may lead to PTSD as described in the DSM-5. The additional question asks respondents to list "any other very stressful event or experience." The first 16 items are rated on a six-point scale where responses range from "happened to me" to "doesn't apply," however this measure does not yield a total score, instead the LEC-5 records information about potentially traumatic experiences respondents may have experienced, witnessed, learned about, or was a part of their job that have occurred throughout their lifetime. The LEC-5 is a checklist screening for potentially traumatic events where more positive responses indicate greater exposure PTEs which could inform a recommendation for these respondents to be assessed with a structured interview for a PTSD diagnosis.

Life Stressor Checklist- Revised (LSC-R). The Life Stressor Checklist-Revised (LSC-R; Wolfe, Kimerling, Brown, Chrestman, & Levin, 1997) is a 30-item self-report measure which assess stressful or potentially traumatic events that may have occurred during the respondent's lifetime. Each item asks additional questions related to age, perceived harm, feelings of fear/helplessness, and impact of the event within the last year. The LSC-R asks certain questions specific to women (e.g. abortion and miscarriage), however the authors state the instrument can also be utilized by men. Items are rated on a "yes"/"no" format where positively endorsed items can be summed to compute a total score with a range from a low of 0 to a high of 30. The authors include additional scoring options: 1) to add weight to each question by utilizing the five-point Likert-type response option for each sub-question "e" which asks how much the event has affected the respondent in the last year that yields a score ranging from 0-150, or 2) to score the positive responses to coincide with DSM-IV criteria for PTSD by utilizing sub-questions "c," which asks the respondent if they believed themselves or someone else could be *killed* or seriously *harmed* at the time of the event and "d" which asks the respondent if they experienced feelings of *intense* helplessness, fear, or horror at the time of the event.

North Shore Trauma History Checklist (NTHC). The North Shore Trauma History Checklist (NTHC; North Shore- Long Island Jewish Health System, Inc., 2006) is a 20-item questionnaire created to facilitate an interview by a clinician to assess for trauma exposure. The NTHC provides language for the interviewer to begin the assessment and instructions for the clinician to take notes in accordance with DSM-IV criteria for PTSD. Respondents are asked questions concerning age of onset and duration of trauma exposure. The NTHC is a measure of potentially traumatic events (e.g. natural disasters, homelessness, witnessing violence, experiencing abuse) occurring across the respondents' lifetime. An additional question is provided for the clinician to ask about what the respondent considers to be the most significant traumatic event(s) in which the interviewer is again provided language to facilitate this final question. Items are rated on a "yes"/"no" format where positively endorsed questions can be summed to compute a total score with a range from a low of zero to a high of 20 or more depending on how many positive indications are noted for the sub-questions for items 9, 10, 11, 13, 14, and 19.

Stressful Life Events Screening Questionnaire- Revised (SLESQ-R). The Stressful Life Events Screening Questionnaire- Revised (SLESQ-R; Green, Chung, Daroowalla, Kaltman, &

DeBenedictis, 2006) is an update to the Stressful Life Events Screening Questionnaire (SLESQ; Goodman, Corcoran, Turner, Yuan, & Green, 1998) where the authors made improvements to the original measure after conducting qualitative studies during an evaluation of the cultural validity of the SLESQ. The revised version is a 13-item self-report instrument the authors recommend for use in general settings to screen for lifetime exposure to potentially traumatic events (e.g. life-threating illness and/or accidents, physical and sexual assault). The SLESQ-R rates items on a "yes"/"no" format where positively endorsed questions can be summed to compute a total score with a range from a low of zero to a high of 13. For each item, respondents are asked follow-up questions (e.g. their age at the time of the event) and other details specific to the event/potentially traumatic stressor. The SLESQ-R was designed to screen for DSM-IV criteria of PTSD where higher scores could inform respondents to be assessed with a structured interview for a PTSD diagnosis.

Trauma Assessment for Adults-Self Report (TAA-SR). The Trauma Assessment for Adults (TAA) is available as a self-report measure or interview version where both were created as a brief screen for exposure to traumatic events (Orsillo, 2001). The Trauma Assessment for Adults-Self Report (TAA-SR; Resnick, Falsetti, Kilpatrick, & Freedy, 1996) is a 17-item self-report screening measure which examines potentially traumatic events over the course of a lifetime. Respondents are asked questions concerning combat exposure during military service, experiencing a natural disaster, sexual and/or physical assault, or other potentially traumatic events alongside follow-up questions about their age at the time, the number of times of occurrence, and the degree of suffering. The TAA-SR rates items on a "yes"/"no" format where positively endorsed questions can be summed to compute a total score with a range from a low of zero to a high of 17. Follow-up questions provide additional information that may prove helpful in referring respondents for further assessment with a structured interview for diagnosis.

Trauma History Questionnaire (THQ). The Trauma History Questionnaire (THQ; Green, 1996) is a 24-item self-report instrument designed to measure respondents' history of exposure to potentially traumatic events over the course of their lifetime in relation to DSM- IV criteria for PTSD. The questionnaire begins with normalizing language concerning serious or traumatic life events and divides questions into sections which cover crime experiences, general disaster and trauma, and physical and sexual experiences. The THQ rates items on a "yes"/"no" format where positively endorsed questions can be summed to compute a total score with a range from a low of zero to a high of 24. Follow-up questions for items marked *yes* ask respondents to indicate the number of times and to list approximate age(s) occurred/of occurrence respectively. Although the THQ was originally intended to be utilized alongside a structured interview for diagnosis, it has been used as a standalone screening tool (Hooper, Stockton, Krupnick, & Green, 2011). Higher scores recorded on the THQ demonstrate greater exposure to potentially traumatic events during the respondent's lifetime.

Traumatic Antecedents Questionnaire (TAQ). The Traumatic Antecedents Questionnaire (TAQ; Luxenberg, Spinazzola, & Van der Kolk, 2001) is a 41-item self-report measure that collects data for experiences occurring during specific age periods: young child, age zero to six; school age child, ages seven-12; adolescent, ages 13-18; and as an adult. The measure collects data across respondents' lifetime for the purpose of assessing exposure to a range of potentially traumatic events at distinct developmental stages. The following 10 domains of

experience are assessed by the TAQ: (1) competence, (2) safety, (3) neglect, (4) separation from primary caregiver(s), (5) emotional abuse, (6) physical abuse/assault, (7) sexual abuse/assault, (8) witnessing, (9) other traumas (i.e., impersonal traumas such as natural disasters, and serious accident as well as other undefined experiences), and (10) exposure to drugs and alcohol (Spinazzola, 2019). “The first two domains represent experiences of adaptive functioning, while the latter eight domains assess exposure to traumatic or adverse experiences” (Spinazzola, 2019). Items are rated on a four-point Likert-type scale with an additional option to select “don’t know” where responses range from 0 (never or not at all) to 3 (often or very much) which yields summary scores for each domain of experience as well as the scores for each of the four specific age periods. Higher scores reflecting more frequency of occurrence within each domain. The authors note item 2 is reverse-scored and item 41 is a measure of “how upsetting it was” for the respondent to answer the previous questions.

Vrana-Lauterbach Traumatic Events Scale- Civilian. The Traumatic Events Questionnaire (TEQ; Vrana & Lauterbach, 1994) originally assessed for 11 specific traumatic events which coincided with DSM-III-R symptomology associated with PTSD, including military combat related questions. The updated version Vrana-Lauterbach Traumatic Events Scale- Civilian (Lauterbach & Vrana, 1996) continues to assess participants’ experience of a variety of traumatic events however, the questionnaire measures events potentially experienced in civilian populations (e.g. serious accidents, natural disasters, crime victimization, sexual or physical abuse) and allows for unspecified traumatic events to be included. The Vrana-Lauterbach Traumatic Events Scale-Civilian is an 11-item measure which asks participants to identify if they have experienced potentially traumatic events, if a positive response is recorded additional sub-questions ask for additional details where each item utilizes a seven-point Likert-type scale to ask both how traumatic the event was at the time and how traumatic it is now, with responses ranging from 1 “not at all” to 7 “extremely”. Two additional questions are asked at the end of the scale for respondents to list “the most traumatic thing that has happened” to them. This measure identifies the rate of traumatic events experienced by respondents where higher scores demonstrate greater exposure to traumatic events during the respondent’s lifetime.

Measures Both Symptoms and Events

Clinician-Administered PTSD Scale for DSM-5 (CAPS-5). The Clinician-Administered PTSD Scale for DSM-5 (CAPS-5; Weathers et al., 2018) is a revision to the widely used Clinician-Administered PTSD Scale (CAPS; Blake et al., 1990) sometimes referred to as the gold-standard in PTSD assessment (Blanchard, Jones-Alexander, Buckley, & Forneris, 1996; Price, Szafranski, van Stolk-Cooke, & Gros, 2016; Prins et al., 2003) which was updated to correspond with PTSD criteria in the DSM-5. The CAPS-5 is a 30-item structured diagnostic interview instrument for PTSD in which three versions were created to measure symptoms and events during different time periods: past week, past month, or worst month, which is a lifetime assessment (Weathers et al., 2013a). The CAPS-5 assesses for 20 PTSD symptoms from the DSM-5 and asks additional questions to provide information for impact of symptoms, PTSD severity, onset and duration of symptoms, subjective distress, and specifications for the dissociative subtype (depersonalization and derealization) (Weathers et al., 2013a). The authors recommend the LEC-5 or another structured trauma screen to be administered before the CAPS-5 to assess for Criterion A, as the instrument provides language for the clinician to

reference the previous identification of stressful experiences/ traumatic event to serve as the basis for additional inquiry (Weathers et al., 2013a). Items one through 20 (which assess for PTSD symptoms from the DSM-5) are rated on a five-point Likert-type scale where responses range from 0 (absent) to 4 (extreme or incapacitating) and yield scores for symptom severity that range from a low of zero to a high of 80 with higher scores reflecting greater symptom severity.

Davidson Trauma Scale (DTS). The Davidson Trauma Scale (DTS; Davidson et al., 1997) is a 17-item self-report measure developed to coincide with each of the 17 PTSD symptom definitions in the DSM-IV. The DTS measures both the severity and frequency of PTSD symptoms and can be used to evaluate treatment (Davidson et al., 1997). Items are rated on a five-point Likert-type scale where frequency responses range from 0 (not at all) to 4 (every day) and severity responses range from 0 (not at all distressing) to 4 (extremely distressing) which yield frequency scores that range from a low of zero to a high of 68 and severity scores that also range from a low of zero to a high of 68 with higher scores reflecting greater symptom severity and/or frequency. The DTS allows for scoring subscales for each of the three PTSD symptom clusters: items 1-4 and 17 represent cluster B (intrusive re-experiencing), items 5-11 represent cluster C (avoidance and numbness), and items 12-16 represent cluster D (hyperarousal). Additionally, a total score (ranging from 0 to 136) can also be computed by summing all frequency and severity items.

Polyvictimization/ Trauma Symptom Checklist. The Polyvictimization/Trauma Symptom Checklist was developed by the Safe Start Center, the American Bar Association (ABA) Center on Children and the Law, and Child & Family Policy Associates in an effort to aid legal advocates for children in recognizing both the prevalence and impact of polyvictimization "and perform more trauma-informed legal and judicial system advocacy" (Pilnik & Kendall, 2012, p.1). This checklist was not created as a diagnostic measure and is not intended for use as an interview or self-report instrument, rather it provides a way for legal advocates to organize information gathered during client interviews or from other service providers (Pilnik & Kendall, 2012). The Polyvictimization/Trauma Symptom Checklist is comprised of 23-items concerning past experiences and 22-items of past and current symptoms in which options are given to mark "in the past year" and/or "over her/his lifetime" for each of the 45-items. The authors recommend the checklist to be used with clients of any age, but do not intend for the checklist to result in a numerical score (Pilnik & Kendall, 2012). A flowchart on trauma-informed actions is provided for those utilizing the checklist, which shows potential next steps for course of action in a child/youth *has, may need* format (e.g. child/youth *has* experienced past severe victimization, child/youth *may need* trauma-specific mental health assessment/services).

Posttraumatic Diagnostic Scale for DSM-5 (PDS-5). The Posttraumatic Diagnostic Scale for DSM-5 (PDS-5; Foa et al., 2016) previously referred to as the Posttraumatic Stress Scale-Self Report-5 (PSS-SR-5; Friedman, 2015) is a revision to the Posttraumatic Stress Diagnostic Scale (PTDS or PDS; Foa, Cashman, Jaycox, & Perry, 1997) which was updated to assess "PTSD symptom severity and diagnosis using the DSM-5 criteria" (Foa et al., 2016, p. 1166). The original PDS was developed as a revision to the PTSD Symptom Scale—Self-Report Version (PSS-SR; Foa, Riggs, Dancu, & Rothbaum, 1993) to correspond with PTSD symptomology criteria in the DSM-IV. As with the previous versions, the PDS-5 is a self-report measure currently comprised of 24-items that assess PTSD symptom severity over the last

month. The instrument begins with two questions which screen for trauma by asking respondents if they have experienced or witnessed a number of events before asking which traumatic experience bothers them the most. The following 20 items examine symptomology based on clusters within the DSM-5 where: questions 1-5 are concerned with intrusion, items 6 and 7 coincide with avoidance, questions 8-14 examine changes in mood and cognition, and items 15-20 correspond with arousal and hyperactivity. Questions 21 and 22 address distress and interference while questions 23 and 24 explore symptom onset and duration. Items 1 through 22 are rated on a five-point Likert-type scale where responses range from 0 (not at all) to 4 (six or more times a week/severe) and yield a total score that ranges from a low of zero to a high of 88 with higher scores reflecting greater symptom severity.

Single-Item PTSD Screener (SIPS). The Single-Item PTSD Screener (SIPS; Gore, Engel, Freed, Liu, & Armstrong, 2008) was developed as a single-item measure for use in a primary care setting to screen for PTSD. The authors note the prevalence of PTSD in primary care settings and assessed the SIPS against the shortest validated PTSD screener, the four-item PC-PTSD, which is mandated by the VA for use in clinics (see review above). The single question asked by the SIPS is: “Were you recently bothered by a past experience that caused you to believe you would be injured or killed? (e.g. witnessed or experienced a serious accident or illness, threatened with a weapon, physically or sexually assaulted, experienced a natural disaster, participated in wartime combat).” Response options include, “not bothered at all,” “bothered a little,” and “bothered a lot” (Gore, Engel, Freed, Liu, & Armstrong, 2008, p.392). The authors report that the SIPS failed to perform as well as the PC-PTSD, but argued that the latter is hard to remember and “a sufficiently reliable and valid” SIPS question “could significantly improve the implementation of PTSD screening in a busy primary care setting” (Gore, Engel, Freed, Liu, & Armstrong, 2008, p. 395).

Trauma History Screen (THS). The Trauma History Screen (THS; Carlson et al., 2011) is a 14-item self-report measure developed to assess exposure to high magnitude stressors (HMSs), traumatic stressors (TSs), and persisting posttraumatic distress (PPD) events as defined in DSM-IV field trials for PTSD (Kilpatrick et al., 1998). Carlson et al. (2011) characterize HMSs as “sudden events that have been found to cause extreme distress in most of those exposed” whereas TS describes “HMS events that caused extreme distress for an individual” and “events associated with significant subjective distress that lasts more than a month are referred to as” PPD events (p. 464). The 14 questions which assess exposure to potentially traumatic events (HMSs) rate items on a “yes”/“no” format with a space provided for listing the number of times something like this has happened. The THS asks an additional question to determine if any of the previous events bothered the respondent emotionally (TS: “yes”/“no”) and provides additional space (boxes) for further probes for each event with a positive indication. These probes assess for additional dimensions including perceived threat of injury or death, helplessness, and dissociation which are rated on a yes/ no format. Two final items utilize a Likert-type response format: the first addresses the duration of distress and offers a four-point scale (PPD; from a low of *not at all* to a high of *a month or more*) and the second which asks how much the event bothered the respondent emotionally that offers a five-point scales (TS; from low of *not at all* to a high of *very much*). Scores for the initial 14 items range from a low of zero to a high of 14, when “yes” responses are summed, with higher scores reflecting greater exposure to potentially traumatic events/stressors (HMSs). The THS

also provides administrators the ability to “distinguish between HMS events that had relatively little emotional impact and PPD events that were associated with lasting, high levels of distress” (Carlson et al., 2011, p. 474).

Discussion

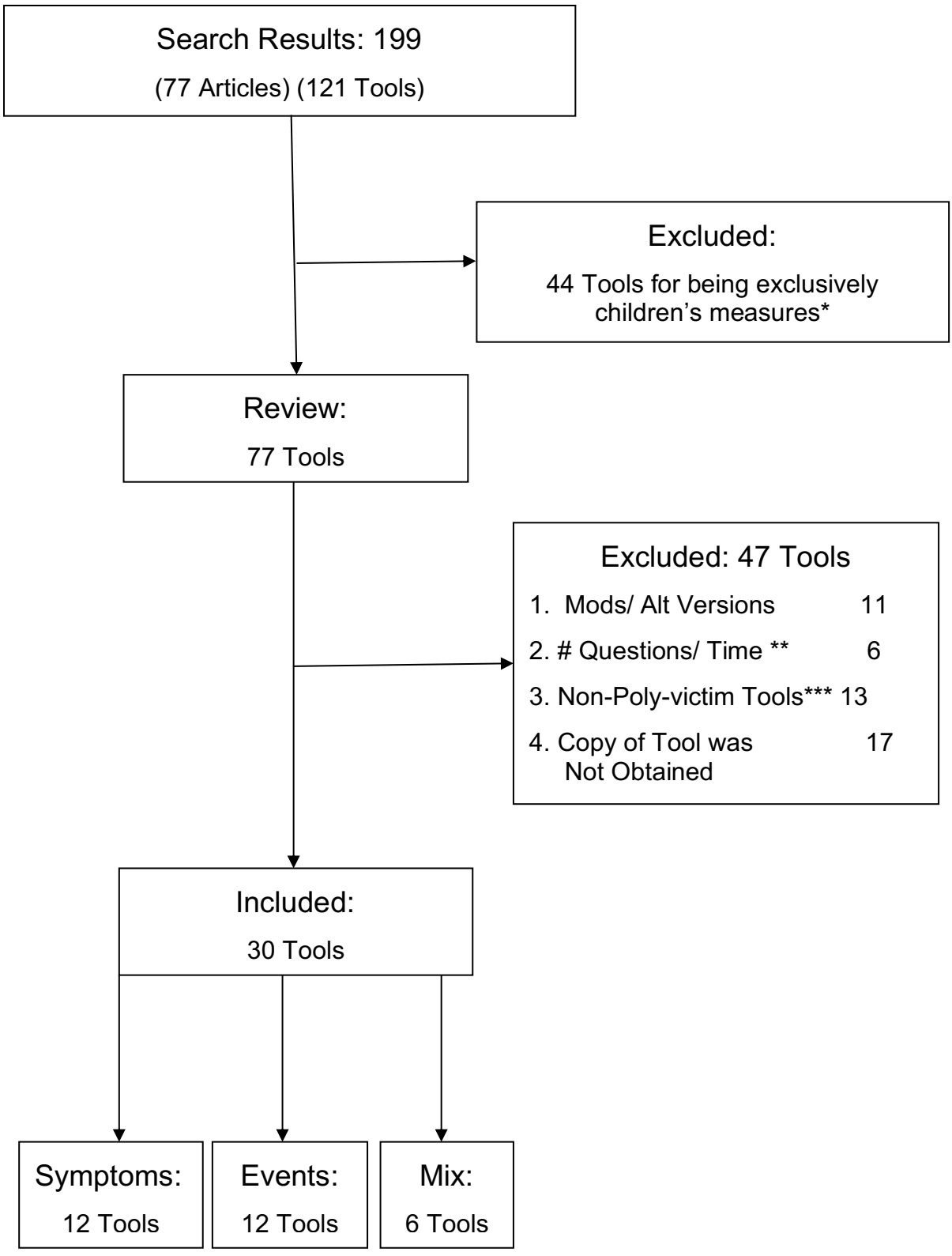
While PTSD differs from polyvictimization, where PTSD is defined as a “traumatic stress reaction that develops in response to a significant trauma” (SAMHSA, n.d., section 1, p. 6) and polyvictimization refers to the experience of multiple victimizations of different kinds, both have been found as a powerful predictor of trauma symptoms (Finkelhor, Ormrod, & Turner, 2007; Turner, Hamby, & Banyard, 2013). PTSD is a reaction to trauma and polyvictimization is categorized as an experience of multiple traumas, however both are considered predictors of trauma symptomology. This relationship between polyvictimization and PTSD justifies the review of multiple measures assessing for symptomology and exposure to events the DSM considers as definitions of a PTSD diagnosis.

While there were many tools that measure polyvictimization in children, few tools focused on polyvictimization for adults. Most Family Justice Centers serve primarily adult survivors and as such required a tool that would help identify or assess the level of polyvictimization in their adult clients. The vast majority of research and literature focuses on children. Therefore, a broader scope of research had to be developed.

In terms of a review of instruments that could potentially screen for polyvictimization in a Family Justice Center, tools that are concerned with exposure to events, instruments that assess for symptomology, and tools that represent a mixture of both are relevant as each could potentially screen for reactions to the potentially traumatic event, the experience of the potentially traumatic events, or a mixture of both to screen for polyvictimization.

While no single instrument was identified as the most appropriate measure to screen for polyvictimization in Family Justice Centers, items from most instruments were shown to be valid and reliable by the authors. As such, the Demonstration Initiative participants began the development of an Assessment Tool that was a combination of items selected from individual tools as the basis for an instrument created specifically to screen for polyvictimization in the Family Justice Center framework.

Appendix 1: Decision Tree



Appendix 2: Examined Criteria Note-

*Symptoms, Events, or Mix; ** Brief Possible Screen

Instrument	Authors	Number of Items	Measure	Assessment*	Screening/ Assessment As defined by author	Time To Administer	Administered	Respondents
ACE (Adverse Childhood Experiences)	Felitti et al. (1998)	10	Self-Report	Events	Not Identified	Not Identified	Not Identified	Adult
AES (Adult Experiences Survey)	Mersky, Janczewski, & Nitkowski (2018)	19	Self-Report	Events	Assessment	Not Identified	Non-Mental Health Staff	Adult
Breslau Screening	Breslau, Peterson, Kessler, & Schultz (1999)	7	Self-Report	Symptoms	Screening	Not Identified	Non-Mental Health Staff	Adult
CAPS-5 (Clinician-Administered PTSD Scale for DSM-5)	Weathers et al. (2018)	30	Interview	Mix	Gold-Standard Assessment	45-60 mins	Mental Health Professional	Adult
CSS (Crisis Support Scale)	Joseph, Andrews, Williams, & Yule (1992)	14	Self-Report	Events	Not Identified	Not Identified	Not Identified	Adult
CTD (Cumulative Trauma Disorder Scale)	Kira et al. (2012)	16	Self-Report	Symptoms	Screening	Not Identified	Non-Mental Health Staff	Adults/Adolescents
DTS (Davidson Trauma Scale)	Davidson et al. (1997)	17	Self-Report	Mix	Assessment **	Not Identified	Not Identified	Adult
IES-R (Impact of Event Scale-Revised)	Weiss & Marmar (1997)	22	Self-Report	Symptoms	Screening	Not Identified	Not Identified	Adult
JVQ-R2 (Juvenile Victimization Questionnaire:2nd Revision- Screener Sum Version: Adult Retrospective Form)	Finkelhor, Hamby, Turner, & Ormrod (2011)	34	Interview or Self-Report	Events	Screening	15 - 20 mins	Mental Health Professional	Adults

LASC (Los Angeles Symptom Checklist)	King, King, Leskin, & Foy (1995)	43	Self-Report	Symptoms	Assessment	Not Identified	Not Identified	Adults/ Adolescents
LEC-5 (Life Events Checklist for DSM-5)	Weathers et al. (2013b)	17	Self-Report	Events	Screening	Not Identified	Not Identified	Adult
LSC-R (Life Stressor Checklist -Revised)	Wolfe, Kimerling, Brown, Chrestman, & Levin (1997)	30	Self-Report	Events	Assessment	Not Identified	Mental Health Professional	Adult
NSESSS-PTSD (National Stressful Events Survey for PTSD-Short Scale)	LeBeau et al. (2014)	9	Self-Report	Symptoms	Assessment and Screening	Not Identified	Mental Health Professional	Adult
NTHC (North Shore Trauma History Checklist	North Shore- Long Island Jewish Health System, Inc. (2006)	20	Interview	Events	Assessment	Not Identified	Mental Health Professional	Adults/ Adolescents
PC-PTSD-5 (Primary Care PTSD Screen for DSM-5)	Prins et al. (2016)	5	Interview	Symptoms	Screening	Not Identified	Non-Mental Health Staff	Adult
PCL-5 (PTSD Checklist for DSM-5)	Weathers et al. (2013c)	20	Self-Report	Symptoms	Assessment and Screening	Not Identified	Mental Health Professional	Not Identified
Abbreviated PCL-C (Abbreviated PTSD Checklist-Civilian Version)	Lang & Stein (2005)	2 or 6	Self-Report	Symptoms	Screening	Not Identified	Non-Mental Health Staff	Adult
PDS-5 (Posttraumatic Diagnostic Scale for DSM-5)	Foa et al. (2016)	24	Self-Report	Mix	Not Identified	Not Identified	Not Identified	Not Identified
Polyvictimization/ Trauma Symptom Checklist	Pilnik & Kendall (2012)	45	Not For Use as Interview or Self-Report	Mix	Not For Diagnostic Use	Not Identified	Legal Advocates	Any Age

PPTSD-R (Purdue PTSD Questionnaire-Revised)	Lauterbach & Vrana (1996)	17	Self-Report	Symptoms	Assessment	Not Identified	Non-Mental Health Staff	Adult
SIPS (Single-Item PTSD Screener)	Gore, Engel, Freed, Liu, & Armstrong (2008)	1	Interview	Mix	Screening	Not Identified	Non-Mental Health Staff	Not Identified
SLESQ-R (Stressful Life Events Screening Questionnaire)	Green, Chung, Daroowalla, Kaltman, & DeBenedictis (2006)	13	Self-Report	Events	Screening	Not Identified	Non-Mental Health Staff	Not Identified
SPRINT (Short Post-Traumatic Stress Disorder Rating Interview)	Connor & Davidson (2001)	10	Self-Report	Symptoms	Screening	5-10 mins	Not Identified	Not Identified
TAA-SR (Trauma Assessment for Adults-Self Report)	Resnick, Falsetti, Kilpatrick, & Freedy (1996)	17	Self-Report	Events	Screening	Not Identified	Not Identified	Adult
TAQ (Trauma Antecedents Questionnaire)	Luxenberg, Spinazzola, & Van der Kolk, 2001	41	Self-Report	Events	Assessment	Not Identified	Not Identified	Not Identified
THQ (Trauma History Questionnaire)	Green (1996)	24	Self-Report	Events	Assessment and Screening	Not Identified	Not Identified	Adult
THS (Trauma History Screen)	Carlson et al. (2011)	14	Self-Report	Mix	Screening	Not Identified	Not Identified	Not Identified
TSC-40 (Trauma Symptom Checklist)	Elliott & Briere (1992)	40	Self-Report	Symptoms	Not Identified	Not Identified	Research Only	Adult
TSQ (Trauma Screening Questionnaire)	Brewin et al. (2002)	10	Self-Report	Symptoms	Screening	Not Identified	Not Identified	Adult
Vrana-Lauterbach Traumatic Events Scale-Civilian	Lauterbach & Vrana (1996)	11	Self-Report	Events	Screening	Not Identified	Not Identified	Not Identified

Chapter 3

From Screener to Assessment: The Polyvictimization Assessment Tool

Authors: Alliance for HOPE International

CHAPTER 3: From Screener to Assessment: The Polyvictimization Assessment Tool

The Fundamental Goal of the Tool

The Polyvictimization Assessment Tool was designed to help Family Justice Center staff better serve survivors by addressing both their immediate needs and the cumulative impacts of trauma and trauma-related symptoms experienced across their lifetimes. The Assessment Tool is an information integration instrument that functions as a summary of information gathered during interactions with a client over the course of their visit(s) to a Center. It allows intake staff, advocates, and partners to organize information gathered about past/current victimizations and symptomology in one place. With client consent, Center staff and partners are able to share client information about their current and past situations, thus reducing the need for a survivor to retell their experience and allowing partners to more effectively address long-term client needs. Furthermore, the use of the Assessment Tool at Centers not only provides better tailored services to current clients, but analyzing aggregate, de-identified Center data allows staff to understand prevalent victimizations in the community and identify additional partners/services needed onsite.

Assessment Tool Design

The Assessment Tool was collaboratively developed over a three year period, with more than 24 iterations drafted by OVC, the Alliance, OU, the six demonstration sites, and their research partners. As previously outlined in Chapter 2, development began only after an extensive review of the literature and existing instruments, in addition to input from all Centers about how the Assessment Tool should be utilized and the content it should contain. Based on the review of trauma literature and other validated tools, sites determined that the Assessment Tool should include an events section and a symptomology section. However, the journey to the final Polyvictimization Assessment Tool was neither linear nor direct; it took months of conversation, negotiation, and constant re-evaluation. This chapter seeks to outline and share this process so that future users understand the Assessment Tool and its intent. For detailed information on how the Assessment Tool should be utilized, please see the Polyvictimization Assessment Tool Resource Guidebook.

Throughout development, testing, and implementation, it remained clearly established that the Assessment Tool is not intended to be diagnostic. The terms “polyvictim” and “polyvictimization” should never be used to label, diagnose, pathologize, or judge a person receiving services, but rather to acknowledge and validate each client’s experience (Edmund & Bland, 2011). As such, this Assessment Tool was developed to be utilized by any frontline staff member, regardless of their licensure or educational degree.

While a scoring mechanism is included in the events and symptomology sections of the Assessment Tool, it is not intended to be used for diagnostic purposes. The calculated totals are a way to determine the number of victimizations or symptoms recently experienced in

order to identify clients who are potentially most vulnerable and may need accelerated treatment and services.

Although the Assessment Tool was also designed to capture information across the client's lifetime, the score for the category "in the last year" is particularly pertinent for prevention and care because it identifies the most recent victimizations experienced and gives service providers insight into the most relevant needs of the client. Polyvictimization research has identified that victimization often has a cumulative effect and clusters around a number of prior circumstances, indicating that individuals with a high number of victimizations (usually defined as more than seven in one year) continue to be victimized the following year and are vulnerable to more severe types of violence (Finkelhor et al., 2011). As such, the number of victimizations identified as occurring within the last year could be an indicator of future risk, life adversity, and psychological distress, while additionally signaling the need for further assessments, interventions, and intensive case management (Finkelhor et al., 2011).

Guiding Principles of the Assessment Tool

Since the start of the Initiative, there was an understanding that adaptations and changes would be made to the Assessment Tool throughout the three year Demonstration Initiative, based on survivor, site, and national expert feedback, as well as lessons learned during pilot testing and final implementation of the Assessment Tool itself. Because of the Assessment Tool's ever-changing nature, the Alliance, the six sites, and the research partners wanted to ensure that certain elements of the Assessment Tool's use would remain constant and would be adhered to by Initiative sites and future users of the Assessment Tool. These key elements became the guiding principles of the Assessment Tool and governed how it was used and administered. It was the intent of all Initiative participants to utilize and administer the Assessment Tool in a client-centered, hope-centered, and trauma-informed way. To this end, the guiding principles attempt to actualize this vision and state that the Assessment Tool:

1. Is client-centered and used to guide service delivery;
2. Is dynamic and flexible;
3. Screens for lifetime victimization;
4. Is conversational;
5. Is strengths-based and hope-centered;
6. Includes symptoms and events;
7. Can be implemented in two or more parts;
8. Is an information integration tool;
9. Is used with adult survivors; and
10. Will be used in conjunction with site-specific screeners.

Why Symptomology?

Asking clients about symptomology is often seen as outside the scope of an advocate's role; however, during the review of existing tools and literature, it was determined by Centers that the final Assessment Tool should have a symptomology section. One major reason guiding this determination was the potential opportunity for frontline staff to provide trauma-based psychoeducation and address the connection between the victimizations and adversities experienced by clients and the manifestations of symptoms in their bodies. The belief was that

this would help mitigate the impact of trauma by normalizing and contextualizing the lived experience of survivors. Understanding the symptoms in addition to the events experienced allows service providers to build deeper and stronger connections with their clients and create pathways for long-term healing and justice (see Chapter 11 for a deeper dive into lessons learned).

Some participants in this Initiative shared that it was often easier for survivors to discuss how they are physically feeling than it was to articulate the difficult experiences they have lived. For example, some clients did not initially identify as sexual assault survivors, but through the symptomology section were able to discuss their ongoing mental health symptoms and other physical manifestations, which, when discussed at further length with advocacy staff, led to disclosures of experiences that would be classified as sexual assault. However, ongoing conversations with the demonstration sites revealed varying degrees of comfort with symptomology questions. Some Centers initially only felt comfortable with having trained mental health professionals ask symptomology questions rather than integrating them into intakes conducted by advocate staff. Regardless of advocates' formal mental health training, the symptomology section of the Assessment Tool created a different pathway for frontline staff and clients to discuss the traumatic events clients experienced. It also provided an opportunity to empower clients with the choice on how they wanted to share their stories and the opportunity for staff to provide psychoeducation around how the event and physical manifestations may be related.

Due to this conversation around the utility and importance of including symptomology questions, participants in this Initiative took extra care to ensure that all language and concepts were accessible to frontline staff, regardless of their profession or licensure.

Development of the Polyvictimization Assessment Tool: From Screener to Assessment Tool

At the beginning of the Initiative, the intention was to create a screening tool rather than an assessment tool. Screening tools are generally shorter and able to be used with all clients visiting a service provider, and are designed to identify clients who would be eligible for a longer assessment (Crandal, 2017). For instance, a Post-Traumatic Stress Disorder (PTSD) screener identifies individuals from a larger population who, based on the results, are more likely to have PTSD. These clients are thus "screened in" to a smaller subset of the group with whom the PTSD assessment is utilized. This assessment is both longer and more extensive than the screener. Assessments are also more commonly used by mental health professionals to assist with formal diagnoses of clients. The Initiative first labeled the Assessment Tool as a screener partially due to this latter generalization about assessments serving a diagnostic purpose and being utilized primarily by mental health professionals. However, the tides began to shift during pilot testing when it became clear that the instrument was far too expansive and all-encompassing to be considered a screening tool.

During the Assessment Tool's development, all Initiative demonstration sites advocated for the inclusion of questions/topics that were most relevant and important to their clients and communities. In order to develop a tool that could be widely applicable across a variety of

Centers, a large number of questions were included. The comprehensive and holistic nature of the questions expanded the instrument beyond the scope of a traditional screener, morphing the instrument into what is now known as the Polyvictimization Assessment Tool. Despite being initially referred to as a screening tool during its development, for consistency and simplicity, the instrument will be referred to as the Polyvictimization Assessment Tool, or simply Assessment Tool, throughout this book.

Version 1 of the Assessment Tool - The Original Instrument

The first draft of the Polyvictimization Assessment Tool, released on November 9, 2017, was developed with feedback and input from the six demonstration sites. The categories, questions, and topics on the Assessment Tool were pulled from a variety of validated instruments selected from the literature review and later identified as critical by the six sites (see Chapter 2). While pulled from existing tools, many of the questions were re-worded to ensure similar style and formatting throughout the Assessment Tool. When first released in November of 2017, the Assessment Tool included 42 event topics/categories and 20 symptomology topics/categories.

There were four time periods next to each event and symptom that could be marked for: Child (0-12), Teen (13-17) Adult (18+), and In the Last Year.

The first iteration of the Assessment Tool included the following answer options in the events section:

- “Happened” for it happened to them personally;
- “Witnessed” for they witnessed it happen to someone else;
- “Learned about” for they learned about it happening to a close family member or close friend;
- “Part of job” for when they were exposed to it as a part of their job (example: military, police, or other first responder);
- “Not sure” and;
- “Doesn’t apply”.

These answer options were selected as they provided background to the events and thus could help inform service delivery. Additionally, these categories avoided the potential of minimizing the experiences of survivors by accounting for vicarious trauma. The symptomology section had the answer options of “happened”, indicating that the client had experienced the symptoms, and “not sure”.

Categories of the Assessment Tool

The events section included the following categories: assault, strangulation, fear of violence, sexual abuse/assault, sex/labor trafficking, other forced/unwanted sexual experiences, captivity, sexual harassment, emotional/verbal abuse, neglect, lack of love/support system, substance abuse, stalking, extreme poverty, homelessness, severe physical injury or illness, causing serious injury/death to someone, permanent/long-term loss, separation from children, disrupted caregiving, jail/prison time, bullying, discrimination, cybercrime, community violence, system-induced trauma, robbery, seen or heard someone die, living/lived in a war zone, victim

of terrorism, primary caretaker for someone with high needs, natural disaster, manmade disaster, exposed to dangerous chemicals, animal cruelty, and other.

Additionally, the topics of assault, sexual abuse/assault, emotional/verbal abuse, and stalking were further broken down into additional sub-categories to capture the different types of perpetrators possible. The categories of assault and sexual abuse/assault were each listed three times on the Assessment Tool with a different perpetrator for each instance: partner, parent, or caregiver; and non-relative caregiver, family friend, or stranger. Emotional/verbal abuse was listed twice: once for when the abuse was perpetrated by a partner and a second time for when the abuse was perpetrated by a parent, caretaker, friend, etc. Stalking was listed once for when committed by a partner and a second time for when committed by a friend or other. The reason for listing the same questions with different perpetrator options was to ensure that the Assessment Tool captured all the different variations of abuse that can occur. Since the Assessment Tool does not track the number of times the abuse was committed in each time period, but instead tracks whether or not it has transpired during the time periods, it was decidedly the best way to avoid minimizing the occurrence of the trauma and to accurately reflect the experiences of each survivor.

Phrasing on assessment tools can often include clinical language that does not necessarily resonate with the experiences of survivors. For this reason, great effort was spent to ensure the wording and phrasing of each category included on the Assessment Tool was easy to understand and explain to a client and that examples of common victimizations were listed to provide context. For example, the phrase “system-induced trauma” may not immediately resonate with a survivor when asked explicitly but if the same survivor is asked if they have had difficult experiences within the criminal justice system, they may respond with “yes”.

When first released in November of 2017, the symptomology section included the following symptoms: suicidal attempt or ideation, self-harming behaviors, health-risk behaviors, repeated disturbing memories or thoughts, avoidance, distant, irritable/angry, attention/concentration difficulties, physical pain, sleep disturbances, anxiety, jumpy, conduct problems, extreme impulsivity, extreme sadness, extreme low self-esteem, self-blame for experience, numbing, dissociation, attachment problems, and other. Although the symptomology section is not diagnostic, it does contain a short PTSD screener – PTSD Checklist-Civilian Version-Abbreviated (PCL-C) – that can be used to connect clients to higher levels of care. The symptomology section can also give mental health providers additional information on further mental health assessments that may be necessary for clients.

The question “other” was included in both the events and symptomology sections of the Assessment Tool so that staff could ask about and note anything else the client may want to share that was not explicitly included in the Assessment Tool otherwise. The Initiative believed this question was important because the Assessment Tool is intended to be a useful device for Center staff to capture all relevant information. In addition, this question allowed the Initiative to create a feedback loop during pilot testing and identify areas that may have potentially been missed during development. Finally, a “notes” section was included, as the Assessment Tool would not effectively serve its purpose if staff could not note information that came up organically but did not fall under an existing topic/category. Additionally, the Initiative held the belief that experiences with trauma are relative, and the absence of an event or experience on

the Assessment Tool does not discount the possibility that a survivor experienced it as traumatic.

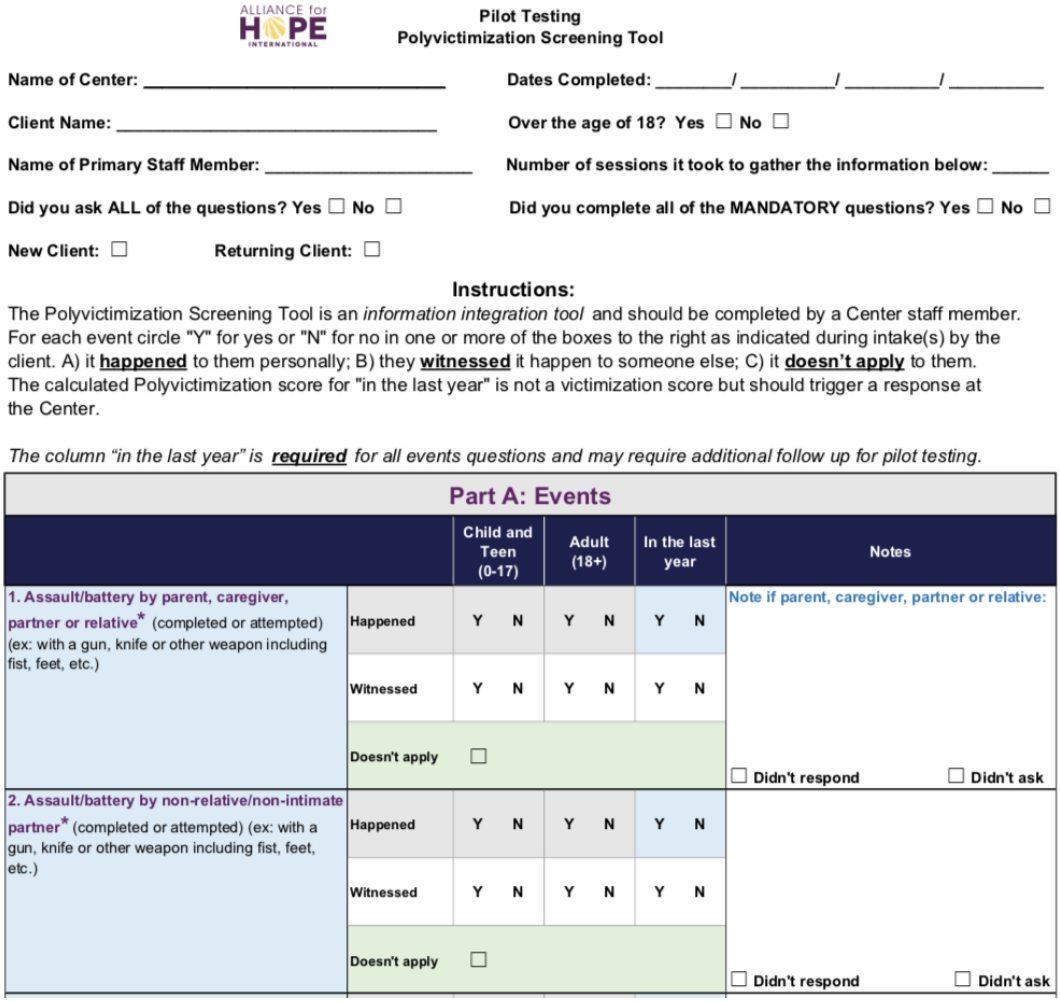
Version 2 of the Assessment Tool: The Pilot Testing Tool

Upon release of the first version of the Assessment Tool, sites had the opportunity to provide feedback and suggest changes after reviewing with their staff, partners, and communities. Their edits and feedback resulted in the version of the Polyvictimization Assessment Tool that was used during pilot testing from March 1, 2018 to May 31, 2018. Site feedback about the original Assessment Tool released in November of 2017 was that it was simply too long. Although the intention had been to make the Assessment Tool as comprehensive as possible, sites felt the sub-questions ("happened", "witnessed", "learned about", "part of job", and "not sure") within each topic made it lengthy and cumbersome for frontline staff. To remedy this, sites suggested narrowing down the sub-questions to "happened" and "witnessed", as they felt these categories would accurately capture the client's life experience in a succinct manner. The category of "witnessed" was kept, as it is especially useful when recording information about childhood trauma. The child and teen categories were also combined in an effort to reduce the Assessment Tool's length. In addition, substantial changes in wording and grouping were made to the following categories: assault, sexual abuse/assault, stalking, emotional/verbal abuse, and natural and manmade disasters. Finally, despite the desire to shorten the Assessment Tool, two new event categories emerged: financial abuse and immigration related trauma. The addition of these questions came from Centers who identified these events as common forms of victimizations experienced by their survivors and were not covered anywhere else on the Assessment Tool.

In the symptomology portion of the Assessment Tool, sites wanted to add the topic "currently experiencing pain" in order to attend to the client's most immediate needs and address any physical pain they may be experiencing. The language in the Assessment Tool was also amended to ensure that sites felt comfortable with the categories chosen and the messages they conveyed.

Mandatory Questions

The first iterations of the Assessment Tool included mandatory questions that were marked with an asterisk (*) and highlighted in blue. The Initiative believed these questions required additional follow-up from service providers, such as in-depth assessments, immediate medical attention, or support from counselors. Because the Assessment Tool was intended to be survivor-led and completed conversationally and retrospectively, it became important to establish ways in which the Assessment Tool itself could be validated. In order to accomplish this objective, mandatory questions were established as the baseline to inform national research and evaluation goals. The national researcher, local researchers, and the Alliance continued to have conversations about data and decided that in order for the Assessment Tool to capture the prevalence of polyvictimization, all events and symptomology questions on the Assessment Tool had to be asked, or at least accounted for.



Pilot Testing
Polyvictimization Screening Tool

Name of Center: _____ Dates Completed: _____/_____/_____/_____

Client Name: _____ Over the age of 18? Yes ☐ No ☐

Name of Primary Staff Member: _____ Number of sessions it took to gather the information below: _____

Did you ask ALL of the questions? Yes ☐ No ☐ Did you complete all of the MANDATORY questions? Yes ☐ No ☐

New Client: ☐ Returning Client: ☐

Instructions:

The Polyvictimization Screening Tool is an *information integration tool* and should be completed by a Center staff member. For each event circle "Y" for yes or "N" for no in one or more of the boxes to the right as indicated during intake(s) by the client. A) it **happened** to them personally; B) they **witnessed** it happen to someone else; C) it **doesn't apply** to them. The calculated Polyvictimization score for "in the last year" is not a victimization score but should trigger a response at the Center.

*The column "in the last year" is **required** for all events questions and may require additional follow up for pilot testing.*

Part A: Events

		Child and Teen (0-17)	Adult (18+)	In the last year	Notes
1. Assault/battery by parent, caregiver, partner or relative* (completed or attempted) (ex: with a gun, knife or other weapon including fist, feet, etc.)	Happened	Y N	Y N	Y N	Note if parent, caregiver, partner or relative:
	Witnessed	Y N	Y N	Y N	
	Doesn't apply	☐			☐ Didn't respond ☐ Didn't ask
2. Assault/battery by non-relative/non-intimate partner* (completed or attempted) (ex: with a gun, knife or other weapon including fist, feet, etc.)	Happened	Y N	Y N	Y N	
	Witnessed	Y N	Y N	Y N	
	Doesn't apply	☐			☐ Didn't respond ☐ Didn't ask

Figure 1: Polyvictimization Assessment Tool Version 2. Used During Pilot Testing March to May 2018. See Appendix 1 for complete Assessment Tool.

Piloting the Polyvictimization Assessment Tool

Pilot testing for the Polyvictimization Assessment Tool took place from March 1, 2018 to May 31, 2018. The purpose of pilot testing was to collect and analyze data on the efficacy and feasibility of the Assessment Tool. Additionally, it sought to find and institutionalize ways to improve responses to information collected with the Assessment Tool, and to collect data on the prevalence of polyvictimization. Additional emphasis was placed on identifying the most common types of victimizations and symptoms, and identifying the partners or services missing from Family Justice Centers based on feedback from clients and Center staff.

Initially, sites, the Alliance, and OVC were interested in having all FJC staff participate in pilot testing the Assessment Tool. However, it became clear that starting with a smaller group of staff was a better approach because of the extensive work, time, and training necessary to prepare intake staff for using the Assessment Tool and building expertise. As such, each site selected a small team within their intake staff to participate in pilot testing. With this smaller

subset, the Alliance was able to provide targeted training and technical assistance. Learning Exchange Team (LET) video conference meetings continued to take place during pilot testing with frontline staff, researchers, executive directors, and project points of contact from each site.

The Alliance and the national researcher, Dr. Chan Hellman, reviewed the number of new and returning clients each site served during a year and utilized that number of clients served to determine the ***minimum*** number of Polyvictimization Assessment Tools that each site should aim to complete during the pilot. The table below illustrates the Assessment Tool completion goals for each Center.

	New Clients	3% New	Returning Clients	3% Returning	Total
Tulsa	4013	30	1111	8	**38**
Stanislaus	1157	9	2890	22	**30**
Sonoma	1325	12	1502	13	**25**
Queens	4348	33	1158	9	**41**
New Orleans	581	12	531	13	**25**
Milwaukee	2304	17	3298	25	**42**
Total Tools to be Completed					186

Figure 2: Pilot Testing Site Goals for Assessment Tools to be Completed

Before pilot testing began, the Alliance and Centers agreed it was critical for frontline staff to receive in-depth training on how to use the Assessment Tool in order to avoid re-traumatizing clients. The Alliance developed a training module for frontline staff that focused on mock intakes via video conference. The purpose of the mock intakes was to ensure that staff felt comfortable with the categories in the Assessment Tool and understood its nature, intended format, and use. The Alliance set up individual meetings with frontline staff administering the Assessment Tool during pilot testing and conducted several practice sessions. During these practice sessions, the Alliance would utilize a client case scenario and the frontline staff members would practice their approach when using the Assessment Tool. During the practice sessions, frontline staff were able to talk through their fears around asking symptomology questions, learn how to use a conversational approach instead of a checklist system, identify their own biases, address difficult subjects, and determine how to identify which services may be helpful for a client when the victimizations identified were not interpersonal violence (IPV) or domestic violence (DV) related. This process was conducted over several weeks and was successful in helping frontline staff feel ready to pilot test the Assessment Tool.

Once pilot testing began, the Alliance held monthly video conference calls with frontline staff implementing the Assessment Tool, interviewed them about their experiences, and provided technical assistance around any challenges they were experiencing. The Alliance used a set of standardized questions that focused on identifying additional training needs, understanding the

user's experience with the Assessment Tool, documenting and addressing challenges frontline staff were facing, and noting any changes occurring in service delivery due to the Assessment Tool. In addition, the Alliance wanted to ensure that clients were not negatively impacted by the Assessment Tool and dedicated portions of each call to ask about any positive or negative experiences reported by clients during pilot testing.

As staff began asking clients more in-depth questions about their life experiences, frontline staff shared that they noticed an increase in empathy and understanding for their clients. This shifted their service delivery approach by increasing the amount of time they spent on intake, which created a deeper understanding of client needs and established additional ways to best follow up with the client. However, an unintended consequence of the Assessment Tool was that frontline staff experienced increased levels of vicarious trauma symptoms due to the difficult subjects the Assessment Tool brought up and the extensive discussion of a client's lifetime victimization. The increased levels of vicarious trauma reported by staff utilizing the Assessment Tool was a major lesson learned in the Initiative and highlighted the importance of developing processes, protocols, and internal mechanisms to protect and support staff implementing the Assessment Tool. When utilizing the Assessment Tool, staff need increased support from their Centers in the form of formal and informal debriefing opportunities. This lesson and others will be further discussed in Chapter 11.

Pilot Testing Results

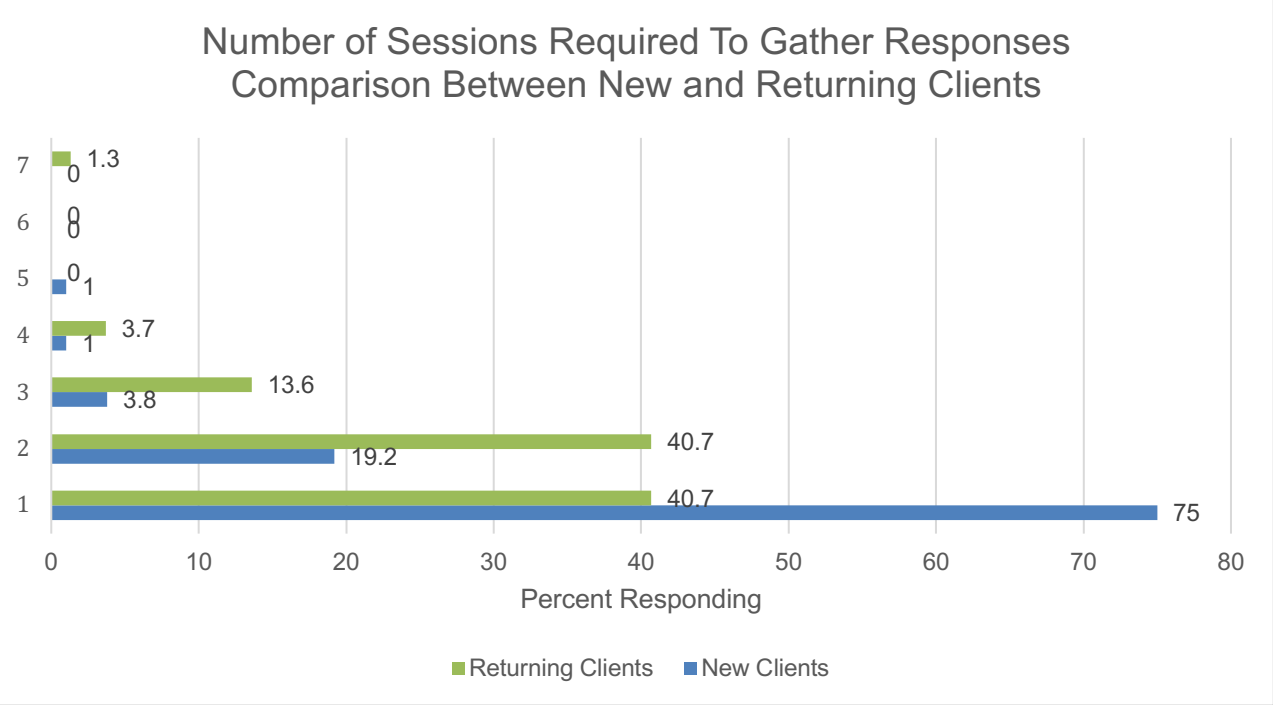


Figure 3: Pilot Testing Data - Number of Sessions Required to Gather Responses: Comparison Between New and Returning Clients

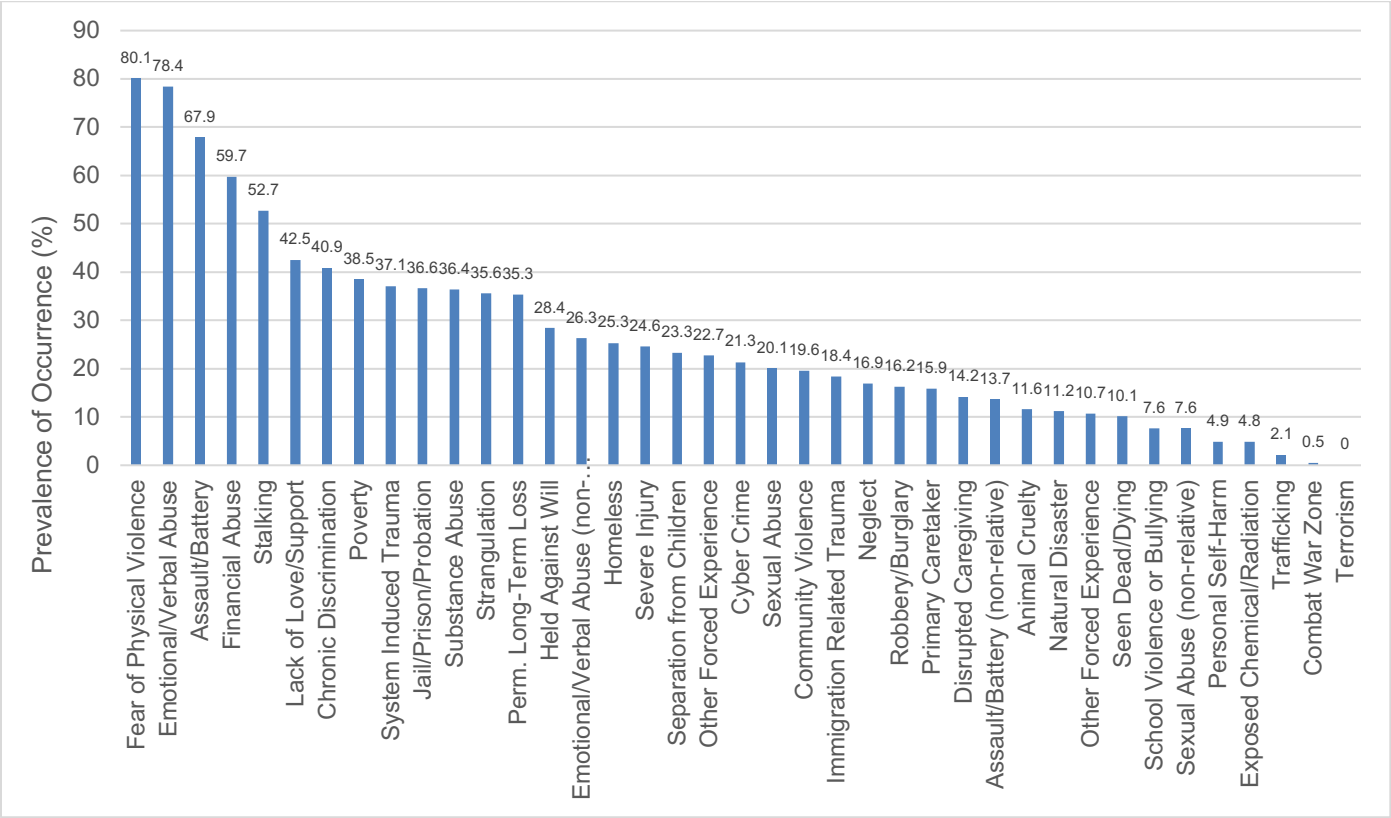


Figure 4: Pilot Testing Data - Prevalence of Event Occurrence in the Last Year

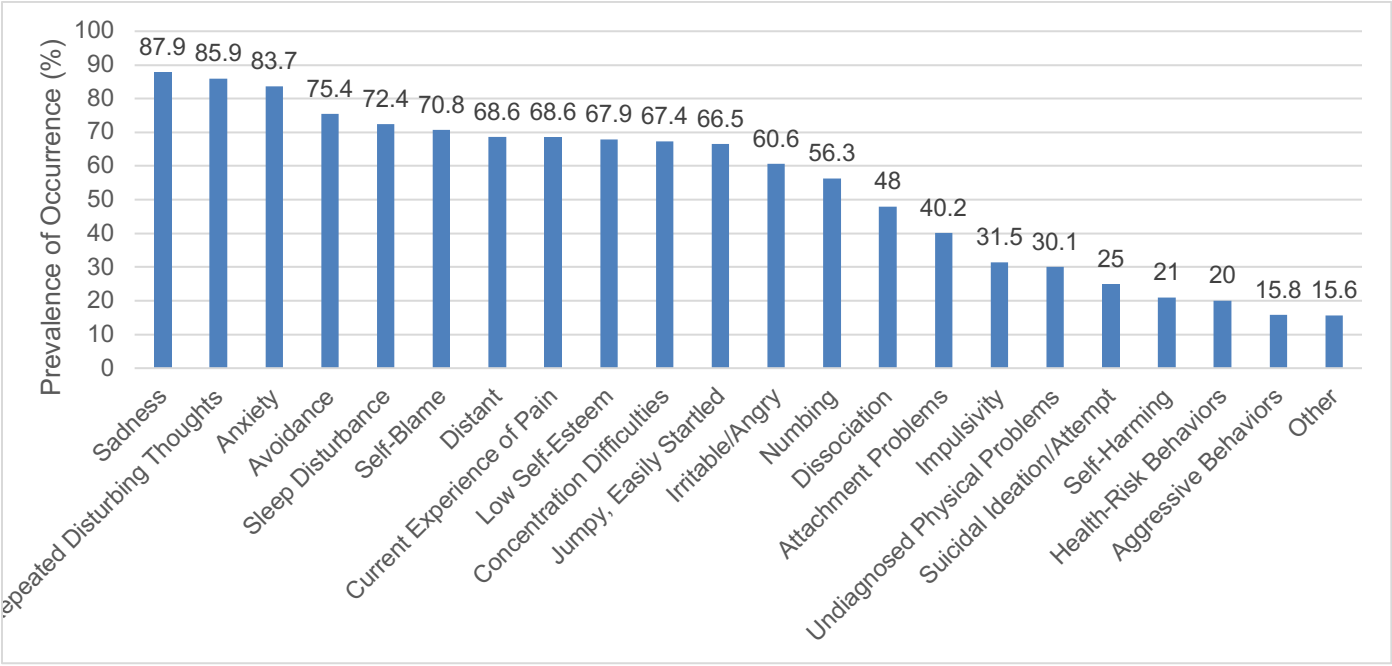


Figure 5: Pilot Testing Data - Prevalence of Trauma Symptoms in the Last Year

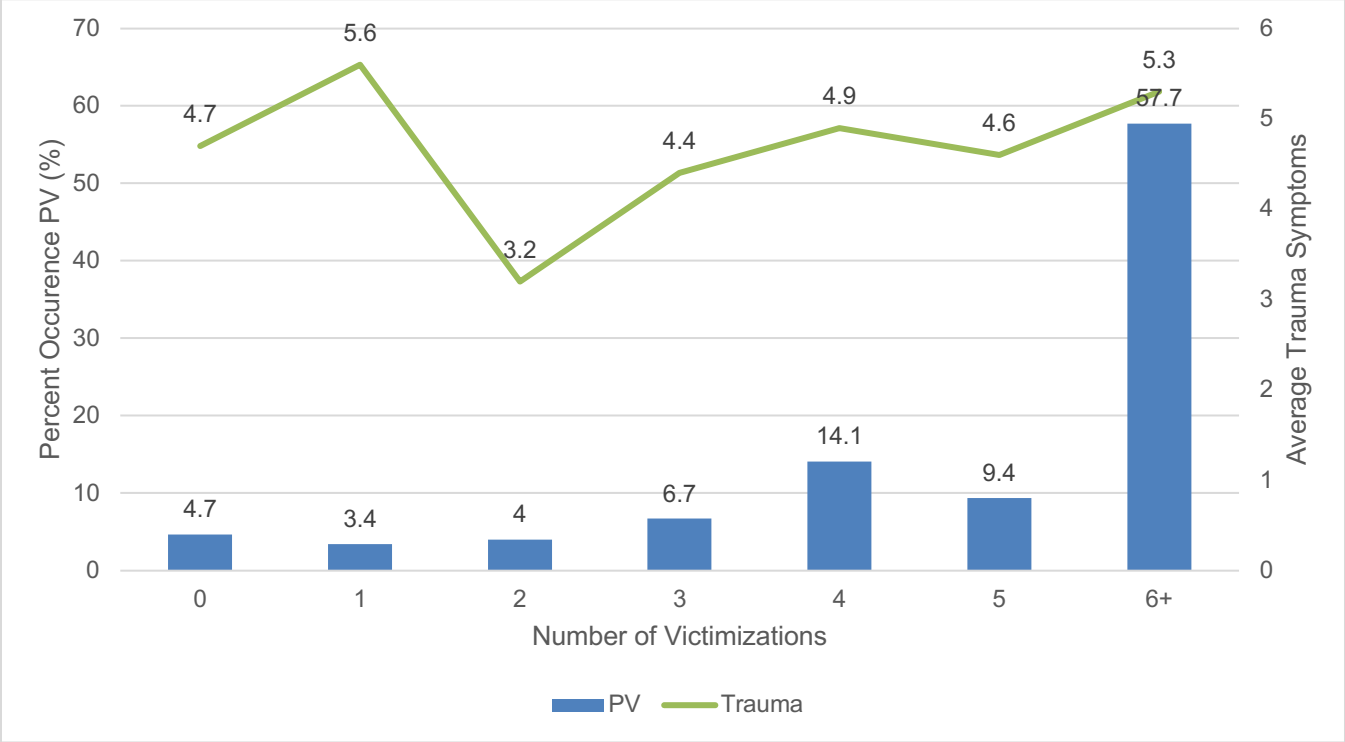


Figure 6: Pilot Testing Data - Relationship Between Multiple Types of Victimizations in the Last Year and Trauma Symptoms

Version 3 of the Tool: Post Pilot Testing Revisions

After pilot testing ended on May 31, 2018, the Alliance and the Centers conducted a systematic and thorough method for editing and revising Version 2 of the Assessment Tool. According to feedback gathered during pilot testing, it was critical for Initiative members to review the Assessment Tool question by question and instruction by instruction to determine which items to keep and which items needed to be changed. To accomplish this, the Alliance created an extensive anonymous survey that asked Centers to vote on:

A. Each question of the Assessment Tool and if they would like to keep, delete, or change the question (both events and symptomology);
B. Format of the Assessment Tool (including keeping or removing the “witnessed” column);
C. Mandatory questions;
D. How many versions of the Assessment Tool should exist (lifetime, childhood, adults, in the last year, or just one version encompassing all timeframes); and
E. Whether the Assessment Tool should screen for lifetime victimization or only victimizations in the last year.

To finalize the Polyvictimization Assessment Tool, four LET calls and one in-person meeting were held with representatives from each site. During these calls, the Initiative discussed any survey items that did not receive a two-thirds majority or greater vote. This led to discussions on which questions to remove, question formatting and wording, and any additional administration options to make the Assessment Tool more user-friendly. Though the central

feedback during pilot testing largely emphasized the need to condense the Assessment Tool, this survey and dialogue process helped Initiative members realize that every question was critical for Centers and clients and as such, only a small number of questions were deleted.

Version 2 of the Assessment Tool had 39 event questions and 22 symptomology questions. Through the prior revision process, it was eventually shortened to 26 event questions and 18 symptomology questions. The Assessment Tool was condensed largely by merging questions, with only four victimizations completely removed. The four victimizations removed from the event section were: personally causing serious harm, injury, or death to someone else; been in or lived in a military combat war zone; being a primary caretaker; and being exposed to dangerous chemicals or radioactivity that might threaten one's health. The one symptom removed from the symptomology section was attachment problems. The category for witnessing victimizations was also removed from the Assessment Tool.

During the revision process, further care was taken to ensure that clients would not feel judged or stigmatized by phrasing and to ensure that the information recorded on the Assessment Tool could not be used against the client. All members of the Initiative reiterated their support for having the Assessment Tool remain confidential and only shared with consent among privileged service providers if the information would help survivors obtain the services they requested.

Learning Exchange Team (LET) Meeting to Finalize the Assessment Tool

On September 28, 2018, the Alliance, OVC, and the six Centers gathered in Milwaukee, Wisconsin to discuss the challenges that arose during pilot testing. Dr. Hellman and Susan Williams, Deputy Director of OVC, facilitated the conversation and provided Centers with a platform to share challenges and discuss strategies for overcoming them. Centers shared their frustrations with the length of the Assessment Tool, the criteria for completion, the importance of flexibility given the fact that many clients only visit their Centers once, and the need for Spanish and Russian translations. This meeting was critical to articulating the Initiative's shared vision and values and served as a way for all sites and partners to re-energize and refocus the Initiative.

During the meeting, sites expressed the need for flexibility in implementation, both in terms of final goal numbers for completed Assessment Tools and the timeline allotted for this process, and the desire to develop individual site-specific screening tools at the local level that would screen clients in for the longer Assessment Tool. After extensive dialogue with LET representatives, the Alliance and OVC supported the solution of developing Screeners to better address the needs of Centers experiencing capacity challenges. The Alliance, OVC, and demonstration sites also agreed it was imperative to translate the Assessment Tool into Russian and Spanish in order to streamline the process for bilingual frontline staff who had to conduct their own time-consuming translations while utilizing the Assessment Tool.

An unintended consequence of the strict evaluation parameters developed during pilot testing was that staff felt immense internal pressure to complete the Assessment Tool. While much of this pressure was self-imposed, it still led to increased stress levels across sites. Therefore, a new criterion for 'completed' Assessment Tools was implemented that included the options "Client did not respond", "User did not ask", and "Not appropriate to ask" as a means to reduce

the pressure of completing the Assessment Tool in its entirety. Sites, the Alliance, and OVC discussed the definition of each new category and the specific situations wherein each would apply. “Client did not respond” would be used if a client did not respond to a question or share any information about a category; “User did not ask” would be used if the user was not able to ask the question due to time constraints or any other limitations; and “Not appropriate to ask” would be used if the client expressed they did not want to discuss a specific topic during the assessment.

Final Implementation

Final implementation began December 1, 2019 and lasted until May 31, 2019. The goals of final implementation were to utilize the final Polyvictimization Assessment Tool, triangulate the prevalence data found during pilot testing, and institutionalize the use of this assessment in everyday practice at the Centers. It was also during final implementation that Centers were able to implement their Screeners. These Screeners can be found in Appendices 3 - 7.

Based on feedback from pilot testing, each site identified the projected number of Assessment Tools they would be able to complete during final implementation and submit for national analysis. The local Centers and their researchers also had full control over how information was gathered and analyzed. Furthermore, each Center developed their process for determining how the Screeners would be implemented and the parameters and ways in which a survivor would “screen in” as a polyvictim and be determined eligible for use of the Polyvictimization Assessment Tool. This flexibility led to varying models, Screeners, and approaches to final implementation which reflected the unique needs of each demonstration site.

The Alliance continued their pilot testing practice of holding monthly calls with each Center’s frontline staff in order to help resolve or document any challenges and successes experienced by users or clients. It was also during this time that the Alliance conducted Year 3 site visits and encouraged all Centers to host a day long hope theory training for frontline staff and partners. Integrating hope theory and strengths inventories for clients after utilization of the Assessment Tool remained a focus for ongoing technical assistance.

Chapters 5 - 10 highlight the local experience and findings of the sites. The Alliance encourages interested users of this Assessment Tool to identify Centers similar to their own in order to better understand the journey, challenges, and successes experienced. National results from final implementation data can be found in Chapter 2.

The Power of Multi-Disciplinary Collaboration

The development of the Polyvictimization Assessment Tool was the product of a concerted, joint effort across a multi-disciplinary team, and was in many ways a microcosm of the shift toward multi-agency collaboratives in the Family Justice Center movement. When professionals with varied education, professional experience, lived experience, culture, and community representation come together, survivors benefit. Pulling from the experiences of

professionals who have dedicated their lives to working with survivors, this Initiative created a framework that allows frontline staff to better serve the needs of their clients.

The national experts involved in this Initiative provided staff and Directors with foundational knowledge that they could adapt and build upon using their own experiences and the experiences derived from the Initiative. Each discipline and individual was able to advocate for what they believed would benefit their clients most. This Assessment Tool was informed by research, but not solely driven by quantitative data. The qualitative experiences of survivors, as shared by frontline staff, were the driving force behind any changes made to the Assessment Tool. The recognized need to better serve survivors was the true guiding principle of the Initiative and was supported by everyone involved. The collaborative nature of learning exchange augmented with honest, albeit challenging dialogues allowed Alliance staff, researchers, project coordinators, frontline staff, and partner agencies to expand their perceptions of trauma and service delivery, develop new ways of working together, and broaden their skill sets. And yet, the six Family Justice Centers involved in the Initiative were also very unique. The leadership structures, community demographics, services offered, funding sources, capacities, and community needs were varied and distinct. Each site had their own experience with the Assessment Tool and they resourcefully developed methods of utilizing it that best fit their Centers. The hope is that other Family Justice Centers are able to identify with various strengths and challenges presented in these Centers and consider what it would look like to build upon their innovations and replicate this framework in their communities. Learn more in the following chapters.

Appendix 1: The Polyvictimization Assessment Tool

1. Assessment Tool in English
    a. Pages 54-59
2. Assessment Tool in Spanish
    a. Pages 60-65
3. Assessment Tool in Spanish – Gender Neutral
    a. Pages 66-71
4. Assessment Tool in Russian
    a. Pages 72-77

ALLIANCE for HOPE INTERNATIONAL

THE POLYVICTIMIZATION ASSESSMENT TOOL

Name of Center: _____ **Dates Utilized:** _____/_____/_____/_____

Client Name: _____ **Client ID:**_____ **Over the age of 18? YES ☐ NO ☐**

Name of Staff Member(s): _____/ _____/ _____/ _____

New Client: ☐ **Returning Client:** ☐ **Number of sessions it took to gather the information below:** _____

The Polyvictimization Assessment Tool is an information integration tool. Please ensure confidentiality is explained and honored for each client. For each event below circle "Y" for yes or "N" for no in the boxes to the right as applicable for the different stages of the client's life (Child and Teen, Adult, and In the last year). In addition to "Y" and "N" user may circle other possible responses which include "A" for the **client did not respond** to the question; "B" for the **user did not ask** due to time constraints or other limitations; and "C" for the user did not ask since it was **not appropriate to ask**. For questions that are not applicable to all clients, an additional "Does not apply" response has been included. When marking an event "In the last year," please also mark the respective time period that it would fall under (Child and Teen OR Adult). Answers should be from the client's perspective. If the user has additional input or thoughts, particularly around minimizing, this should be included in the "Notes" section. The number of events calculated for "In the last year" is not a victimization score but should trigger a response at the Center.

Part A: Events

		Child and Teen (0-17)	Adult (18+)	In the last year	Notes
1. Assault/battery by parent, caregiver, partner, or relative (completed or attempted) (ex: with a gun, knife, or other weapon including fist, feet, etc.)	Client did not respond = **A** User did not ask = **B** Not appropriate to ask = **C**	Y N A B C	Y N A B C	Y N A B C	Note if parent, caregiver, partner, or relative:
2. Strangulation and/or positional asphyxia (pressure applied by any means to the neck or anywhere that made it difficult to breathe) (ex: choking, use of body weight or arms, sitting on top of you, etc.)	Client did not respond = **A** User did not ask = **B** Not appropriate to ask = **C**	Y N A B C	Y N A B C	Y N A B C	
3. Sexual abuse/assault by parent, caregiver, partner, relative, friend, or other (completed or attempted) (ex: rape, made to perform any type of sexual act through force or threat of harm)	Client did not respond = **A** User did not ask = **B** Not appropriate to ask = **C**	Y N A B C	Y N A B C	Y N A B C	Note if parent, caregiver, partner, relative, friend, or other:
4. Sex or labor trafficking (ex: being prostituted, forced involvement in sexual performances, forced pornography, involved in domestic servitude or other exploitative labor, etc.)	Client did not respond = **A** User did not ask = **B** Not appropriate to ask = **C**	Y N A B C	Y N A B C	Y N A B C	
5. Other forced/unwanted experience(s) related to your body not including abuse or assault (ex: touching, flashing, reproductive coercion such as forced abortions and family planning, revenge pornography, sexual remarks, sexual jokes, or demands for sexual favors by someone at work or school like a coworker, boss, customer, another student, teacher, etc.)	Client did not respond = **A** User did not ask = **B** Not appropriate to ask = **C**	Y N A B C	Y N A B C	Y N A B C	

		Child and Teen (0-17)	Adult (18+)	In the last year	Notes
6. Held against will (ex: being kidnapped, abducted, held hostage, held captive, prisoner of war, etc.)	Client did not respond = **A** User did not ask = **B** Not appropriate to ask = **C**	Y N A B C	Y N A B C	Y N A B C	
7. Emotional/verbal abuse by parent, caregiver, partner, relative, friend, or other (ex: putting down, fear of physical violence, name calling, mind games, humiliating, guilt trips, spiritual abuse, etc.)	Client did not respond = **A** User did not ask = **B** Not appropriate to ask = **C**	Y N A B C	Y N A B C	Y N A B C	Note if parent, caregiver, partner, relative, friend, or other:
8. Financial abuse (ex: forbidden from working, given allowance, not allowed to access bank accounts, online financial fraud, other financial cybercrimes, etc.)	Client did not respond = **A** User did not ask = **B** Not appropriate to ask = **C**	Y N A B C	Y N A B C	Y N A B C	
9. Neglect by parent, caregiver, partner, relative, friend, or other (ex: being left unattended for long periods, lack of love or support system at home, very often feeling like not loved by family, malnutrition due to lack of adequate food/water, failure to provide necessary medical care that results in hospitalization, etc.)	Client did not respond = **A** User did not ask = **B** Not appropriate to ask = **C**	Y N A B C	Y N A B C	Y N A B C	Note if parent, caregiver, partner, relative, friend, or other:
10. Substance use (ex: you, partner, or a close family member misuse prescription drugs, alcohol, or illicit drugs)	Client did not respond = **A** User did not ask = **B** Not appropriate to ask = **C**	Y N A B C	Y N A B C	Y N A B C	Note if client, parent, caregiver, partner, or relative:
11. Stalking/inappropriate pursuit by parent, caregiver, partner, relative, friend, or other (ex: unwanted repeated contact in-person or via text messages, phone calls, social media, other online platforms including email, etc.)	Client did not respond = **A** User did not ask = **B** Not appropriate to ask = **C**	Y N A B C	Y N A B C	Y N A B C	Note if parent, caregiver, partner, relative, friend, or other:
12. Poverty (ex: did not have enough food to eat, lack of basic needs such as clothes, shoes, etc.)	Client did not respond = **A** User did not ask = **B** Not appropriate to ask = **C**	Y N A B C	Y N A B C	Y N A B C	
13. Homeless (ex: transitional housing, shelter, hotel/motel paid by voucher, someone else's home, a vehicle, an abandoned building, anywhere outside, or anywhere not meant for people to live without having any other options)	Client did not respond = **A** User did not ask = **B** Not appropriate to ask = **C**	Y N A B C	Y N A B C	Y N A B C	

		Child and Teen (0-17)	Adult (18+)	In the last year	Notes
14. Severe physical injury/illness and/or mental illness resulting in hospitalization or incapacitation (ex: severe pain requiring treatment at home, due to an accident, mental health condition, etc.)	Client did not respond = **A** User did not ask = **B** Not appropriate to ask = **C**	Y N A B C	Y N A B C	Y N A B C	
15. Permanent or long-term loss (ex: of a spouse, romantic partner, child, parent or caregiver, due to incarceration, deportation, illness, suicide, death, etc.)	Client did not respond = **A** User did not ask = **B** Not appropriate to ask = **C**	Y N A B C	Y N A B C	Y N A B C	
16. Immigration-related trauma (ex: separated from support network, language barriers, trouble finding a job, unfamiliar environment and food, deportation, etc.)	Client did not respond = **A** User did not ask = **B** Not appropriate to ask = **C**	Y N A B C	Y N A B C	Y N A B C	
	Does not apply ☐				
17. Separation from child(ren) or disrupted caregiving as a child (ex: the loss of custody, visitation, or kidnapping/ abduction of a child; a change of custody among family members, numerous changes in foster care placements, or deportation as a child)	Client did not respond = **A** User did not ask = **B** Not appropriate to ask = **C**	Y N A B C	Y N A B C	Y N A B C	
	Does not apply ☐				
18. Jail/prison/probation/parole/ detention time (ex: you, partner, close family member, etc.)	Client did not respond = **A** User did not ask = **B** Not appropriate to ask = **C**	Y N A B C	Y N A B C	Y N A B C	Note if client, parent, caregiver, partner, or relative:
19. Bullying (ex: verbal or physical violence in-person or online via social media and other online platforms in the workplace, school, etc.)	Client did not respond = **A** User did not ask = **B** Not appropriate to ask = **C**	Y N A B C	Y N A B C	Y N A B C	
20. Chronic or repeated discrimination (ex: discrimination based on race, ethnicity, where family comes from, gender, gender identity/expression, sexual orientation, ability/disability, etc.)	Client did not respond = **A** User did not ask = **B** Not appropriate to ask = **C**	Y N A B C	Y N A B C	Y N A B C	
21. Community violence (ex: physical assault/battery by a stranger; robbery, burglary, mugging, or identity theft; victim of terrorist attack; mass shootings; street riots; drive-by shootings; stabbings; beatings; heard gunshots; etc.)	Client did not respond = **A** User did not ask = **B** Not appropriate to ask = **C**	Y N A B C	Y N A B C	Y N A B C	

		Child and Teen (0-17)	Adult (18+)	In the last year	Notes
22. System-induced trauma (ex: violent arrest situations, difficult experiences testifying against abuser at trial, police brutality, etc.)	Client did not respond = **A** User did not ask = **B** Not appropriate to ask = **C**	Y N A B C	Y N A B C	Y N A B C	
23. Seen someone who was dead, or dying, or watched or heard them being killed (in real life not on TV. or in a movie, etc.)	Client did not respond = **A** User did not ask = **B** Not appropriate to ask = **C**	Y N A B C	Y N A B C	Y N A B C	
24. Natural and/or man-made disaster (ex: a hurricane, earthquake, flood, tornado, fire, train crash, building collapse, etc.)	Client did not respond = **A** User did not ask = **B** Not appropriate to ask = **C**	Y N A B C	Y N A B C	Y N A B C	
25. Animal cruelty (ex: abuse or threats to pet in attempts to create fear or manipulate)	Client did not respond = **A** User did not ask = **B** Not appropriate to ask = **C**	Y N A B C	Y N A B C	Y N A B C	
	Does not apply ☐				
26. Other (ex: anything really scary or very upsetting that occurred that is not included above or any other experiences that were not covered)	Client did not respond = **A** User did not ask = **B** Not appropriate to ask = **C**	Y N A B C	Y N A B C	Y N A B C	
TOTAL LIVED VICTIMIZATIONS BY AGE GROUP:					

For each symptom circle "Y" for yes or "N" for no in the boxes to the right as applicable for the different stages of the client's life (Child and Teen, Adult, In the last year, and Current Symptom). In addition to "Y" and "N" user may circle other possible responses which include "A" for the client did not respond to the question; "B" for the user did not ask due to time constraints or other limitations; and "C" for the user did not ask since it was not appropriate to ask. When marking a symptom as a "Current Symptom" and "In the last year," please also mark the respective time period that it would fall under (Child and Teen OR Adult). Answers should be from the client's perspective. If the user has additional input or thoughts, particularly around minimizing, this should be included in the "Notes" section. The number of symptoms for "In the last year" and "Current Symptoms" are calculated and should assist in guiding service delivery.

Part B: Symptoms						
		Child and Teen (0-17)	Adult (18+)	In the last year	Current Symptom	Notes
1. Experiencing pain and/or physical symptom(s) that have not been diagnosed or are resistant to treatment	Client did not respond = **A** User did not ask = **B** Not appropriate to ask = **C**	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
2. Suicide attempt, discussion, or thoughts of suicide	Client did not respond = **A** User did not ask = **B** Not appropriate to ask = **C**	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
3. Self-harming behavior(s) (ex: cutting, eating disorder including overeating, etc.)	Client did not respond = **A** User did not ask = **B** Not appropriate to ask = **C**	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
4. Health-risk behavior(s) (ex: excessive use of drugs/ alcohol, sharing needles, unprotected sex with multiple partners, etc.)	Client did not respond = **A** User did not ask = **B** Not appropriate to ask = **C**	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
5. Repeated disturbing memories, thoughts, or images of a stressful experience	Client did not respond = **A** User did not ask = **B** Not appropriate to ask = **C**	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
6. Avoidance (ex: avoiding places, people or other stimuli associated with past trauma, feelings, or physical sensations that remind you of the trauma, etc.)	Client did not respond = **A** User did not ask = **B** Not appropriate to ask = **C**	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
7. Cut off (ex: feeling distant or isolated)	Client did not respond = **A** User did not ask = **B** Not appropriate to ask = **C**	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
8. Irritable/angry (ex: feeling irritable, having angry outbursts, or rage)	Client did not respond = **A** User did not ask = **B** Not appropriate to ask = **C**	Y N A B C	Y N A B C	Y N A B C	Y N A B C	

		Child and Teen (0-17)	Adult (18+)	In the last year	Current Symptom	Notes
9. Attention/concentration difficulties (ex: easily distracted/inattentive)	Client did not respond = **A** User did not ask = **B** Not appropriate to ask = **C**	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
10. Sleep disturbances (ex: night terrors, sleeplessness, excessive sleepiness, etc.)	Client did not respond = **A** User did not ask = **B** Not appropriate to ask = **C**	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
11. Anxiety (ex overly tense, worried, or stressed to the point of withdrawal from activities, experiencing panic attacks, or needing excessive reassurances)	Client did not respond = **A** User did not ask = **B** Not appropriate to ask = **C**	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
12. Hypervigilance (ex: jumpy, startles easily, overly aware or concerned about potential dangers, etc.)	Client did not respond = **A** User did not ask = **B** Not appropriate to ask = **C**	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
13. Aggressive or violent behaviors, even if done so unintentionally or unexpectedly (ex: physically or verbally aggressive, destroys property, etc.)	Client did not respond = **A** User did not ask = **B** Not appropriate to ask = **C**	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
14. Impulsivity (sudden, strong, even irrational urge to engage in behavior without considering consequences first) (ex: stealing, truancy, etc.)	Client did not respond = **A** User did not ask = **B** Not appropriate to ask = **C**	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
15. Sadness (apathy/despair)	Client did not respond = **A** User did not ask = **B** Not appropriate to ask = **C**	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
16. Low self-esteem (ex. I am bad, there is something seriously wrong with me, self-blame for the experience, etc.)	Client did not respond = **A** User did not ask = **B** Not appropriate to ask = **C**	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
17. Numbing, dissociating (ex: limited emotional range, avoiding thinking or talking about the future or goal setting, "feeling flat," etc.)	Client did not respond = **A** User did not ask = **B** Not appropriate to ask = **C**	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
18. Other (ex: any changes in behavior, physical well being, or mood that have occurred since the incident(s)that are not included above)	Client did not respond = **A** User did not ask = **B** Not appropriate to ask = **C**	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
SYMPTOMS PRESENT IN THE LAST YEAR AND CURRENT SYMPTOMS:						

HERRAMIENTA DE EVALUACIÓN DE VICTIMIZACIÓN MÚLTIPLE

Nombre del Centro: _____ Fechas de Visitas: _____/_____/ _____/ _____

Nombre del Cliente: _____Número de identificación del Cliente:_____ ¿Mayor de 18 años? **SI** □ **NO** □

Nombre de el(los) miembro(s) del personal: _____/ _____/ _____/ _____

Nuevo Cliente: □ Cliente Habitual: □ Número de sesiones que tomó recopilar la información a continuación: _____

La herramienta de evaluación de victimización múltiple es una herramienta de integración de la información. Por favor asegúrese de explicar y honrar la confidencialidad para cada cliente. Para cada evento abajo haga un círculo alrededor de la "S" si su respuesta es sí o alrededor de la "N" si su respuesta es no, en las casillas a la derecha, según sea el caso para las diferentes etapas de la vida del cliente (niño y adolescente, adulto y en el último año). Además de marcar "S" y "N" el usuario puede hacer un círculo en otras respuestas posibles que incluyen "A" **si el cliente no respondió** a la pregunta; "B" si el **usuario no hizo la pregunt**a debido a las limitaciones de tiempo o a otras limitaciones; y "C" si el usuario no hizo la pregunta puesto que **no era apropiado hacerl**a. Para las preguntas que no son aplicables a todos los clientes, se ha incluido la respuesta adicional "No aplica". Al marcar un evento "en el último año", por favor también marque el período de tiempo respectivo bajo el cual aplica (niño y adolescente O adulto). Las respuestas deben ser desde la perspectiva del cliente. Si el usuario tiene aportes o comentarios adicionales, particularmente si se trata de minimizar los hechos, esto debería incluirse en la sección de "Notas". El número de eventos calculados para "En el último año" no es una calificación de victimización pero debería desencadenar una respuesta en el centro.

Parte A: Eventos

		Niño y adolescente (0-17)	Adulto (18+)	En el último año	Notas
1. Ataque/agresión por los padres, cuidadores, pareja o familiar (realizado o intentado) (ejemplo: con una pistola, cuchillo u otra arma como el puño, los pies, etc.)	El cliente no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	Anotar si es el padre o madre, cuidador, pareja, o pariente:
2. Estrangulación o asfixia posicional (presión aplicada por cualquier medio en el cuello o en cualquier lugar que dificulte la respiración) (ejemplo: asfixia, uso del peso del cuerpo o los brazos, sentarse encima de usted, etc.)	El cliente no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	
3. Abuso sexual/agresión por los padres, cuidadores, pareja, familiar, amigo u otra persona (realizado o intentado) (ejemplo: violación, forzado a realizar cualquier acto sexual por medio de la fuerza o amenaza de daño)	El cliente no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	Anotar si es el padre o madre, cuidador, pareja, pariente, amigo u otro:
4. Explotación sexual o laboral (ejemplo: ser prostituido, ser forzado a participar en actos sexuales, ser forzado a la pornografía, la servidumbre doméstica u otro trabajo explotador, etc.)	El cliente no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	
5. Otra(s) experiencia(s) forzada(s)/ no deseadas relacionadas con su cuerpo, sin incluir el abuso o agresión (ex: ejemplo: ser tocado, exhibicionismo, coerción reproductiva tal como el aborto forzado y la planificación familiar, pornografía por venganza, comentarios sexuales, chistes sexuales o exigencias de favores sexuales por alguien en el trabajo o la escuela como un colega de trabajo, jefe, cliente, otro estudiante, maestro, etc.)	El cliente no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	

		Niño y adolescente (0-17)	Adulto (18+)	En el último año	Notas
6. Detenido contra su voluntad (ejemplo: ser secuestrado, raptado, tomado como rehén, en cautiverio, prisionero de guerra, etc.)	El cliente no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	
7. Abuso emocional/verbal por parte de padres, cuidadores, pareja, familiar, amigo u otro (ejemplo: menosprecio, miedo de violencia física, insultos, juegos mentales, humillaciones, hacer sentir culpable, abuso espiritual, etc.)	El cliente no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	Anotar si es el padre o madre, cuidador, pareja, pariente, amigo u otro:
8. Abuso financiero (ejemplo: prohibirle trabajar, limita dinero, prohibir el acceso a cuentas bancarias, fraude financiero en línea, otros ciberdelitos financieros, etc.)	El cliente no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	
9. Negligencia o descuido por el padre o madre, cuidador, compañero, pariente, amigo u otro (ejemplo: ser desatendido por períodos prolongados, negarle amor o un sistema de apoyo en casa, con mucha frecuencia no sentirse amado por la familia, desnutrición debido a la falta de alimentos y agua suficiente, falta de atención médica necesaria que resulta en hospitalización, etc.)	El cliente no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	Anotar si es el padre o madre, cuidador, pareja, pariente, amigo u otro:
10. Drogadicción (ejemplo: usted, su pareja o un familiar cercano usa medicamentos, alcohol o drogas ilícitas indebidamente)	El cliente no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	Anotar si es el cliente, padre o madre, cuidador, pareja o pariente:
11. Acecho/Acoso, o ser persiguida por padres, cuidadores, parejas, familiares, amigos u otros (ejemplo: contacto repetido indeseado en persona o a través de mensajes de texto, llamadas telefónicas, por redes sociales, otras plataformas en línea, incluyendo el correo electrónico, etc.)	El cliente no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	Anotar si es el padre o madre, cuidador, pareja, pariente, amigo u otro:
12. Pobreza (ejemplo: no tenía suficiente comida para comer, falta de necesidades básicas tales como ropa, zapatos, etc.)	El cliente no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	
13. Sin hogar (ejemplo: vivienda transitoria, albergue, hotel/motel pagado por bono, casa de otra persona, un vehículo, un edificio abandonado, en cualquier lugar afuera, o en cualquier lugar no destinado para que las personas vivan sin tener otras opciones)	El cliente no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	

		Niño y adolescente (0-17)	Adulto (18+)	En el último año	Notas
14. Lesión/enfermedad física severa y/o enfermedad mental que resulta en hospitalización o incapacidad (ejemplo: dolor severo que requiere tratamiento en el hogar debido a un accidente, estado de salud mental, etc.)	El cliente no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	
15. Pérdida permanente o a largo plazo (ejemplo: de un cónyuge, pareja romántica, hijo, padre o cuidador, debido a encarcelamiento, deportación, enfermedad, suicidio, muerte, etc.)	El cliente no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	
16. Traumas relacionados con inmigración (ejemplo: ser separado de la red de apoyo, barreras lingüísticas, problemas para encontrar un trabajo, ambiente y alimentos desconocidos, deportación, etc.)	El cliente no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	S N A B C No aplica ☐	S N A B C	S N A B C	
17. Separación del(los) niño(s) o cuidado infantil interrumpido cuando era niño (ejemplo: la pérdida de la custodia, visitas, o secuestro/rapto de un niño; un cambio de custodia entre familiares, numerosos cambios en la custodia adoptiva, o la deportación cuando era niño)	El cliente no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	S N A B C No aplica ☐	S N A B C	S N A B C	
18. Tiempo en la cárcel/prisión/ libertad condicional/libertad vigilada/ detención (ejemplo: usted mismo, pareja, familiar cercano, etc.)	El cliente no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	Anotar si es el cliente, padre o madre, cuidador, pareja o pariente:
19. Intimidación, Bullying, o Acoso (ejemplo: violencia verbal o física en persona o en línea a través de las redes sociales y otras plataformas en línea en el lugar de trabajo, la escuela, etc.)	El cliente no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	
20. Discriminación crónica o repetitiva (ejemplo: discriminación basada en la raza, grupo étnico, origen geográfico familiar, género, identidad/ expresión de género, orientación sexual, capacidad/discapacidad, etc.)	El cliente no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	
21. Violencia comunitaria (ejemplo: ataque físico/agresión por un extraño; asalto, robo, atraco, o robo de identidad; víctima de atentado terrorista; tiroteos masivos; disturbios callejeros; disparos desde un vehículo; puñaladas; golpes; escuchar disparos; etc.)	El cliente no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	

		Niño y adolescente (0-17)	Adulto (18+)	En el último año	Notas
22. Trauma inducido por el sistema (ejemplo: situaciones de detención violenta, experiencias difíciles testificando en contra de un agresor en un juicio, brutalidad policial, etc.)	El cliente no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	
23. Haber visto a alguien que estaba muerto, o muriendo, o haber visto o escuchado que los mataban (en la vida real no en la televisión o en una película, etc.)	El cliente no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	
24. Desastres naturales o provocados por el hombre (ejemplo: huracán, terremoto, inundación, tornado, incendio, choque de trenes, colapso de edificio, etc.)	El cliente no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	
25. Crueldad hacia los animales (ejemplo: abusos o amenazas a la mascota en un intento de crear miedo o de manipular)	El cliente no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	S N A B C No aplica ☐	S N A B C	S N A B C	
26. Otros (ejemplo: algo realmente espantoso o muy perturbador que ocurrió y que no está incluido en las experiencias anteriores o cualquier otra que no fue cubierta)	El cliente no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	
TOTAL DE VICTIMIZACIONES VIVIDAS POR GRUPO DE EDAD:					

Para cada síntoma haga un círculo alrededor de la "S" si la respuesta es sí o alrededor de la "N" si la respuesta es no en las casillas a la derecha según sea el caso para las diferentes etapas de la vida del cliente (niño y adolescente, adulto, en el último año y síntoma actual). Además de marcar "S" y "N" el usuario puede hacer un círculo en otras respuestas posibles que incluyen "A" **si el cliente no respondió** a la pregunta; "B" si el **usuario no hizo la pregunta** debido a las limitaciones de tiempo o a otras limitaciones; y "C" si el usuario no hizo la pregunta puesto que **no era apropiado hacerla**. Al marcar un síntoma como un "síntoma actual" y "en el último año", por favor, también marque el período de tiempo respectivo bajo el cual aplica (niño y adolescente O adulto). Las respuestas deben ser desde la perspectiva del cliente. Si el usuario tiene aportes o comentarios adicionales, particularmente si se trata de minimizar los hechos, esto debería incluirse en la sección de "Notas". El número de síntomas "En el último año" y "Síntomas actuales" se calculan y deberían ayudar a orientar la prestación de servicios.

Parte B: Síntomas						
		Niño y adolescente (0-17)	Adulto (18+)	En el último año	Síntoma actual	Notas
1. Tiene dolor o síntomas físicos que no han sido diagnosticados o son resistentes al tratamiento	El cliente no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	S N A B C	
2. A intentado suicidio, o habla sobre suicidio, o tiene pensamientos de suicidio	El cliente no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	S N A B C	
3. Alguna vez a tratado de hacerse daño fisico (ejemplo: cortarse, trastorno alimentario como comer en exceso, etc.)	El cliente no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	S N A B C	
4. Comportamiento(s) con riesgos para la salud) (ejemplo: uso excesivo de drogas y alcohol, compartir agujas, sexo sin protección con múltiples parejas, etc.)	El cliente no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	S N A B C	
5. Repite recuerdos, pensamientos o imágenes inquietantes de una experiencia estresante	El cliente no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	S N A B C	
6. Evasión (ejemplo: evitar lugares, personas u otros estímulos asociados con el trauma pasado, o con sentimientos o sensaciones físicas que le recuerdan el trauma, etc.)	El cliente no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	S N A B C	
7. Distanciarse (ejemplo: sentirse distante o aislado)	El cliente no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	S N A B C	
8. Irritable/enojado (ejemplo: sentirse irritable, tener estallidos de enojo, o ira)	El cliente no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	S N A B C	

		Niño y adolescente (0-17)	Adulto (18+)	En el último año	Síntoma actual	Notas
9. Dificultades de atención/ concentración (ejemplo: falta de atención/distraerse fácilmente)	El cliente no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	S N A B C	
10. Disturbios del sueño (ejemplo: terrores nocturnos, insomnio, somnolencia excesiva, etc.)	El cliente no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	S N A B C	
11. Ansiedad (ejemplo: excesivamente tenso, preocupado o estresado hasta el punto de retirarse de actividades, sufrir ataques de pánico, o necesidad de ser reconfortado excesivamente)	El cliente no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	S N A B C	
12. Hipervigilancia (ejemplo: asustadizo, se sobresalta fácilmente, demasiado consciente o preocupado por los peligros potenciales, etc.)	El cliente no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	S N A B C	
13. Comportamientos agresivos o violentos, incluso si son sin querer o son inesperados (ejemplo: physically or verbally aggressive, destroys property, etc.)	El cliente no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	S N A B C	
14. Comportamiento(s) con riesgos para la salud (ejemplo: uso excesivo de drogas y alcohol, compartir agujas, sexo sin protección con múltiples parejas, etc.)	El cliente no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	S N A B C	
15. Tristeza (apatía/desesperación)	El cliente no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
16. Baja autoestima (ejemplo: yo soy malx, hay algo seriamente mal conmigo, auto culparse por la experiencia, etc.)	El cliente no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
17. Adormecimiento, disociación (ejemplo: rango emocional limitado, evitar pensar o hablar sobre el futuro o fijación de metas, "sentirse planx", etc.)	El cliente no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
18. Otros (ejemplo: cualquier cambio en el comportamiento, bienestar físico o estado de ánimo desde el incidente o incidentes que no están incluido(s) anteriormente)	El cliente no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
LOS SÍNTOMAS QUE SE PRESENTAN EN EL ÚLTIMO AÑO Y LOS SÍNTOMAS ACTUALES:						

HERRAMIENTA DE EVALUACIÓN DE VICTIMIZACIÓN MÚLTIPLE

Nombre del Centro: _____ Fechas de Visitas: _____/_____/ _____/ _____

Nombre de lx Clientx: _____Número de identificación lx Clientx:_____ ¿Mayor de 18 años? **SI** □ **NO** □

Nombre de lx(lxs) miembrx(s) del personal: _____/ _____/ _____/_____

Nuevx Clientx: □ Clientx Habitual: □ Número de sesiones que tomó recopilar la información a continuación: _____

La herramienta de evaluación de victimización múltiple es una herramienta de integración de la información. Por favor asegúrese de explicar y honrar la confidencialidad para cada clientx. Para cada evento abajo haga un círculo alrededor de la "S" si su respuesta es sí o alrededor de la "N" si su respuesta es no, en las casillas a la derecha, según sea el caso para las diferentes etapas de la vida de lx clientx (niñx y adolescente, adultx y último año). Además de marcar "S" y "N" lx usuarix puede hacer un círculo en otras respuestas posibles que incluyen "A" **si lx clientx no respondió a la pregunta**; "B" si lx **usuarix no hizo la pregunta** debido a las limitaciones de tiempo o a otras limitaciones; y "C" si lx **usuarix no hizo la pregunta puesto que no era apropiado hacerla**. Para las preguntas que no son aplicables a todos **lxs clientxs**, se ha incluido la respuesta adicional "No aplica". Al marcar un evento "en el último año", por favor también marque el período de tiempo respectivo bajo el cual aplica (niñx y adolescente O adultx). Las respuestas deben ser desde la perspectiva de lx clientx. Si lx usuarix tiene aportes o comentarios adicionales, particularmente si se trata de minimizar los hechos, esto debería incluirse en la sección de "Notas". El número de eventos calculados para "En el último año" no es una calificación de victimización pero debería desencadenar una respuesta en el centro.

Parte A: Eventos

		Niñx y adolescente (0-17)	Adultx (18+)	En el último año	Notas
1. Ataque/agresión por los progenitorxs, cuidadorxs, pareja o familiar (realizado o intentado) (ejemplo: con una pistola, cuchillo u otra arma como el puño, los pies, etc.)	Lx clientx no respondió = **A** Lx usuarix no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	Anotar si es lx progenitxrs, cuidadorxs, pareja, o pariente:
2. Estrangulación o asfixia posicional (presión aplicada por cualquier medio en el cuello o en cualquier lugar que dificulte la respiración) (ejemplo: asfixia, uso del peso del cuerpo o los brazos, sentarse encima de usted, etc.)	Lx clientx no respondió = **A** Lx usuarix no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	
3. Abuso sexual/agresión por los progenitorxs, cuidadorxs, pareja, familiar, amigx u otra persona (realizado o intentado) (ejemplo: violación, forzadx a realizar cualquier acto sexual por medio de la fuerza o amenaza de daño)	Lx clientx no respondió = **A** Lx usuarix no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	Anotar si es lx progenitxrs, cuidadorx, pareja, pariente, amigx u otrx:
4. Explotación sexual o laboral (ejemplo: ser prostituidx, ser forzadx a participar en actos sexuales, ser forzadx a la pornografía, la servidumbre doméstica u otro trabajo explotador, etc.)	Lx clientx no respondió = **A** Lx usuarix no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	
5. Otra(s) experiencia(s) forzada(s)/ no deseadas relacionadas con su cuerpo, sin incluir el abuso o agresión (ex: ejemplo: ser tocadx, exhibicionismo, coerción reproductiva tal como el aborto forzado y la planificación familiar, pornografía por venganza, comentarios sexuales, chistes sexuales o exigencias de favores sexuales por alguien en el trabajo o la escuela como unx colega de trabajo, jefx, clientx, otrx estudiante, maestrx, etc.)	Lx clientx no respondió = **A** Lx usuarix no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	

		Niño y adolescente (0-17)	Adulto (18+)	En el último año	Notas
6. Detenidx contra su voluntad (ejemplo: ser secuestradx, raptadx, tomadx como rehén,en cautiverio, prisionerx de guerra, etc.)	Lx clientx no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	
7. Abuso emocional/verbal por parte de progenitorxs, cuidadorxs, pareja, familiar, amigx u otrx (ejemplo: menosprecio, miedo de violencia física, insultos, juegos mentales, humillaciones, hacer sentir culpable, abuso espiritual, etc.)	Lx clientx no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	Anotar si es el padre o madre, cuidador, pareja, pariente, amigo u otro:
8. Abuso financiero (ejemplo: prohibirle trabajar, limita dinero, prohibir el acceso a cuentas bancarias, fraude financiero en línea, otros ciberdelitos financieros, etc.)	Lx clientx no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	
9. Negligencia o descuido por el progenitorxs, cuidadorx, compañerx, pariente, amigx u otrx (ejemplo: ser desatendido por períodos prolongados, negarle amor o un sistema de apoyo en casa, con mucha frecuencia no sentirse amadx por la familia, desnutrición debido a la falta de alimentos y agua suficiente, falta de atención médica necesaria que resulta en hospitalización, etc.)	Lx clientx no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	Anotar si es el padre o madre, cuidador, pareja, pariente, amigo u otro:
10. Drogadicción (ejemplo: usted, su pareja o un familiar cercano usa medicamentos, alcohol o drogas ilícitas indebidamente)	Lx clientx no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	Anotar si es el cliente, padre o madre, cuidador, pareja o pariente:
11. Acecho/Acoso, o ser persiguidx por progenitorxs, cuidadorxs, parejas, familiares, amigxs u otrxs (ejemplo: contacto repetido indeseado en persona o a través de mensajes de texto, llamadas telefónicas, por redes sociales, otras plataformas en línea, incluyendo el correo electrónico, etc.)	Lx clientx no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	Anotar si es el padre o madre, cuidador, pareja, pariente, amigo u otro:
12. Pobreza (ejemplo: no tenía suficiente comida para comer, falta de necesidades básicas tales como ropa, zapatos, etc.)	Lx clientx no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	
13. Sin hogar (ejemplo: vivienda transitoria, albergue, hotel/motel pagado por bono, casa de otra persona, un vehículo, un edificio abandonado, en cualquier lugar afuera, o en cualquier lugar no destinado para que las personas vivan sin tener otras opciones)	Lx clientx no respondió = **A** El usuario no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	

		Niñx y adolescente (0-17)	Adultx (18+)	En el último año	Notas
14. Lesión/enfermedad física severa y/o enfermedad mental que resulta en hospitalización o incapacidad (ejemplo: dolor severo que requiere tratamiento en el hogar debido a un accidente, estado de salud mental, etc.)	Lx clientx no respondió = **A** Lx usuarix no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	
15. Pérdida permanente o a largo plazo (ejemplo: de un cónyuge, pareja romántica, hijx, progenitorxs o cuidadorx, debido a encarcelamiento, deportación, enfermedad, suicidio, muerte, etc.)	Lx clientx no respondió = **A** Lx usuarix no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	
16. Traumas relacionados con inmigración (ejemplo: ser separadx de la red de apoyo, barreras lingüísticas, problemas para encontrar un trabajo, ambiente y alimentos desconocidos, deportación, etc.)	Lx clientx no respondió = **A** Lx usuarix no preguntó = **B** No es adecuado preguntar = **C**	S N A B C No aplica ☐	S N A B C	S N A B C	
17. Separación de lx(lxs) niñx(s) o cuidado infantil interrumpido cuando era niñx (ejemplo: la pérdida de la custodia, visitas, o secuestro/ rapto de unx niñx; un cambio de custodia entre familiares, numerosos cambios en la custodia adoptiva, o la deportación cuando era niñx)	Lx clientx no respondió = **A** Lx usuarix no preguntó = **B** No es adecuado preguntar = **C**	S N A B C No aplica ☐	S N A B C	S N A B C	
18. Tiempo en la cárcel/prisión/ libertad condicional/libertad vigilada/detención (ejemplo: usted mismx, pareja, familiar cercanx, etc.)	Lx clientx no respondió = **A** Lx usuarix no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	Anotar si es lx clientx, progenotorxs, cuidadorx, pareja o pariente:
19. Intimidación, Bullying, o Acoso (ejemplo: violencia verbal o física en persona o en línea a través de las redes sociales y otras plataformas en línea en el lugar de trabajo, la escuela, etc.)	Lx clientx no respondió = **A** Lx usuarix no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	
20. Discriminación crónica o repetitiva (ejemplo: discriminación basada en la raza, grupo étnico, origen geográfico familiar, género, identidad/expresión de género, orientación sexual, capacidad/ discapacidad, etc.)	Lx clientx no respondió = **A** Lx usuarix no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	
21. Violencia comunitaria (ejemplo: ataque físico/agresión por unx extrañx; asalto, robo, atraco, o robo de identidad; víctima de atentado terrorista; tiroteos masivos; disturbios callejeros; disparos desde un vehículo; puñaladas; golpes; escuchar disparos; etc.)	Lx clientx no respondió = **A** Lx usuarix no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	

		Niñx y adolescente (0-17)	Adultx (18+)	En el último año	Notas
22. Trauma inducido por el sistema (ejemplo: situaciones de detención violenta, experiencias difíciles testificando en contra de uxn agresorx en un juicio, brutalidad policial, etc.)	Lx clientx no respondió = **A** Lx usuarix no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	
23. Haber visto a alguien que estaba muerto, o muriendo, o haber visto o escuchado que los mataban (en la vida real no en la televisión o en una película, etc.)	Lx clientx no respondió = **A** Lx usuarix no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	
24. Desastres naturales o provocados por el hombre (ejemplo: huracán, terremoto, inundación, tornado, incendio, choque de trenes, colapso de edificio, etc.)	Lx clientx no respondió = **A** Lx usuarix no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	
25. Crueldad hacia los animales (ejemplo: abusos o amenazas a la mascota en un intento de crear miedo o de manipular)	Lx clientx no respondió = **A** Lx usuarix no preguntó = **B** No es adecuado preguntar = **C**	S N A B C No aplica ☐	S N A B C	S N A B C	
26. Otros (ejemplo: algo realmente espantoso o muy perturbador que ocurrió y que no está incluido en las experiencias anteriores o cualquier otra que no fue cubierta)	Lx clientx no respondió = **A** Lx usuarix no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	
TOTAL DE VICTIMIZACIONES VIVIDAS POR GRUPO DE EDAD::					

Para cada síntoma haga un círculo alrededor de la "S" si la respuesta es sí o alrededor de la "N" si la respuesta es no en las casillas a la derecha según sea el caso para las diferentes etapas de la vida del cliente (niño y adolescente, adulto, en el último año y síntoma actual). Además de marcar "S" y "N" el usuario puede hacer un círculo en otras respuestas posibles que incluyen "A" **si el cliente no respondió** a la pregunta; "B" si el **usuario no hizo la pregunta** debido a las limitaciones de tiempo o a otras limitaciones; y "C" si el usuario no hizo la pregunta puesto que **no era apropiado hacerla**. Al marcar un síntoma como un "síntoma actual" y "en el último año", por favor, también marque el período de tiempo respectivo bajo el cual aplica (niño y adolescente O adulto). Las respuestas deben ser desde la perspectiva del cliente. Si el usuario tiene aportes o comentarios adicionales, particularmente si se trata de minimizar los hechos, esto debería incluirse en la sección de "Notas". El número de síntomas "En el último año" y "Síntomas actuales" se calculan y deberían ayudar a orientar la prestación de servicios.

Parte B: Síntomas						
		Niñx y adolescente (0-17)	Adultx (18+)	En el último año	Síntoma actual	Notas
1. Tiene dolor o síntomas físicos que no han sido diagnosticados o son resistentes al tratamiento	Lx clientx no respondió = **A** Lx usuarix no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	S N A B C	
2. A intentado suicidio, o habla sobre suicidio, o tiene pensamientos de suicidio	Lx clientx no respondió = **A** Lx usuarix no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	S N A B C	
3. Alguna vez a tratado de hacerse daño fisico (ejemplo: cortarse, trastorno alimentario como comer en exceso, etc.)	Lx clientx no respondió = **A** Lx usuarix no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	S N A B C	
4. Comportamiento(s) con riesgos para la salud) (ejemplo: uso excesivo de drogas y alcohol, compartir agujas, sexo sin protección con múltiples parejas, etc.)	Lx clientx no respondió = **A** Lx usuarix no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	S N A B C	
5. Repite recuerdos, pensamientos o imágenes inquietantes de una experiencia estresante	Lx clientx no respondió = **A** Lx usuarix no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	S N A B C	
6. Evasión (ejemplo: evitar lugares, personas u otros estímulos asociados con el trauma pasado, o con sentimientos o sensaciones físicas que le recuerdan el trauma, etc.)	Lx clientx no respondió = **A** Lx usuarix no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	S N A B C	
7. Distanciarse (ejemplo: sentirse distante o aislado)	Lx clientx no respondió = **A** Lx usuarix no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	S N A B C	
8. Irritable/enojado (ejemplo: sentirse irritable, tener estallidos de enojo, o ira)	Lx cliente no respondió = **A** Lx usuarix no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	S N A B C	

		Niño y adolescente (0-17)	Adulto (18+)	En el último año	Síntoma actual	Notas
9. Dificultades de atención/ concentración (ejemplo: falta de atención/distraerse fácilmente)	Lx clientx no respondió = **A** Lx usuarix no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	S N A B C	
10. Disturbios del sueño (ejemplo: terrores nocturnos, insomnio, somnolencia excesiva, etc.)	Lx clientx no respondió = **A** Lx usuarix no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	S N A B C	
11. Ansiedad (ejemplo: excesivamente tenso, preocupado o estresado hasta el punto de retirarse de actividades, sufrir ataques de pánico, o necesidad de ser reconfortado excesivamente)	Lx clientx no respondió = **A** Lx usuarix no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	S N A B C	
12. Hipervigilancia (ejemplo: asustadizo, se sobresalta fácilmente, demasiado consciente o preocupado por los peligros potenciales, etc.)	Lx clientx no respondió = **A** Lx usuarix no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	S N A B C	
13. Comportamientos agresivos o violentos, incluso si son sin querer o son inesperados (ex: physically or verbally aggressive, destroys property, etc.)	Lx clientx no respondió = **A** Lx usuarix no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	S N A B C	
14. Comportamiento(s) con riesgos para la salud (ejemplo: uso excesivo de drogas y alcohol, compartir agujas, sexo sin protección con múltiples parejas, etc.)	Lx clientx no respondió = **A** Lx usuarix no preguntó = **B** No es adecuado preguntar = **C**	S N A B C	S N A B C	S N A B C	S N A B C	
15. Sadness (apathy/despair)	Lx clientx no respondió = **A** Lx usuarix no preguntó = **B** No es adecuado preguntar = **C**	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
16. Low self-esteem (ex. I am bad, there is something seriously wrong with me, self-blame for the experience, etc.)	Lx clientx no respondió = **A** Lx usuarix no preguntó = **B** No es adecuado preguntar = **C**	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
17. Numbing, dissociating (ex: limited emotional range, avoiding thinking or talking about the future or goal setting, "feeling flat," etc.)	Lx clientx no respondió = **A** Lx usuarix no preguntó = **B** No es adecuado preguntar = **C**	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
18. Other (ex: any changes in behavior, physical well being, or mood that have occurred since the incident(s) that are not included above)	Lx clientx no respondió = **A** Lx usuarix no preguntó = **B** No es adecuado preguntar = **C**	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
SYMPTOMS PRESENT IN THE LAST YEAR AND CURRENT SYMPTOMS:						

ОПРОСНИК ОЦЕНКИ МНОГОРАЗОВОЙ ТРАВМАТИЗАЦИИ

Название центра: _____ Даты применения: _____/ _____/ _____/ _____

ФИО клиента: _____ Номер клиента:_____ Старше 18 лет? Да ☐ Нет☐

ФИО сотрудника(ов): _____/ _____/ _____/_____

Новый клиент: ☐ Повторный клиент: ☐ Число сессий, за которые была собрана информация ниже: _____

Опросник оценки многоразовой травматизации разработан с целью сбора и интеграции информации. Не забудьте объяснить каждому клиенту про конфиденциальность такой информации и не нарушайте ее конфиденциальность. Напротив каждого описанного ниже события обведите кружком “Да” или “Нет” в расположенных справа квадратиках в соответствии с этапами жизни клиента (ребенок или подросток, взрослый, за последний год). В дополнение к “Да” или “Нет” опрашивающий может обвести кружком другие возможные ответы, что включает “A”, если клиент не ответил на вопрос; “B”, если опрашивающий не спросил из-за недостатка времени или по другим причинам; и “C”, если опрашивающий не спросил, поскольку это был неподходящий вопрос. В отношении ответов, применимых не ко всем клиентам, был включен дополнительный ответ “Неприменимо”. Помечая событие “за последний год”, также укажите период времени, под который оно подпадает (ребенок или подросток ИЛИ взрослый). Ответы должны даваться с точки зрения клиента. Если опрашивающий хочет добавить собственные дополнения или соображения, в частности, по минимизации, их следует внести в графу “Примечания”. Число событий, подсчитанных “за последний год”, не является оценкой травматизации в баллах, но должно послужить основанием для ответа в Центре.

Часть A: События

		Ребенок и подросток (0-17)	Взрослый (18+)	За последний год	Примечания
1. Нападение/избиение родителем, воспитателем, партнером или родственником (совершенное или его попытка) (напр., с ружьем, ножом или другим оружием, включая кулак, ноги и т.п.)	Клиент не ответил = **A** Опрашивающий не спросил = **B** Неподходящий вопрос = **C**	Да Нет A B C	Да Нет A B C	Да Нет A B C	Отметьте, если родитель, воспитатель, партнер или родственник:
2. Удушение и/или позиционная асфиксия (давление, оказываемое с помощью любых средств на шею или другое место и вызывающее трудности с дыханием, напр., удушение, использование веса тела или рук, сидение сверху на человеке и т.п.)	Клиент не ответил = **A** Опрашивающий не спросил = **B** Неподходящий вопрос = **C**	Да Нет A B C	Да Нет A B C	Да Нет A B C	
3.Сексуальное посягательство/насилие со стороны родителя, воспитателя, партнера, родственника, друга или другого лица (совершенное или его попытка) (напр., изнасилование, принуждение выполнить сексуальное действие любого типа силой или угрозами причинения вреда	Клиент не ответил = **A** Опрашивающий не спросил = **B** Неподходящий вопрос = **C**	Да Нет A B C	Да Нет A B C	Да Нет A B C	Отметьте, если родитель, воспитатель, партнер, родственник, друг или другое лицо:
4. Торговля людьми с целью сексуальной или трудовой эксплуатации (напр., принуждение заниматься проституцией, насильственное вовлечение в действия сексуального характера, порнографию, бытовое рабство или другая трудовая эксплуатация и т.п.)	Клиент не ответил = **A** Опрашивающий не спросил = **B** Неподходящий вопрос = **C**	Да Нет A B C	Да Нет A B C	Да Нет A B C	
5. Другой опыт насилия/недобровольных действий, связанных с вашим телом, не включающий сексуальное посягательство или нападениен (напр., дотрагивание, оголение половых органов, репродукционное насилие, такое как аборт или планирование семьи по принуждению, порнография с целью мщения, замечания и шутки сексуального характера или требования сексуальных услуг со стороны кго-либо на работе или в учебном заведении, например, сотрудника, начальника, заказчика, другого студента, преподавателя и т.п.)	Клиент не ответил = **A** Опрашивающий не спросил = **B** Неподходящий вопрос = **C**	Да Нет A B C	Да Нет A B C	Да Нет A B C	

		Ребенок и подросток (0-17)	Взрослый (18+)	За последний год	Примечания
6. Удержание против воли(напр., киднеппинг, похищение, удержание в заложниках, в плену, в качестве военнопленного и т.п.)	Клиент не ответил = **A** Опрашивающий не спросил = **B** Неподходящий вопрос = **C**	Да Нет A B C	Да Нет A B C	Да Нет A B C	
7. Эмоциональное/словесное оскорбление со стороны родителя, воспитателя, партнера, родственника, друга или другого лица (напр., “опускание”, страх физического насилия, брань, манипулирование сознанием, унижение, вызывание чувства вины, религиозное насилие и т.п.)	Клиент не ответил = **A** Опрашивающий не спросил = **B** Неподходящий вопрос = **C**	Да Нет Да Нет	Да Нет Да Нет	Да Нет Да Нет	Отметьте, если родитель, воспитатель, партнер, родственник, друг или другое лицо:
8. Финансовое насилие (напр., запрет работать, выдача содержания, недопущение к банковским счетам, финасовое мошенничество в интернете, другие финансовые киберпреступления и т.п.)	Клиент не ответил = **A** Опрашивающий не спросил = **B** Неподходящий вопрос = **C**	Да Нет A B C	Да Нет A B C	Да Нет A B C	
9. Отсутствие заботы со стороны родителя, воспитателя, партнера, родственника, друга или другого лица (напр., оставление без внимания на длительные периоды времени, отсутствие любви или системы поддержки дома, очень частое чувство нелюбимого в семье, истощение из-за отсутствия адекватного питания/воды, непредоставление необходимой медицинской помощи, приведшая к госпитализации, и т.п.)	Клиент не ответил = **A** Опрашивающий не спросил = **B** Неподходящий вопрос = **C**	Да Нет A B C	Да Нет A B C	Да Нет A B C	Отметьте, если родитель, воспитатель, партнер, родственник, друг или другое лицо:
10. Употребление психоактивных веществ (напр., вы, ваш партнер или близкий родственник злоупотребляете рецептурными лекарствами, алкоголем или наркотиками)	Клиент не ответил = **A** Опрашивающий не спросил = **B** Неподходящий вопрос = **C**	Да Нет A B C	Да Нет A B C	Да Нет A B C	Отметьте, если клиент, родитель, воспитатель, партнер или родственник:
11. Травля/недопустимое преследование со стороны родителя, воспитателя, партнера, родственника, друга или другого лица (напр., нежелательный повторный контакт лично или путем текстовых сообщений, телефонных звонков, социальных сетей, других онлайновых платформ, включая электронную почту, и т.п.)	Клиент не ответил = **A** Опрашивающий не спросил = **B** Неподходящий вопрос = **C**	Да Нет A B C	Да Нет A B C	Да Нет A B C	Отметьте, если родитель, воспитатель, партнер, родственник, друг или другое лицо:
12. Бедность (напр., отсутствие достаточного количества продуктов питания, предметов базовых потребностей человека, таких как одежда, обувь и т.п.)	Клиент не ответил = **A** Опрашивающий не спросил = **B** Неподходящий вопрос = **C**	Да Нет A B C	Да Нет A B C	Да Нет A B C	
13. Бездомность (напр., временное жилье, приют, отель/мотель, оплачиваемый ваучером, чужой дом, машина, заброшенное здание, жизнь на улице или в другом месте, непредназначенном для проживания людей, при отсутствии каких-либо других вариантов)	Клиент не ответил = **A** Опрашивающий не спросил = **B** Неподходящий вопрос = **C**	Да Нет A B C	Да Нет A B C	Да Нет A B C	

		Ребенок и подросток (0-17)	Взрослый (18+)	За последний год	Примечания
14. Серьезная физическая травма/болезнь и/ или психическое заболевание, приводящие к госпитализациии или ограничению дееспособности (напр., сильные боли, требующие лечения на дому, вследствие несчастного случая, психического состояния и т.п.)	Клиент не ответил = **A** Опрашивающий не спросил = **B** Неподходящий вопрос = **C**	Да Нет A B C	Да Нет A B C	Да Нет A B C	
15. Постоянная или долгосрочная потеря (напр., супруга, возлюбленного, ребенка, родителя или воспитателя из-за заключения в тюрьму, депортации, болезни, самоубийства, смерти и т.п.)	Клиент не ответил = **A** Опрашивающий не спросил = **B** Неподходящий вопрос = **C**	Да Нет A B C	Да Нет A B C	Да Нет A B C	
16. Травма, связанная с иммиграцией (напр., отлучение от системы поддержки, языковой барьер, трудности с поисками работы, незнакомая обстановка, непривычная еда, депортация и т.п.)	Клиент не ответил = **A** Опрашивающий не спросил = **B** Неподходящий вопрос = **C**	Да Нет A B C	Да Нет A B C	Да Нет A B C	
17. Разлучение с ребенком (детьми) или разрыв связи с воспитывающим его человеком для ребенках (напр., потеря опеки, посещений или киднеппинг/похищение ребенка, смена опекуна в пределах семьи, многочисленные перемены патронажных семей или депортация в детском возрасте)	Клиент не ответил = **A** Опрашивающий не спросил = **B** Неподходящий вопрос = **C**	Неприменимо ☐			
		Да Нет A B C	Да Нет A B C	Да Нет A B C	
		Неприменимо ☐			
18. Предварительное заключение/тюрьма/ условный срок/досрочное освобождение/ содержание под стражей (напр., вас, партнера, близкого родственника и т.п.)	Клиент не ответил = **A** Опрашивающий не спросил = **B** Неподходящий вопрос = **C**	Да Нет A B C	Да Нет A B C	Да Нет A B C	Отметьте, если клиент, родитель, воспитатель, партнер или родственник:
19. Травля (напр., словесное или физическое насилие, личное или с помощью интернета в социальных сетях или посредством других онлайновых платформ на работе, в школе и т.п.)	Клиент не ответил = **A** Опрашивающий не спросил = **B** Неподходящий вопрос = **C**	Да Нет A B C	Да Нет A B C	Да Нет A B C	
20. Хроническая или повторная дискриминация (напр., дискриминация на основе расы, этнического происхождения, места прежнего жительства семьи, пола, гендерной идентичности/ самовыражения, сексуальной ориентации, возможностей/инвалидности и т.п.)	Клиент не ответил = **A** Опрашивающий не спросил = **B** Неподходящий вопрос = **C**	Да Нет A B C	Да Нет A B C	Да Нет A B C	
21. Насилие в публичных местах (напр., физическое нападение/избиение незнакомым; ограбление, кража со взломом, уличный грабеж или кража идентичности; жертва террористической атаки; масовая стрельба; уличные мятежи; стрельба из проезжающей машины; ножевые удары; избиения; звуки выстрелов и т.п.)	Клиент не ответил = **A** Опрашивающий не спросил = **B** Неподходящий вопрос = **C**	Да Нет A B C	Да Нет A B C	Да Нет A B C	

		Ребенок и подросток (0-17)	Взрослый (18+)	За последний год	Примечания
22. Травма, обусловленная системой (напр., ситуации ареста с насилием, трудный о пыт дачи показаний против обидчика в суде, полицейский произвол и т.п.)	Клиент не ответил = **A** Опрашивающий не спросил = **B** Неподходящий вопрос = **C**	Да Нет A B C	Да Нет A B C	Да Нет A B C	
23. Видеть мертвого или умирающего человека или видеть или слышать, как его убивалип (в жизни, не по телевизору, в кино и т.п.)	Клиент не ответил = **A** Опрашивающий не спросил = **B** Неподходящий вопрос = **C**	Да Нет A B C	Да Нет A B C	Да Нет A B C	
24. Стихийные бедствия и/ или техногенные катастрофы (напр., ураган, землетрясение, наводнение, торнадо, пожар, крушение поезда, обрушение здания и т.п.)	Клиент не ответил = **A** Опрашивающий не спросил = **B** Неподходящий вопрос = **C**	Да Нет A B C	Да Нет A B C	Да Нет A B C	
25. Жестокость к животным (напр., насилие или его угрозы по отношению к домашним животным с целью устрашения или манипулирования)	Клиент не ответил = **A** Опрашивающий не спросил = **B** Неподходящий вопрос = **C**	Да Нет A B C Неприменимо ☐	Да Нет A B C	Да Нет A B C	
26. Другое (напр., что-либо очень пугающее или расстраивающее, не включенное выше, или любые другие события, здесь не упомянутые)	Клиент не ответил = **A** Опрашивающий не спросил = **B** Неподходящий вопрос = **C**	Да Нет A B C	Да Нет A B C	Да Нет A B C	
ОБЩЕЕ ЧИСЛО ПЕРЕЖИВШИХ ВИКТИМИЗАЦИЮ ПО ВОЗРАСТНЫМ ГРУППАМ:					

Напротив каждого описанного ниже симптома обведите кружком “Да” или “Нет” в расположенных справа квадратиках в соответствии с этапами жизни клиента (ребенок или подросток, взрослый, за последний год, текущий симптом). В дополнение к “Да” или “Нет” опрашивающий может обвести кружком другие возможные ответы, что включает “A”, если **клиент не ответил** на вопрос; “B”, если **опрашивающий не спросил из**-за недостатка времени или по другим причинам; и “C”, если опрашивающий не спросил, поскольку это **был неподходящий вопрос**. Помечая симптом как “текущий симтом” и “за последний год”, также укажите период времени, под который он подпадает (ребенок или подросток ИЛИ взрослый). Ответы должны даваться с точки зрения клиента. Если опрашивающий хочет добавить собственные дополнения или соображения, в частности, по минимизации, их следует внести в графу “Примечания”. Число симптомов “за последний год” и “текущие симптомы” подсчитывается и должно помочь в определении необходимых услуг.

Часть Б: Симптомы						
		Ребенок и подросток (0-17)	**Взрослый (18+)**	**За последний год**	**Текущий симптом**	**Примечания**
1. Боль и/или другие физические симптомы, которые не были диагностированы или не поддаются лечению	Клиент не ответил = **A** Опрашивающий не спросил = **B** Неподходящий вопрос = **C**	Да Нет A B C	Да Нет A B C	Да Нет A B C	Да Нет A B C	
2. Попытка самоубийства, его обсуждение или суицидальные мысли	Клиент не ответил = **A** Опрашивающий не спросил = **B** Неподходящий вопрос = **C**	Да Нет A B C	Да Нет A B C	Да Нет A B C	Да Нет A B C	
3. Самоповреждающее поведениео (напр., нанесение порезов, расстройство пищевого поведения, включая переедание, и т.п.)	Клиент не ответил = **A** Опрашивающий не спросил = **B** Неподходящий вопрос = **C**	Да Нет A B C	Да Нет A B C	Да Нет A B C	Да Нет A B C	
4. Угрожающее здоровью поведение (напр., неумеренное потребление наркотиков/алкоголя, пользование одним шприцем, незащищенный секс с множественными партнерами и т.п.)	Клиент не ответил = **A** Опрашивающий не спросил = **B** Неподходящий вопрос = **C**	Да Нет A B C	Да Нет A B C	Да Нет A B C	Да Нет A B C	
5. Повторяющиеся тревожные воспоминания, мысли или образы перенесенного стресса	Клиент не ответил = **A** Опрашивающий не спросил = **B** Неподходящий вопрос = **C**	Да Нет A B C	Да Нет A B C	Да Нет A B C	Да Нет A B C	
6. Избегание (напр., избегание мест, людей или других стимулов, связанных с травмой, чувствами или физическими ощущениями в прошлом, которые напоминают о травме, и т.п.)	Клиент не ответил = **A** Опрашивающий не спросил = **B** Неподходящий вопрос = **C**	Да Нет A B C	Да Нет A B C	Да Нет A B C	Да Нет A B C	
7. Оторванность (напр., чувство отдаленности или изолированности)	Клиент не ответил = **A** Опрашивающий не спросил = **B** Неподходящий вопрос = **C**	Да Нет A B C	Да Нет A B C	Да Нет A B C	Да Нет A B C	
8. Irritable/enojado (ejemplo: sentirse irritable, tener estallidos de enojo, o ira)	Клиент не ответил = **A** Опрашивающий не спросил = **B** Неподходящий вопрос = **C**	Да Нет A B C	Да Нет A B C	Да Нет A B C	Да Нет A B C	

		Ребенок и подросток (0-17)	Взрослый (18+)	За последний год	Текущий симптом	Примечания
9. Трудности с вниманием/ концентрацией (напр., лего отвлекается/невнимателен)	Клиент не ответил = **A** Опрашивающий не спросил = **B** Неподходящий вопрос = **C**	Да Нет A B C	Да Нет A B C	Да Нет A B C	Да Нет A B C	
10. Нарушения сна (напр., ночные страхи, бессонница, повышенная сонливость и т.п.)	Клиент не ответил = **A** Опрашивающий не спросил = **B** Неподходящий вопрос = **C**	Да Нет A B C	Да Нет A B C	Да Нет A B C	Да Нет A B C	
11. Тревожность (напр., излишняя напряженность, беспокойство или стресс, доходящие до прекращения активности, панических атак или потребности в чрезмерном успокаивании)	Клиент не ответил = **A** Опрашивающий не спросил = **B** Неподходящий вопрос = **C**	Да Нет A B C	Да Нет A B C	Да Нет A B C	Да Нет A B C	
12. Сверхнастороженность (напр., нервный, легко пугается, излишнее осознание потенциальных опасностей или тревоги по их поводу и т.п.)	Клиент не ответил = **A** Опрашивающий не спросил = **B** Неподходящий вопрос = **C**	Да Нет A B C	Да Нет A B C	Да Нет A B C	Да Нет A B C	
13. Агрессивное или буйное поведение, в том числе ненамеренное или неожиданное (напр., физическая или словесная агрессия, ломание имущества и т.п.)	Клиент не ответил = **A** Опрашивающий не спросил = **B** Неподходящий вопрос = **C**	Да Нет A B C	Да Нет A B C	Да Нет A B C	Да Нет A B C	
14. Импульсивность (внезапная сильная, даже иррациональная, потребность совершить что-либо, не подумав о последствиях, например, украсть, совершить прогул и т.п.)	Клиент не ответил = **A** Опрашивающий не спросил = **B** Неподходящий вопрос = **C**	Да Нет A B C	Да Нет A B C	Да Нет A B C	Да Нет A B C	
15. Печаль (апатия/отчаяние)	Клиент не ответил = **A** Опрашивающий не спросил = **B** Неподходящий вопрос = **C**	Да Нет A B C	Да Нет A B C	Да Нет A B C	Да Нет A B C	
16. Низкая самооценка (напр., я плохая, со мной что-то серьезно не так, самообвиния по поводу пережитого и т.п.)	Клиент не ответил = **A** Опрашивающий не спросил = **B** Неподходящий вопрос = **C**	Да Нет A B C	Да Нет A B C	Да Нет A B C	Да Нет A B C	
17. Оцепенение, дисассоциация (напр., ограниченный диапазон эмоций, избегание мыслей или разговоров о будущем или постановки целей, чувство вялости и т.п.)	Клиент не ответил = **A** Опрашивающий не спросил = **B** Неподходящий вопрос = **C**	Да Нет A B C	Да Нет A B C	Да Нет A B C	Да Нет A B C	
18. Другое (напр., любые изменения в поведении, физическом состоянии или настроении, случившиеся после инцидента(ов) и не вкюченные выше)	Клиент не ответил = **A** Опрашивающий не спросил = **B** Неподходящий вопрос = **C**	Да Нет A B C	Да Нет A B C	Да Нет A B C	Да Нет A B C	
СИМПТОМЫ ЗА ПОСЛЕДНИЙ ГОД И ТЕКУЩИЕ СИМПТОМЫ:						

Appendix 2: Additional Polyvictimization Resources

1. Polyvictimization Assessment Tool Resource Guidebook
2. Creating Cultures of Trauma-Informed Care Toolkit
3. Family Justice Center Client Process Mapping
4. Webinars for Frontline staff
    a. Creating Pathways to Justice, Hope, and Healing Through a Polyvictimization Framework
    b. Utilizing the Polyvictimization Assessment Tool: Frontline Staff's Experience
    c. Frontline Staff Training Webinar Series
        i. Transforming the Way You Approach Your Intake
        ii. Suicide Assessment
        iii. Polyvictimization Overview
        iv. Mental Health 101
        v. Hope Theory
        vi. Grounding and De-escalation

Appendix 3: New Orleans Screener

New Orleans Family Justice Center

Short Polyvictimization Screener

Screener Question:	Follow up prompt (for any response: yes, no, unsure), affirmation of any client's response and giving context to the question:
One of the things we've learned from our clients is they've been hurt or abused at other times over the course of their life. Is this something you identify with?	Here at the FJC we want to support you as a whole person in your healing process. This is the space we're trying to create, that you feel comfortable to talk about your life.

Appendix 4: Sonoma Screener

Family Justice Center of Sonoma County

Your answers below can help us ensure that you receive all of the assistance and services that you need while here at the Family Justice Center. None of the information that you provide here will be reported to any law enforcement or child protective agency. You may interpret and answer the questions in the way that fits you best and no further explanation beyond answering "YES" or "NO" is necessary at this time. You may answer any or all of the questions below.

Please fill in the bubble for either "YES" or "NO" as such: ●
Please DO NOT put a check mark (✓) or "X" (⊗)

	YES	NO
1. Have you experienced any physical harm or assault?	○	○
2. Have you experienced any type of emotional or verbal abuse?	○	○
3. Have you experienced any natural or man-made disaster?	○	○
4. Have you experienced any type of sexual abuse?	○	○
5. Have you felt threatened?	○	○
6. Have you experienced the long-term loss of someone close to you?	○	○
7. Have you experienced any financial difficulties?	○	○

By signing below, you understand that the information provided above is not required and that you will not be denied services for not providing answers. You consent that the information provided above may be used for the purposes of research and education, but that the information used for these purposes will not include your name and will not be able to be traced back to you.

Signature_____ Date_____

Appendix 5: Tulsa Screener

Tulsa Family Safety Center

Polyvictimization Screener

1. Have you experienced any physical harm?
2. Have you experienced any type of emotional abuse?
3. Have you experienced any type of traumatic loss?
4. Have you felt threatened?
5. Have you experienced any type of sexual abuse?
6. Have you been the victim or perpetrator of a crime?
7. Have you experienced any financial difficulties?
8. Did you experience any type of abuse or neglect as a child?
9. Have you experienced a natural or man-made disaster?
10. Have you experienced any other adverse situations?

Appendix 6: Stanislaus Screener

Stanislaus Family Justice Center

Short Screener for Polyvictimization Tool

This short screener will be used on our initial intake. If a client answers Yes to any of these questions we will move forward and attempt to complete the Polyvictimization Tool.

Has there been other incidents of abuse with this partner or any other, similar to the incident that brought you here today? YES NO

Were you exposed to abuse as a child or teen? YES NO

Appendix 7: Queens Screener

Queens Family Justice Center

Polyvictimization Screening Questions

	YES	NO
1. **ASSAULT:** Have you ever been **assaulted or harmed** with a gun, knife, or any other weapon, or has someone hit you with a fist or kicked you? This could be completed or attempted incident, by a partner, dating partner, family member, caregiver, non-relative,or stranger:	○	○
2. **SEXUAL ABUSE/ASSAULT:** Have you ever been forced or coerced to engage in unwanted **sexual activity?** This could be completed or attempted incident, by a partner, dating partner, family member, caregiver, non-relative,or stranger:	○	○
3. **STALKING:** Have you ever been **stalked** or inappropriately pursued by a partner, friend, or someone else? Stalking refers to unwanted repeated contact, including through text messages, phone calls, social media, or in person:	○	○
4. **STRANGULATION:** Have you ever experienced **strangulation**, or having someone put pressure on your neck or anywhere that made it hard to breathe? This could be through choking, use of body weight or arms, by sitting on you, or another way:	○	○
5. **ROBBERY:** Have you ever been **robbed, mugged,** or had your home or car **burgled?** This could be completed or attempted incident:		
6. **CYBERCRIME:** Have you ever experienced **cybercrime,** such as cyber bullying, bullying on social media (such as Facebook), or online theft, where someone has used your email, bank account, or other online account without your permission:	○	○
7. **WITNESSING VIOLENCE:** Have you ever seen or heard (in person, not on TV) violence, such as **shootings or gunshots, stabbings, beatings, sexual assaults,** etc. inside your home or in your neighborhood:	○	○

THE SCREENER SHOULD COMPLETE THE FOLLOWING QUESTION:

In your opinion, to what extent did this client experience polyvictimization?
(with 1 being not at all and 10 being very severe experiences of polyvictimization)

NOTE: *Polyvictimization has been defined as multiple victimizations of different kids.*

○ ○ ○ ○ ○ ○ ○ ○ ○ ○

1 2 3 4 5 6 7 8 9 10

Chapter 4

What We Learned in Numbers: The Data from the Polyvictimization Demonstration Initiative

Authors: Alliance for HOPE International

CHAPTER 4: What We Learned in Numbers: The Data from the Polyvictimization Demonstration Initiative

Rich and valuable data was collected both during pilot testing and final implementation of this Demonstration Initiative. The analysis below highlights some of the data and trends found from all Centers and seeks to highlight some of the differences between pilot testing data and final implementation. However, Center chapters highlight some of the site specific data unique to each of their communities. It is important to note, that while data was a critical component of this Demonstration Initiative, it was not the guiding focus. Throughout the course of the Initiative, members had to collectively and intentionally orient themselves toward the primary goal of the Demonstration Initiative and of Vision 21, which was to develop an instrument that would guide survivors toward the services they need, and better assist frontline staff in doing so. While psychometric validity and reliability was important, utility to the Family Justice Center model was the main priority. Thus, members of the Initiative learned to work at the intersection of "research-informed practice and practice-informed research." In addition, the Assessment Tool was developed based upon the systematic literature review of available tools that had already been psychometrically established in the published literature. Therefore, the utility of screening survivors into services was identified as the primary goal. The national research partner, the University of Oklahoma - Hope Research Center, helped facilitate a process that was guided primarily by survivors and frontline staff implementing the Assessment Tool. All national de-identified data is available for further analysis and will continue to be analyzed in the coming years. Alliance for HOPE International, is grateful for the valuable partnership and insight Dr. Chan Hellman, Jason Featherngill, and other local researchers provided throughout this process.

Data from final implementation provided insight into the lived experience of survivors seen at Family Justice Centers, it is however, important to highlight and differentiate it from the prevalence data during pilot testing. Most survivors who completed the Assessment Tool with frontline staff during final implementation were screened in through the site developed Screeners, and therefore are not necessarily representative of the average FJC client. That being said, frontline staff anecdotally report that most clients they work with are in fact polyvictims.

Secondly, while understanding prevalence is important and a critical component of the Polyvictimization Initiative, the Polyvictimization Assessment Tool has functioned more importantly as an information integration tool that provides staff with a way to organize and hold information that previously was never empirically tested or written down in one place. Therefore, understanding the prevalence of polyvictimization helps service providers better coordinate service provision, and assists Centers in creating a feedback loop about the potential services needed onsite to holistically serve clients.

The principal components analysis below, Figure 1, shows meaningful clusters around adversities and victimizations that suggest structural validity of the Assessment Tool. For example, correlations were found around "chronic discrimination", "separation from child", and "community violence". Existing research has demonstrated that marginalized populations and people of color are more likely than their counterparts to receive punitive responses from

human services agencies and other systems, particularly in high-crime neighborhoods (Font, Berger, & Slack, 2012). The clustering of items within these components not only supports the psychometrics of the Assessment Tool, but also justifies its use to identify the cumulative and co-occurring nature of trauma and adversity.

Analysis of the principal analysis data also demonstrated the importance of including events that, from a research standpoint, may not appear statistically significant due to their duplication in several categories. However, from a service provision standpoint, these events provide key insight and guidance around strategy for Assessment Tool implementation and structuring of service delivery. These clusters for example could be used to help cue intake specialists to ask certain associated event questions based on the client's answers. Ultimately, this analysis can help Family Justice Centers determine how to better coordinate multiple services and refine their client mapping processes.

I K1 = 4.69	II K1 = 2.29	III K1 = 2.02	IV K1 = 1.62	V K1 = 1.49	VI K1 = 1.36	VII K1 = 1.21	VIII K1 = 1.13	IX K1 = 1.04	X K1 = 1.01
-Strangulation -Assault/battery -Stalking -Held against will -Emotional/verbal abuse	-Trafficking -Other forced sexual abuse -Bullying	-Chronic discrimination -Other -Separation from child -Community violence	-Homeless -Poverty -Severe physical injury	-Immigration -System induced trauma	-Neglect -Financial abuse -Poverty	-Severe physical abuse -Natural disaster -Permanent loss	-Animal cruelty -Community violence	-Seen someone dead -Permanent loss	-Substance use -Jail/Prison

Figure 1: Principal Components Analysis of Final Polyvictimization Events (In the Last Year)

The principal components analysis also demonstrates correlation between events that could be categorized as adverse experiences and victimizations, that have a clear perpetrator. The clusters above clearly point to the utility of asking about adverse experiences and victimizations alike. Items like emotional and verbal abuse correlated strongly with items that produce high danger assessment scores like strangulation, assault/battery, and stalking. Similarly, events such as natural disasters and permanent loss correlated with severe physical abuse and failing to expand the Assessment Tool to include adverse experiences and traumatic events outside of the traditional scope of FJC services would fail to holistically capture the lives of survivors we serve.

Since the goal of the Assessment Tool was to gain a comprehensive picture of the client, and not just the event/trauma that brought them to the FJC, the Initiative ultimately determined that an Assessment Tool or Screeners with sole emphasis on one particular type of event, e.g. prosecutable crimes, would not align with best practices, as they could potentially screen out polyvictims who do not meet that criteria. Additionally, the concept of screening solely for prosecutable crimes was considered problematic due to its narrow endorsement of justice as a function of the courts and the criminal justice system, thereby diminishing the impact of other forms of healing and justice that may be more available, empowering, or comfortable for polyvictims.

Overall prevalence data both from pilot testing and final implementation point to the importance of including a holistic and broad approach to service delivery in Family Justice Centers. As expressed by frontline staff through their experience, the data supports the belief that FJC clients are coming in with a variety of diverse needs ranging from the specific domestic violence incident that brought them to the Center - to the many times unknown and invisible adverse experiences. The data provided below makes a clear and compelling case for expanding FJC services to include non-traditional partners such as substance use providers, medical services, and expansive mental health services. More importantly however, it demonstrates the clear need for frontline staff to have the training and ability to hold space for survivors regardless of their presenting needs.

Pilot Data and Final Implementation Data

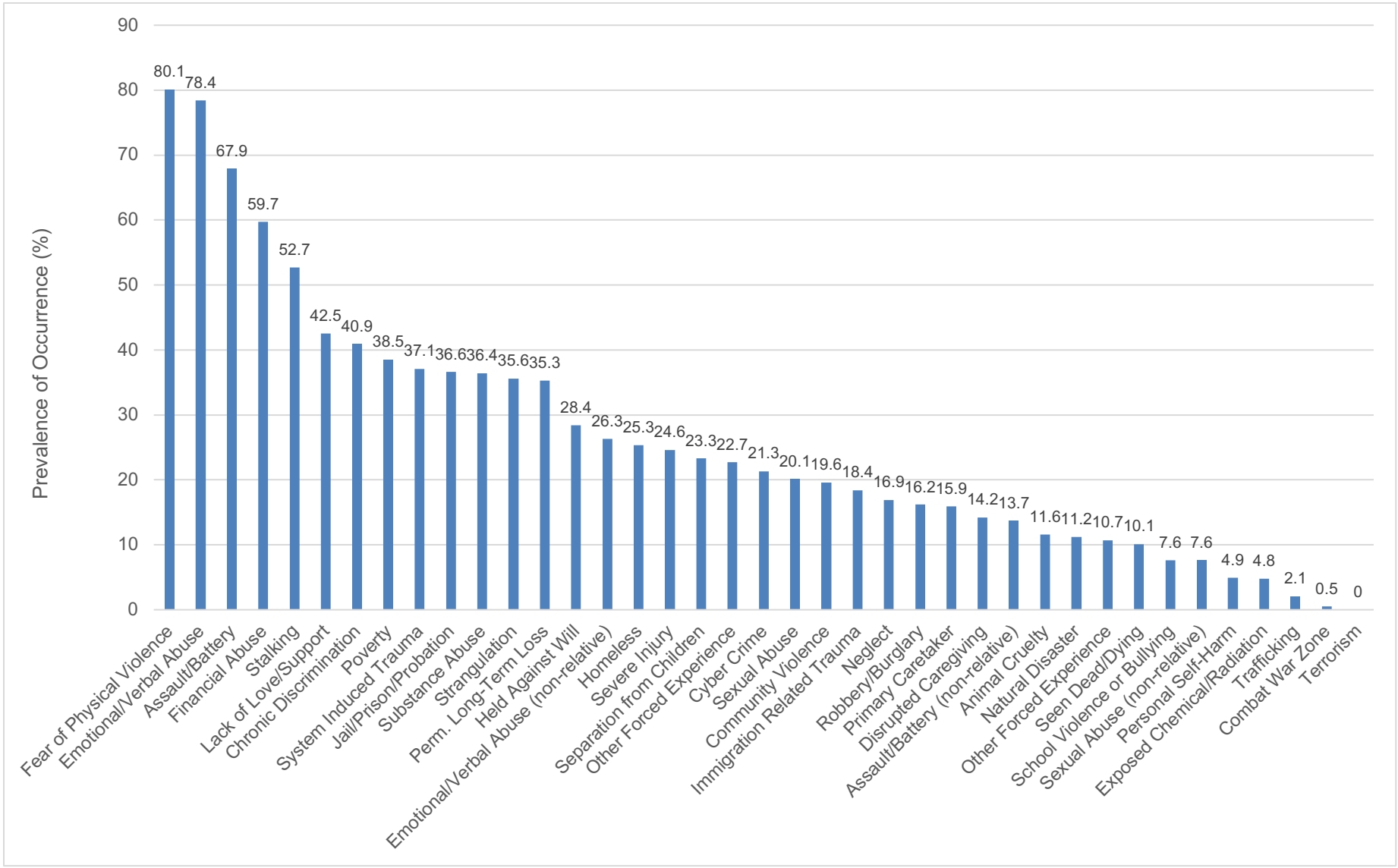


Figure 2: Pilot Testing - Prevalence of Event Occurrence (In the Last Year)

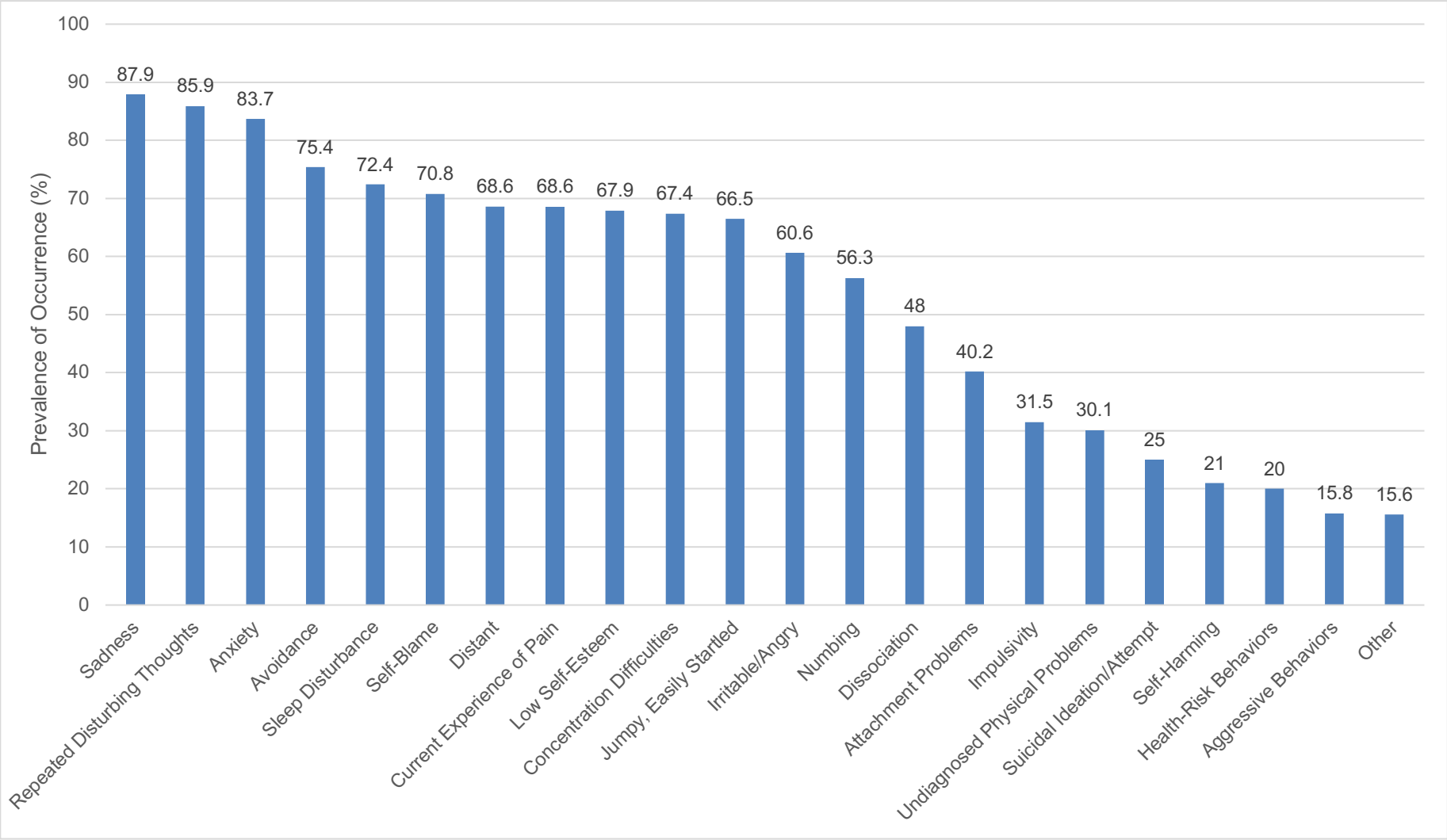


Figure 3: Pilot Testing - Prevalence of Current Symptoms

Table 1: Prevalence of Events Comparison in the Last Year

Prevalence (Events) Comparison In the Last year	
Pilot Testing (n=197)	**Final Implementation (n=389)**
1. Fear of physical violence	10. Emotional/verbal abuse
2. Emotional/verbal abuse	11. Assault and battery
3. Assault and battery	12. Stalking
4. Financial abuse	13. Financial abuse
5. Stalking	14. Poverty
6. Lack of love/support	15. Substance Use
7. Chronic Discrimination	16. Neglect
8. Poverty	17. Strangulation
9. System induced trauma	18. Chronic discrimination

Table 2: Prevalence of Trauma Symptoms Comparison in the Last Year

Prevalence (Trauma Symptoms) Comparison In the Last year	
Pilot Testing (n=197)	**Final Implementation (n=389)**
1. Sadness	1. Anxiety
2. Repeated disturbing thoughts	2. Repeated disturbing thoughts
3. Anxiety	3. Sadness
4. Avoidance	4. Sleep disturbance
5. Sleep disturbance	5. Hypervigilance
6. Self-blame	6. Cutoff

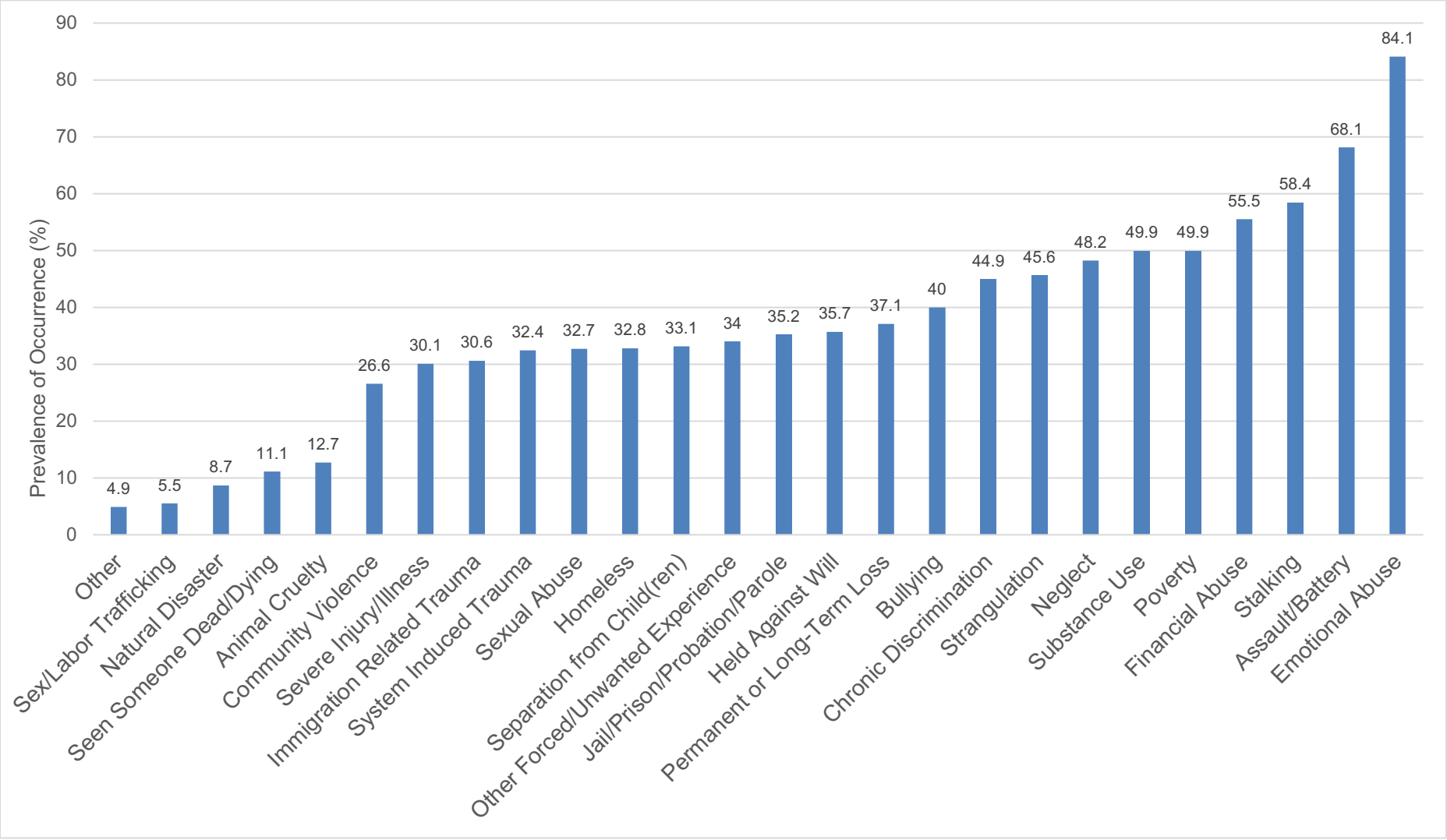


Figure 4: Final Implementation - Prevalence of Event Occurrence (In the Last Year)

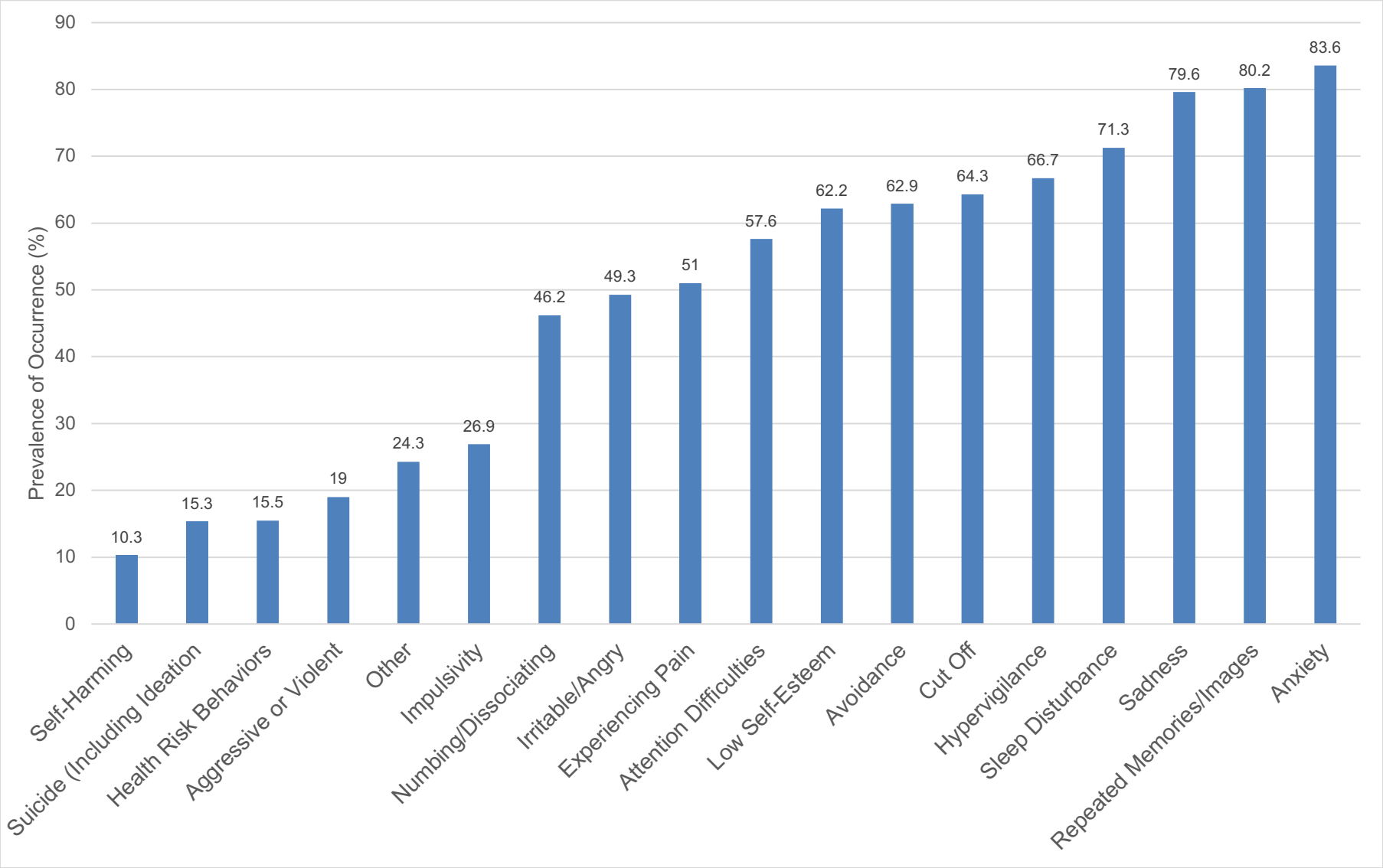


Figure 5: Final Implementation - Prevalence of Current Symptoms

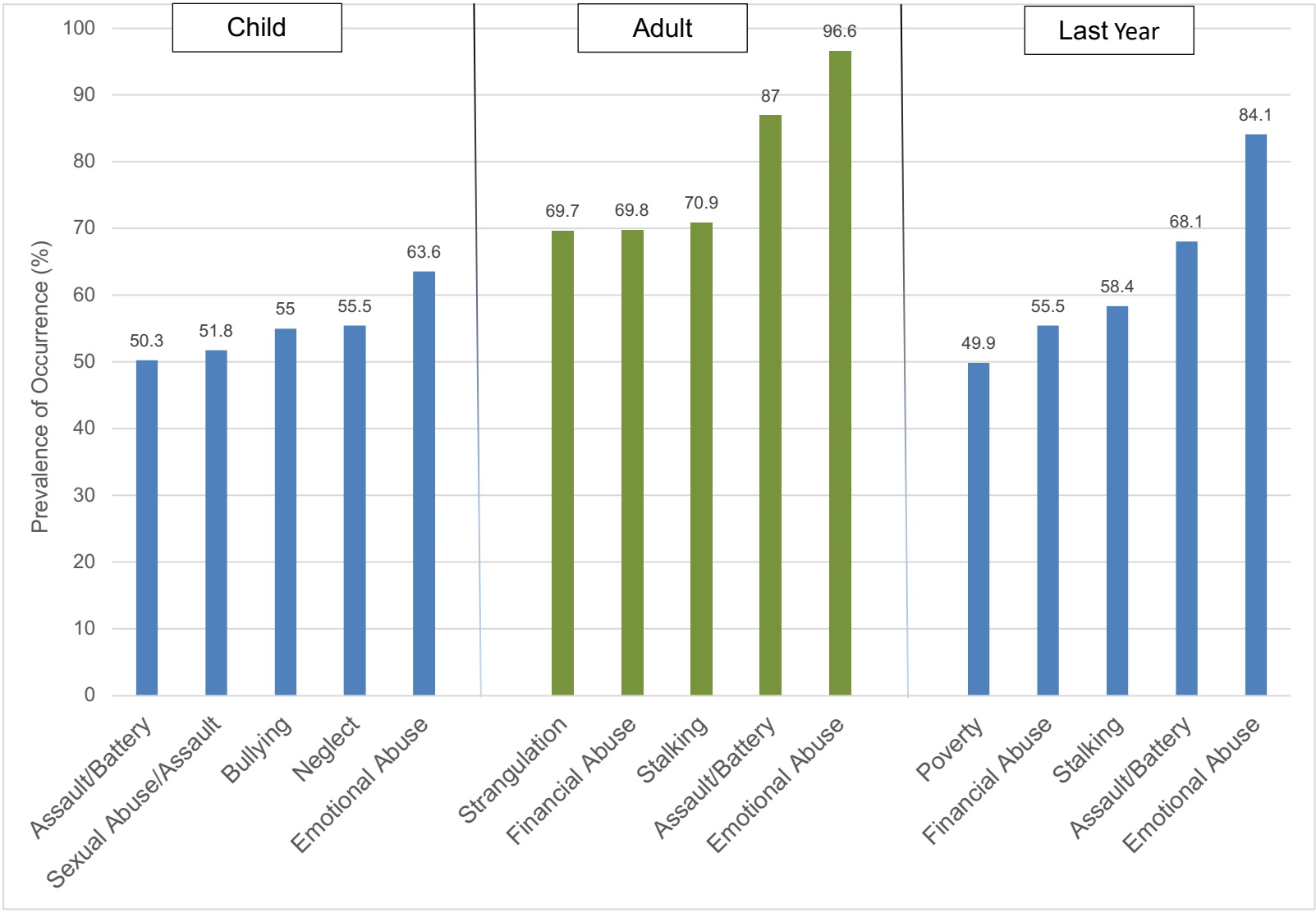


Figure 6: Final Implementation – Top Five Prevalence of Events in a Clients Lifetime

The prevalence of most events during final implementation was similar to the prevalence seen during pilot testing. However, certain anomalies may be explained by the re-wording of questions on the Assessment Tool (changes from Version 2 to Version 3). For instance, the percentage of clients who answered “yes” to the substance use question increased by 13.5% from pilot testing to final implementation. It is worth noting that Version 2 of the Assessment Tool used the term “substance abuse”, whereas the final version of the Assessment Tool used the term “substance use”, which is regarded as the more trauma-informed and less judgmental approach to the topic (Recovery Research Institute, 2010).

As indicated below, final implementation symptom prevalence patterns were notably different from those observed during pilot testing. While the number of current trauma symptoms per number of victimizations experienced in the last year was, on average, lower in the final implementation data set, the number of symptoms was still positively correlated with the number of events, showing that trauma symptoms increased as adverse events accumulated.

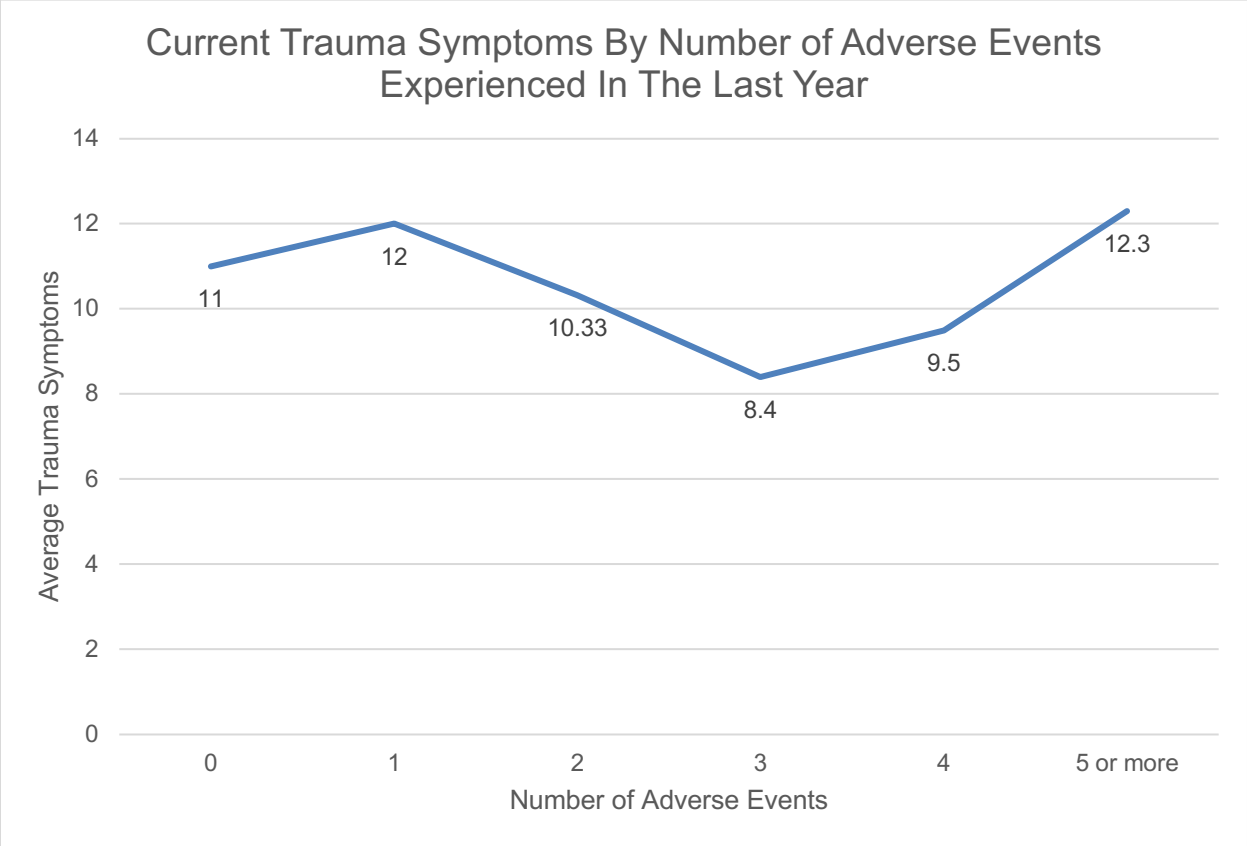


Figure 7: Pilot Testing Data - Trauma Symptoms by Adverse Experiences (In the Last Year)

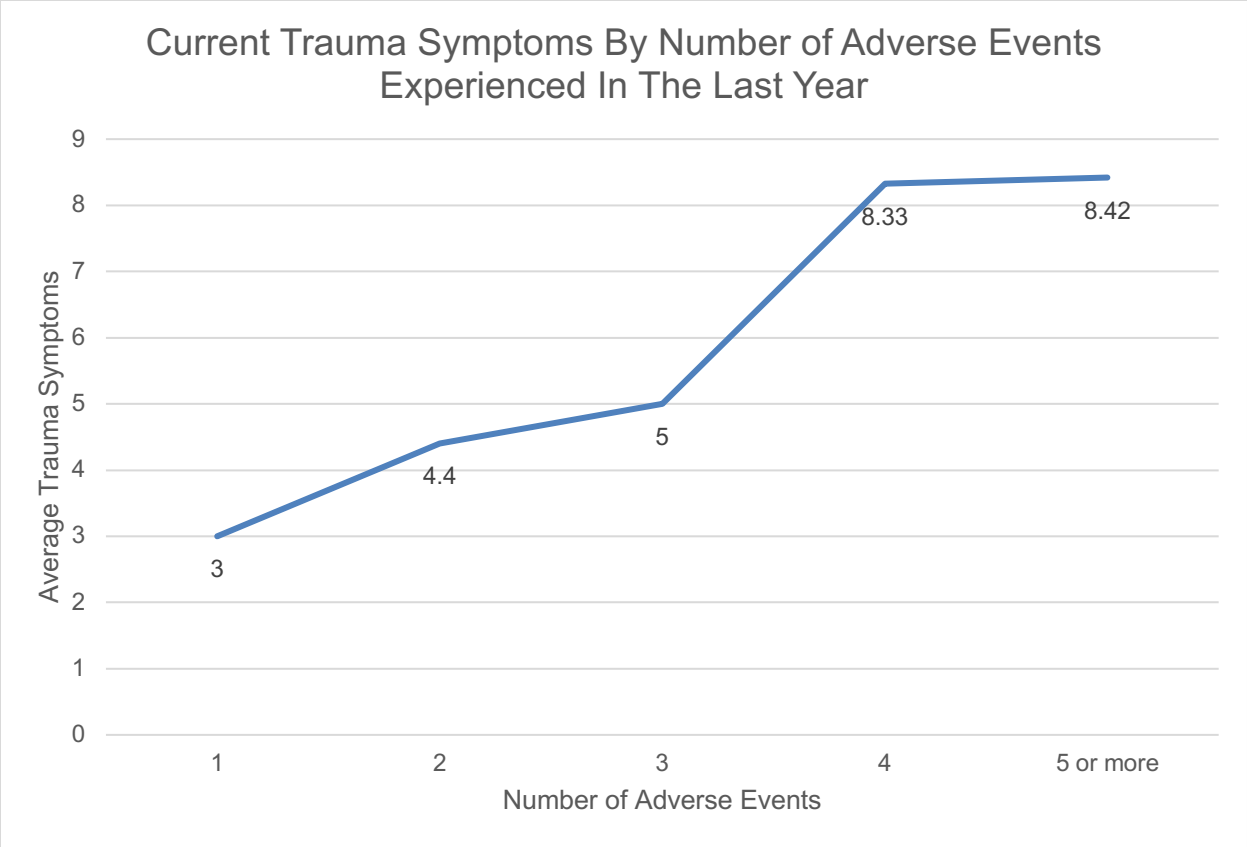


Figure 8: Final Implementation Data - Trauma Symptoms by Adverse Experiences (In the Last Year)

Other findings from final implementation provided insight into service provision and the evolution of how the Assessment Tool was used by frontline staff. During pilot testing analyses, missing data became a focus for the revision toward a final Assessment Tool. To that end, three additional answer fields - A: Client did not respond; B: User did not ask; and C: Was not appropriate to ask - were included after pilot testing to help categorize incomplete Assessment Tools. Prior to final implementation, anecdotal conversations and focus group discussions allowed for a better understanding about why certain questions were not being asked or were not being answered. The “User Did Not Ask” category provides insight into how conversation flows during assessment and what topics may not have an organic pathway or seem pertinent, while also confirming some initial discomfort expressed by frontline staff around asking certain questions.

During interviews conducted with frontline staff, several who administered the Assessment Tool identified the chronic discrimination event as a particularly uncomfortable question to ask clients. There are a variety of reasons why this could be the case, ranging from a lack of training and experience in addressing discrimination and adversities caused by historical oppression, to a lack of existing services designed to help clients process this type of trauma. However, final implementation data revealed just how important it was to ask this question, given that it was an event of relatively high prevalence at a number of Centers: Queens, Sonoma, and Milwaukee identified that nearly 50% of clients had experienced chronic discrimination in the last year, and New Orleans found that 64.3% of clients had experienced chronic discrimination in the

last year. Frontline staff from New Orleans generally agreed that they were comfortable asking this question and emphasized its importance. This highlights the importance of frontline staff asking this question and being trained and comfortable enough to do so.

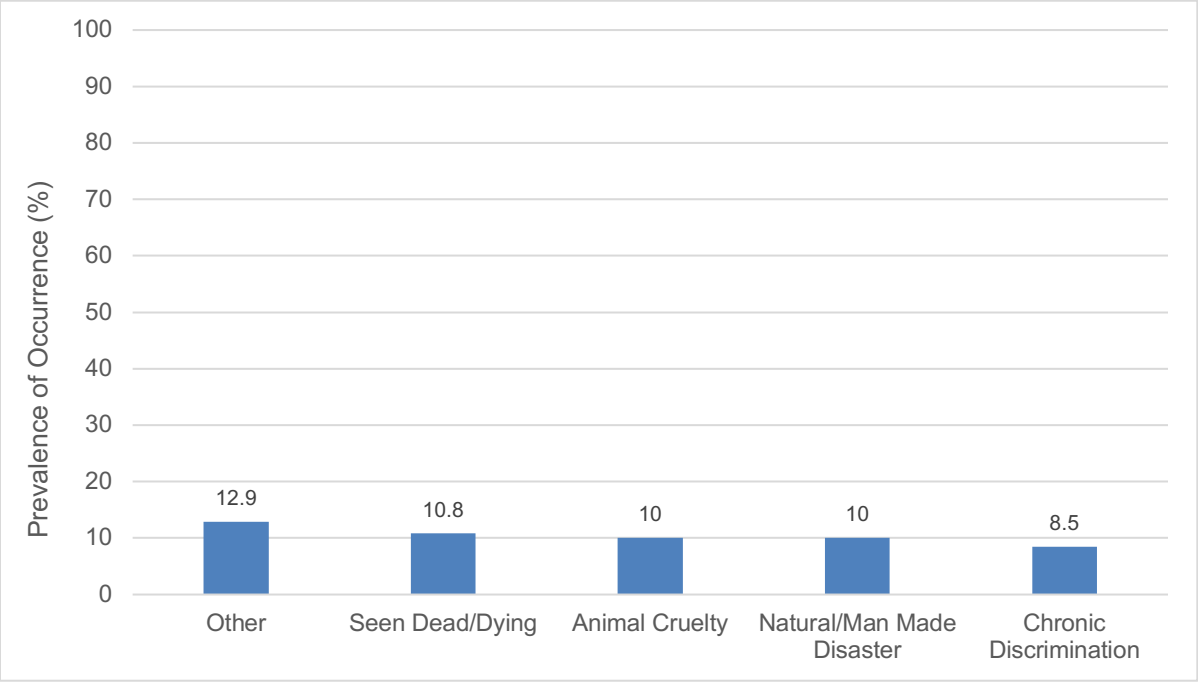


Figure 9: Final Implementation Events - Top Five "User Did Not Ask" (In the Last Year)

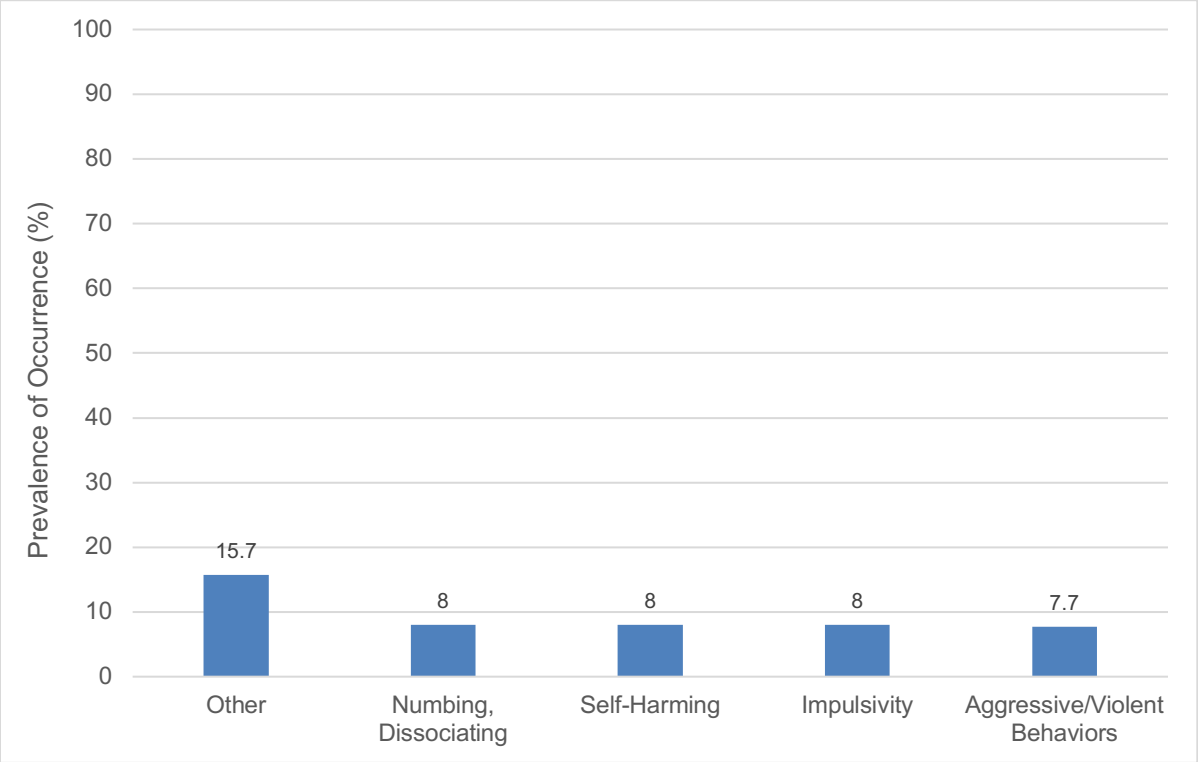


Figure 10: Final Implementation Symptoms - Top Five "User Did Not Ask" (Current)

Future Areas of Research

The data collected and the lessons learned from this Initiative allowed the Alliance, OVC, and OU to critically evaluate the areas needing further evaluation and analysis in the future. Due to the limited time between final implementation data collection and the end of the Initiative, site-specific prevalence was not compared to national prevalence and was seen as outside the scope of several brief discussions on LET calls. Future research on polyvictimization may benefit from community data being analyzed in the context of victimizations and symptoms in a national, generalizable sense, and a deeper dive into the differences in data amongst the communities would be helpful in providing other Family Justice Centers with a more specific framework for implementing the Assessment Tool based on similarities in governance, capacity, partner agencies, and demographics.

Another area that could use particular focus is the relationship between hope and polyvictimization. Frontline staff initially expressed concerns that the Assessment Tool - despite its merits in research, improved service delivery, and psychoeducation - could have unmitigated negative emotional effects on survivors recounting a lifetime of past trauma and victimization. Anecdotal evidence gathered from Sojourner Family Peace Center, which began implementing the Hope Scale following utilization of the Assessment Tool, showed that survivors who were able to take inventory of their strengths and goals developed a more positive and hopeful perspective about their futures. Furthermore, when frontline staff used the Hope Scale multiple times over multiple sessions to track changes in client outlook, they found that clients felt validated and empowered by seeing upward trajectory in their goals and their perceptions of themselves.

Future research should also examine how the Polyvictimization Assessment Tool influences survivors to engage in available services. Do survivors who engage in multiple services experience outcomes differently than survivors who identify as needing services but opt out of the Assessment Tool?

Another avenue of research would examine both how the Assessment Tool impacts partner agency cohesion in service delivery and how it might influence multidisciplinary collaborations. To that end, empirical data on polyvictimization in the Family Justice Centers could influence social policy at the local level by providing evidence necessary to advocate the needs of survivors.

To be clear, there are a multitude of potential research areas that could be pursued to further assess the utility of the assessment to promote hope and healing among survivors in the Family Justice Center model and this Demonstration Initiative began a deeper conversation around these topics and has gathered compelling and significant data for future analysis.

Chapter 5

New Orleans Family Justice Center

New Orleans, Louisiana

Authors: Eva Lessinger, Ashley Ponson, Jakevia Green, and Gabriella Roude

CHAPTER 5: New Orleans Family Justice Center

Organizational Background: New Orleans Family Justice Center

The New Orleans Family Justice Center (NOFJC) opened in 2007 after Hurricane Katrina destroyed the building of the primary domestic violence program, Crescent House shelter. The Director of Crescent House, Mary Claire Landry, decided that New Orleans would not only need to rebuild a shelter for survivors, but also a place they could receive other types of non-residential services. In the spirit of providing survivors with a greater range of opportunities for empowerment, and with a large grant from the Office on Violence Against Women (OVW), the NOFJC was born. The NOFJC is advocacy led as a private nonprofit, with public partners onsite such as law enforcement, prosecution, and city government. Currently, there are 10 onsite partners and more than 20 offsite partners. In an average year, the NOFJC serves approximately 550 new clients and 2,500 returning clients and children.

Community Context: New Orleans

With an estimated population of 391,006 as of 2018, New Orleans is the most populous city of Louisiana, located along the Mississippi River in Southeast Louisiana. While both the city and its citizens are renowned for their vibrancy, culture, and resilience, many people in New Orleans have survived--and continue to face--great adversity and cascading traumatic events. Most notable was Hurricane Katrina, one of the deadliest and most destructive natural disasters to ever strike the United States, killing thousands, leaving hundreds of thousands without homes, jobs, or schools, and devastating entire communities. Hurricane Katrina has been followed by smaller but damaging hurricanes, such as Gustav, Ike, and Isaac; the national recession spanning 2007-2009; and the Deepwater Horizon “BP” oil spill. Each had impacts on the local economy and stability of the Gulf Coast region. Even today, over 25% of New Orleans residents are living in poverty, which is double the national average (U.S. Census Bureau, 2018). In 2017, for the 29th consecutive year, Louisiana was ranked first among all other US states for the per capita murder rate, and although the New Orleans murder rate in 2018 was the lowest it had been in nearly 10 years, it still remains among the highest in the country for cities with a population of 250,000 and greater (FBI: Uniform Crime Report, 2017). While New Orleans has made progress in reference to County Health Rankings, the city continues to rank low in Louisiana and the U.S. overall on many socioeconomic factors such as poverty and employment, housing security, and ranks high in violent crime (Behavioral Health Crisis System Report, 2017). Centuries of disinvestment, segregation and neighborhood blight in New Orleans have resulted in pervasive and cumulative community trauma, which has disrupted the trust, foundational relationships, social cohesion, and social capital that is necessary for community repair and revitalization.

Many clients come to NOFJC in crisis and struggle to overcome multiple barriers in their

journeys toward healing. The mental health service network in New Orleans is not only limited but very challenging to navigate for individuals seeking services and even more so for the high percentage who are uninsured. Prior to Katrina, New Orleans already had one of the highest percentages of its population uninsured at 28%. With five full-time adult counselors, three full-time children's counselors, and several counseling interns, NOFJC currently addresses a crucial gap in mental health services, which are alarmingly scarce citywide. The NOFJC's client base is diverse in all aspects. However, the majority of clients make under $10,000 per year and have not completed college. While poverty is not a cause of domestic violence or sexual assault, it is well understood that survivors with less access to resources or who have been marginalized from social supports have fewer options for safety and are more vulnerable to further victimization.

Prior to embarking on the Demonstration Initiative, the NOFJC team believed that most clients were likely 'polyvictims'. A survey with the mental health counselors based solely on their knowledge of clients' lives from counseling sessions revealed that over 50% had experienced emotional and physical abuse in childhood from multiple people and nearly one third (30%) had reported childhood sexual abuse. Over 50% had been in multiple abusive relationships as adults and many reported symptoms of post-traumatic stress disorder. Many had detailed accounts of parental incarceration, mental illness, neglect, and substance abuse when speaking of their childhoods. The counselors knew that their clients had Adverse Childhood Experiences (ACE) scores of at least four or more without even administering the ACEs assessment. As such, NOFJC staff understood that they were serving polyvictims from the beginning and hoped that the Demonstration Initiative would help confirm assumed prevalence. Once prevalence data was captured, the team hoped to examine whether those clients needed a different service delivery model or whether they were falling through the cracks. The Demonstration Initiative provided a pathway to reflect on these questions in a profound and meaningful way.

Goals and Initiative Focus

The original goals for the Initiative in New Orleans were to better understand polyvictimization as a community, and to create a holistic learning culture to inform the field. Those overarching goals remained throughout the life of the Initiative, while the objectives and activities were continually adjusted as the project developed. The NOFJC aimed to transform its service delivery model with the knowledge and attention on polyvictimization but remained open to whatever outcomes emerged from the process. The team had to relinquish control over the larger decision making process of a national demonstration initiative and focus on what was within its control locally. While the process began to methodically review instruments with the other five sites, the team simultaneously moved to begin creation of the holistic healing program and make necessary changes to the Center. The NOFJC began to reflect on the intake process more deeply, build out a space for movement and mindfulness based therapies to supplement talk therapy, and consider how initial interactions with clients - on the hotline, in the building lobby, at reception, and at intake - needed improvements. The focus shifted from the mental health counseling partners to the case management staff.

Unlike many other Centers across the country, the NOFJC had a robust mental health counseling team already in place. However, the Initiative helped expand the counseling team and shift the service delivery model to improve collaboration between the counseling and case management teams, which were previously operating separately. Aside from the mental health counseling and case management teams, the primary partner throughout the life of the project was the research partner, Institute of Women & Ethnic Studies (IWES).

IWES worked closely with the New Orleans Family Justice Center to support the NOFJC's goals in the national Polyvictimization Demonstration Initiative. Founded in 1993, IWES is a non-profit health organization domiciled in New Orleans. IWES is dedicated to improving the mental, physical and spiritual health and quality of life for women, their families, and communities of color, particularly among marginalized populations, using community engaged research, programs, training, and advocacy. Together, the NOFJC and IWES prioritized the evaluation of organization-wide activities and client services which included the pilot and full implementation of the Polyvictimization Assessment Tool with clients, evaluation of staff clinical supervision with IWES' President and CEO, board-certified psychiatrist Dr. Denese Shervington, and evaluation of the holistic therapies offered to both staff and clients. The IWES Research & Evaluation team worked with NOFJC to organize an evaluation plan based on a shared timeline for data collection, analysis, and dissemination and served a critical role in guiding data collection while staying true to NOFJC's trauma-informed approach. Early on, there had been a shared vision to measure client outcomes in addition to the prevalence of polyvictimization. Over the life of the Initiative, IWES identified how to capture outcome data around the holistic healing program and outcomes in terms of staff improvement in addition to the thorough process evaluation.

Trauma-Informed Care

Training

To better understand the principles of trauma-informed care and how to implement these principles at the NOFJC, Walesa Kanarek, mental health counselor, and Ashley Ponson, Director of Client Services, attended trauma-informed care "Train the Trainer" sessions at the Alliance for HOPE International headquarters in San Diego, CA on June 1 and 2, 2017. Raul Almazar, a Senior Consultant at SAMHSA National Center for Trauma Informed Care, facilitated the training. Over the course of two days, the New Orleans team, alongside two representatives from each of the polyvictimization demonstration sites, received instruction and engaged in detailed discussion on facilitating ongoing training for staff and partners. The NOFJC staff and partners work with high-volume caseloads of polyvictims. In order to become a trauma-informed Center utilizing a polyvictimization framework, staff and partners needed to feel more comfortable identifying the complexity of traumas impacting a client's engagement and respond in a way that does not unintentionally re-traumatize, while maintaining boundaries of their role.

Train the Trainer emphasized that, in order to do this well, Centers must engage as a

staff in discussions that affirms staff experiences working in the field. Centers must challenge traditional notions of how an agency is "supposed to" look and work with clients. The training provided comprehensive information on the prevalence of trauma in society, as well as the effects trauma can have on the individual, family, community, and system levels. The heart of the training provided tools and information on how to effectively communicate trauma-informed care principles to staff and partners, some of whom may not be receptive to the changes necessary to effectively implement new practices.

The emphasis on the Train the Trainer framework impressed upon the NOFJC the need for ongoing training for staff and partners on trauma-informed care. Trauma-informed care training was provided to current NOFJC staff members and is a critical component of the onboarding process for new hires and volunteers. It remains an ongoing training topic for staff and partners and is often open to community members as well.

Clinical Supervision and Case Review

Beginning in May 2017, Dr. Denese Shervington, president and CEO of IWES, facilitated bi-weekly sessions with NOFJC counselors and case managers to provide trauma-informed, client-centered case review and clinical supervision. Eight mental health counselors and six case managers regularly attended the two hour supervision sessions. Sessions facilitated a space where NOFJC staff could receive further training and support to strengthen their capacity to provide quality services to meet client needs. The sessions helped staff better manage their own experiences of secondary trauma. They also allowed staff to examine NOFJC's current policies, procedures, and trainings to ensure they reflect best practices for trauma victims. The supervision sessions provided opportunities for attendees to meaningfully reflect and collectively process their experiences, questions, and concerns. Critically, the sessions allowed for space wherein two separate disciplines could come together to create more shared language and deeper appreciation for the differing but interconnected roles. At the conclusion of the supervision sessions, an evaluation survey was administered among attendees to gauge how the sessions may have contributed to NOFJC counselor or case manager approaches, knowledge, and skills.

From attendee feedback and evaluation of clinical supervision, it was clear that these sessions encouraged NOFJC teams to come together and cross-pollinate ideas, build trust, and foster holistic approaches in working with clients. The 28 sessions offered were well attended, with more than half (64.3%) of participating staff attending between 22 to 28 sessions. Evaluation of the supervision session reflected positive outcomes among case managers and counselors as well as improved engagement with clients.

> "The time allotted with case managers helped me understand their roles more and I appreciated the time to consult with them. By having this time collectively, it helped set boundaries with clients and I believe it helped everyone better understand their roles."
> **-NOFJC Adult Counselor**

"Yes, I feel that the knowledge [gained in supervision] has allowed me to be more competent in the services I provide to my clients. The knowledge has given me more insight on my clients' functioning and continues to inform the interventions that I chose to use with them." **-NOFJC Child Counselor**

NOFJC Transformation

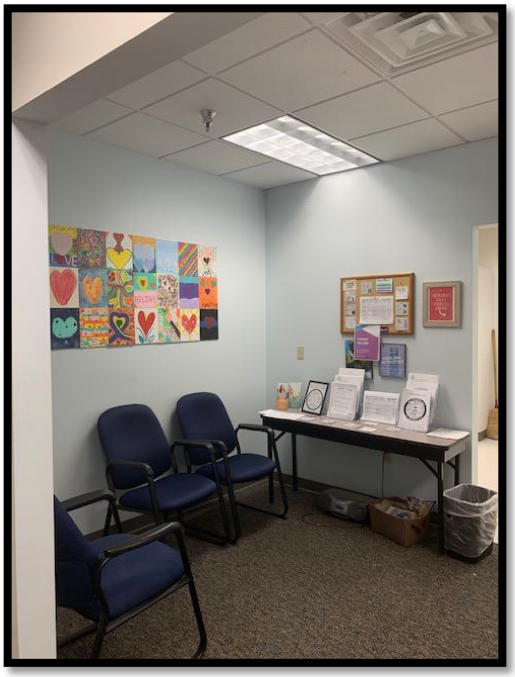
As mentioned above, a critical aspect of what the NOFJC wanted to transform its physical space in order to create a more welcoming environment for clients. Clients' initial impressions of the Center are essential to forming rapport and trust with staff. For example, imagine one is worried about his or her medical condition. One can have a wonderful, compassionate doctor who is perfect for treating this condition. Yet suppose the doctor's building is hard to find, the security guards are rude, the receptionist ignores its patients, and there is no privacy during the visit. The doctor herself does not matter anymore; the patient will not feel good seeing her. The NOFJC felt the same way when reflecting on its space: each touchpoint needed to feel more safe, welcoming, and calm.

Before the Initiative, the NOFJC recognized that it needed to make several changes. Because the Center exists in the United States postal building, clients had to speak with postal police officers through an intercom to get into the building, often requiring them to shout their names in the public lobby area. Despite numerous trainings and conversations with postal police, their role is ultimately building security and therefore they continued to view clients as a potential security risk, inhibiting the possibility of a welcoming atmosphere. Once a client made their way to the elevator, the second floor receptionist was lovely, but overburdened by nonstop phone calls as well as responsibility for the schedule and liaising with all staff and partners. The Playland area for children had not had a makeover or been cleaned out in years, and the staff were resistant to a more trauma-informed approach with children and parents. The mentality which existed in the Playland was one of "tough love" for kids who were struggling and "acting out" due to trauma than one of deep compassion and patience that these behaviors require of staff. Lastly, clients were asked to wait along a wall of windows, while staff and other clients walked by, leaving little sense of privacy.

It took two years to address all of these issues and create the space clients deserved. It took organizational self-reflection, client focus groups, additional funding requests, and staff motivation to transform. Nothing happens overnight. But the dreams were clear and the staff were inspired. First, the NOFJC added a lobby greeter to welcome clients downstairs. It took another year to find the funding, but eventually a second position, Director of Hospitality, was added at reception and given authority to oversee and ensure clients' smooth entry through both the hotline and in person. Two offices were transformed into a waiting room overnight and connected to the kitchen so clients could help themselves to water. Eventually, the Center received coffee donations so that it could offer coffee and tea to clients. In Playland, staff conducted a full-scale overhaul of the space: it was cleaned from top to bottom, re-painted, and stocked with brand new toys, books, and games. The Center hired a child development specialist to work with

new staff on how to be responsive to trauma in children. While the Center has always been proud of its quality services, the Initiative forced staff to reflect on how every level of the Center impacts survivors' experiences.

FJC Waiting Room:



FJC Building Lobby:

FJC Kitchen:

FJC Client Waiting Room:

FJC Children's Room

FJC Lilac Healing Studio

In addition to the new welcoming positions and spaces, the NOFJC also created the Lilac Healing Studio, a large room for holistic healing offerings. The NOFJC wanted to expand the trauma counseling program to include other types of therapies and created a budget item in the Initiative to hire community members with healing expertise. Counselors and staff began to reach out to practitioners and educators who would be especially compassionate to trauma survivors and excited to contribute to updated Center programming. Having a beautiful space provided the opportunity to grow these therapies organically over time. A projector, full wall screen, sound system, and tables and chairs made it fully functional as a training space and area for many types of events and activities. The annual holiday party, teambuilding activities, staff mini-retreats for self-care, and team meetings are held in the Lilac Healing Studio. It is quiet, simple, and tranquil.

Holistic Therapies and Client Feedback

Using the Lilac Healing Studio space, NOFJC began to offer a holistic therapy series in the summer of 2017. Each new modality was made available to NOFJC clients, partner organizations, and staff. Building over time, the holistic therapies now include: massage, belly dancing, NADA acupuncture, reiki, yoga, LGBTQ yoga, strength training, singing, salsa dancing, mindful motion, Brave Play (improvisational comedy), and Sexual Empowerment After Abuse classes. Providing a variety of therapeutic modalities, in addition to mental health counseling services, allows clients to explore new and exciting ways to supplement their individualized coping and healing processes. The therapies also provide an alternative option for clients who do not want traditional counseling services or in instances when counseling services are not yet available. The holistic framework of the therapies aims to meet the diverse self-care needs and interests of clients such as facilitated movement, touch, stillness, breathing, as well as spaces that welcome individual expression, mindfulness, creativity, open communication, and connectedness with others.

Local practitioners who are trauma-informed and attentive to the experiences and needs of NOFJC clients facilitate the weekly therapies, which are greatly appreciated by

clients, staff, and partners. In an effort to share and promote the therapies offered to all clients and staff, NOFJC distributed therapy specific e-flyers via weekly emails with a description of the therapy and the practitioner's information. In addition, an online calendar was created on the NOFJC website as a platform that lists all therapy dates and times for reference. NOFJC staff including case managers, counselors, and front desk staff also share the availability and benefits of onsite therapies with clients.

The IWES Research & Evaluation team worked with NOFJC to develop therapy-specific client feedback forms to gather data on the effectiveness of the therapeutic modalities. All clients were informed that their responses would be kept anonymous.

From the start of the evaluation period in February 2018 through December 2018, a total of 140 holistic therapy sessions were offered to NOFJC clients, staff, and partners. Of the 134 evaluation surveys that were completed, 99 (73.9%) were completed by NOFJC clients, 25 (18.7%) were completed by NOFJC staff or staff of partner organizations, and 10 (7.5%) were completed by unknown respondents. The summaries to follow reflect client responses only.

Table 1: NOFJC Holistic Therapies Offered in 2018

Therapy	Number of Sessions	Average Number of *Client* Attendees *Mean (Range)*	Number of *Client* Evaluations Completed for Therapy
Yoga	41	3 (1-7)	9
Singing Group	35	3 (1-5)	2
Massage	24	4 (1-10)	29
Belly Dancing	16	2 (1-6)	27
NADA Acupuncture	14	4 (1-10)	17
Reiki	8	4 (3-7)	9
Brave Play	2	4 (1-6)	6

Evident from the number of evaluation surveys completed and therapy attendance rosters, sessions were widely attended by clients. Several therapeutic outcome questions were included in the evaluation surveys to capture the various ways participating in the therapies could have positively impacted participants socially, physically, mentally, and emotionally. Holistic therapy participants were asked to respond how much they agreed or disagreed with a series of statements relating to how they felt as a result of participating in the therapy. Here are a select few statements along with quotes from participating clients:

97% of client responses indicated agreement with the statement:

"I feel that I have a safe and friendly network of support at FJC."

80% of client responses indicated agreement with the statement:

"I am better able to cope with the stress in my life."

"I laughed so much my face hurt! And was moved and touched by the openness and kindness of the group."
-Brave Play Client

"I left in such a great mood. I went to Trader Joe's. I have been too anxious to go before. Also took [my] dog for a walk!"
-**Belly Dance Client**

"Love the holistic perspective, free to move as ourselves, the attention to our emotional state. And helps me to keep me grounded when I need to be grounded. Thank you! I have progressed so much and I am functioning much better than I'd anticipated. I've needed this type of help long before the events that led me to FJC…"
-Yoga Client

"Thank you very much for trying to make our everyday better and for treating all who comes to your doors with respect and to help us recover the value that some person made us lose at some point in our lives. Congratulations FJC for trying to improve our lives-- very grateful!"
-Massage Client

IWES' Research & Evaluation Team shared the data collected from the therapy specific evaluation surveys with NOFJC staff and healers (therapy practitioners). NOFJC staff and the healers worked collaboratively to discuss ways to incorporate client feedback in expanding and improving therapies. Having Walesa Kanarek as the point person for this burgeoning program was critical to its success. Walesa stepped up naturally as her passion for providing these therapies to clients was abundant. Without her steadfast attention to the constant coordination needed and to creating the survivor feedback process with IWES, it would not have grown to become the functional and critical program it is today.

Client Mapping Process

The NOFJC approached the client mapping process as an opportunity to receive input from partners and identify gaps in understanding of the system. With any co-located center, various disciplines and professionals will view the larger system in different ways. There is no uniform perception of a client's navigation through a Family Justice Center. Because the NOFJC had not substantially engaged its law enforcement or civil legal partners in the Initiative, Walesa and Ashley decided to conduct a trauma-informed care training with staff and partners as a way of initiating and informing a mapping exercise. Rather than offering a general training on trauma, they instead asked staff and partners to expound on the specific positive and negative aspects of a traumatized client's journey through the Center.

Interestingly, this conversation highlighted a host of unexpected issues, complaints, and feedback about the NOFJC system. One surprising but important theme that emerged was a perceived lack of safety by staff and partners. That conversation led to a safety training several months later with post office inspectors on active shooters, and eventually to the creation of a safety committee. Time and time again, the NOFJC had to be self-reflective and adjust its approaches as issues surfaced throughout the Initiative. The training also highlighted the need for more training, perhaps more specific to each discipline. In the end, the mapping exercise was helpful in providing a structure to self-assess, but required more time. Ideally, the map should be collaborative and re-visited once or twice a year as a tool for the entire system to examine itself through multiple perspectives.

Tool Development and Implementation

Development of the Polyvictimization Assessment Tool began with a comprehensive literature review of polyvictimization definitions, cumulative impacts of compounded traumas, pre-existing validated measures of mental health symptomology, and assessments of exposure to traumatic events. The Alliance slimmed their findings and recommended 30 instruments for all sites to review: 12 screening/assessment tools that focused on symptomology, 12 screening/assessment tools that focused on events, and six screening/assessment hybrid tools assessing both symptoms and events. In reviewing the selected instruments, demonstration sites were charged with providing feedback to the Alliance on what aspects of certain instruments or portions of instruments would be ideal for including in the Assessment Tool. To aid the selection process, two NOFJC interns conducted a supplemental literature review on polyvictimization. NOFJC and IWES reviewed each of the 30 tools. They discussed completion format, the questions most appropriate for the New Orleans context, and how the Assessment Tool should function in NOFJC's setting. Additional considerations included: the amount of time needed for completion, persons implementing the Assessment Tool, and logistics of sharing the Assessment Tool internally among key personnel working with clients. Three instruments - the Life Stressors Checklist-Revised (LSC-R), Trauma History Questionnaire (THQ), and Polyvictimization and Trauma Checklist - were selected for consideration for inclusion in the Assessment Tool on the

basis of 1) being formatted as a checklist; 2) assessing both events and symptoms; 3) capturing events in terms of frequency as well as age of occurrence; 4) assessing symptoms experienced recently as well as over the lifetime; and 5) event and symptoms questions representing the experiences of the population served by NOFJC (e.g. experiences with natural disasters).

Using feedback from all demonstration sites, the Alliance developed the first draft of the Assessment Tool, which included 39 events and 22 symptoms. Review and revision of the Assessment Tool in preparation for pilot testing consisted of many collaborative meetings between the Alliance, researcher Dr. Chan Hellman from the University of Oklahoma, designated contributors from each Family Justice Center demonstration site, and local research partners. NOFJC and IWES participated in regularly scheduled team meetings to discuss the Assessment Tool's content, structure, and implementation protocol to assure that its utilization remained in alignment with NOFJCs trauma-informed, client-centered, and impact driven approach.

Piloting the Polyvictimization Assessment Tool

Piloting of the Assessment Tool took place from March 1, 2018 through May 31, 2018. Administered by Ashley Ponson and Walesa Kanarek, 28 Assessment Tools were completed with 12 new and 16 returning adult female clients. The purpose and intended goals of the Initiative were shared with each of the participating clients who all provided informed consent. Throughout piloting, Ashley and Walesa attended regularly scheduled calls with the national technical assistance team to discuss the progress of implementation along with any challenges faced and/or suggested best practices for completing the Assessment Tool. At the conclusion of pilot testing, completed Assessment Tools were shared with IWES's Research & Evaluation team for local, site-specific analyses and with Dr. Chan Hellman to be included in cross-site and national analyses.

Assessing Symptoms

The quantity of mental and emotional health-related symptoms that were reported as "currently" experienced by clients at the time of participating in the pilot was notably high with clients reporting an average of 10 symptoms (Range: 1-18 symptoms). Clients reported an average of 13 symptoms as being experienced within the last year.

Table 2: Symptoms reported as "Current" among NOFJC clients piloting the Polyvictimization Tool (Top 10 Selection)

Of 28 adult clients,	Currently Experiencing…
78.6% (22)	Repeated disturbing memories, thoughts, or images of a stressful experience
78.6% (22)	Anxiety
71.4% (20)	Sadness
71.4% (20)	Low self-esteem
66.7% (18)	Sleep disturbances
64.3% (18)	Self-blame for experiences
60.7% (17)	Jumpy, startles easily
57.1% (16)	Irritable/angry
57.1% (16)	Pain and/or physical symptom(s) that have not been diagnosed or resistant to treatment
57.1% (16)	Avoidance
53.6% (15)	Attention/concentration difficulties
50.0% (14)	Distant
28.6% (8)	Suicide attempt, discussion or thought of suicide and/or desire to hurt others

Assessing Events

The total number of adverse events experienced in the last year by clients ranged from two events to 19 events with an average of 10 adverse events experienced in the last year.

Table 3: Adverse Events reported as experienced within the last year among NOFJC clients piloting the Polyvictimization Tool (Top 8 Selection)

Of 28 adult clients,	Within the Last Year experienced…
82.1% (23)	System-induced trauma
75% (21)	Fear of physical violence
75% (21)	Emotional/verbal abuse by parent, caregiver or relative
64.3% (18)	Assault by parent, caregiver, partner or relative
64.3% (18)	Chronic or repeated discrimination
53.6% (15)	Financial abuse
46.4% (13)	Community violence
42.9% (12)	Strangulation and/or positional asphyxia

In addition to assessing whether events happened to clients as an adult and/or within the last year, the Assessment Tool was designed to capture victimization experienced over the course of one's lifetime.

Table 4: Adverse Events reported as experienced as an adult AND as a child/teen among NOFJC clients piloting the Polyvictimization Tool (Top 5 Selection)

Of 28 adult clients,	As a Child/Teen AND as an Adult Experienced…
16 clients	Emotional/verbal abuse by parent, caregiver or relative
14 clients	Fear of physical violence
12 clients	Lack of love or a support system at home
11 clients	Assault by parent, caregiver, partner or relative
4 clients	Strangulation and/or positional asphyxia

Full Implementation of the Polyvictimization Assessment Tool

Preparation

Prior to the start of full implementation in December 2018, the NOFJC team facilitated three days of training with all NOFJC staff participating in full implementation of the Assessment Tool, including case management staff, mental health counselors working with adult clients, and emergency shelter partners at Crescent House. The trainings focused on best practices for implementation of the Assessment Tool and general discussion of goals for integration and utilization of the polyvictimization framework at NOFJC. Walesa and Ashley reviewed the Assessment Tool question by question with attendees, and a representative of IWES spoke to the research aspects of the process. Mental health counselors and case managers also met separately to review the process. Ashley led case management staff in an in-depth discussion of how the Assessment Tool would be administered during intake and subsequent case management sessions. Walesa and her supervisor, Veronica Martinez, led the counselors in a discussion of how the Assessment Tool would be administered in therapy sessions. Generally, the therapists anticipated completing the Assessment Tool over several sessions in order to let the client guide the conversation and go more in-depth when needed. The case managers knew that approaching polyvictimization at intake would be more difficult, but they attempted to complete as much as possible with clients who were interested because it was uncertain who would return. One significant aspect of NOFJC's implementation process was the decision to pass the Assessment Tool from the case managers to the counselors. It was determined that any portions of the Assessment Tool not completed by the case manager could be elaborated upon in counseling, and the information would eventually be passed between the two teams. One last training session was held to discuss outstanding questions and specifics that were identified through the previous training days prior to diving into full implementation.

Short Screener

After analyzing the pilot testing experience, many sites discussed the idea of a shortened intake screening tool that would help staff decide which clients would benefit from completing the full Assessment Tool. Rather than choose a subset of existing questions, the NOFJC decided to implement a single screening question. The following question was developed, but also slightly adapted as needed by case managers to fit the individual intake: "*One of the things we've learned from our clients is that they've been hurt or abused at other times over the course of their lives. Is this something you identify with?"* If the client answered "yes", the case manager would ask, *"Is this something you would like to talk about with me today?"* If the client, again, answered affirmatively, the case manager would then initiate the consenting process to begin the Assessment Tool. If the client said "no" but expressed openness to discussing more in the future, the case manager would ask again at subsequent sessions, offering the opportunity to dive in deeper when the client was ready to do so. These simple questions helped determine if clients self-identified with the concept of polyvictimization and also helped discern their willingness to speak about their lived experiences beyond what brought them to NOFJC.

Not only did this offer insight into how clients perceived their experiences, but it also let them know that the NOFJC was ready and able to hear their stories on their own terms. The Screener was never intended to screen someone 'in' or 'out' as a polyvictim, but rather served as an open doorway for a client to pass through only when and if they wished. This type of screening felt more useful to the NOFJC model as the team continues to grapple with using a threshold measurement for who is defined as a polyvictim.

Full Implementation Results

Full implementation of the Assessment Tool took place from December 1, 2018 to May 31, 2019. During this period, the Assessment Tool was completed with 64 clients. All clients were women over the age of 18. Of the 64 clients, 23 (35.94%) were new NOFJC clients at the time Assessment Tool completion began, and 41 (64.06%) were returning NOFJC clients. Fifty-three (82.81%) of the 64 completed Assessment Tools were completed within one to three sessions; the remaining Assessment Tools were completed in 4-9 sessions.

Assessing Symptoms

A variety of symptoms, resultant of traumatic exposures, were reported among NOFJC clients. Table 5 displays the eight most abundantly reported symptoms, ranked in descending order, reported as "currently" being experienced at the time of Assessment Tool administration. On average, NOFJC clients assessed for polyvictimization reported approximately eight symptoms as "current," however as many as 14 were reported by clients (Table 6).

Table 5: Symptoms reported as experienced over lifetime among NOFJC clients (N=64) during full implementation of the Polyvictimization Assessment Tool (Top 8 Selection)

Symptoms Experienced…	...as a Child/Teen	...as an Adult	...in the last year	...currently
	n (%)	n (%)	n (%)	n (%)
Anxiety	22 (34.38)	60 (93.75)	59 (92.19)	50 (78.13)
Repeated disturbing memories, thoughts, or images of a stressful experience	27 (42.19)	59 (92.19)	54 (84.38)	47 (73.44)
Sleep disturbances	24 (37.50)	53 (82.81)	54 (84.38)	43 (67.19)
Avoidance	23 (35.94)	55 (85.94)	52 (81.25)	41 (64.06)
Hypervigilance	22 (34.38)	57 (89.06)	53 (82.81)	41 (64.06)
Cut off	29 (45.31)	56 (87.50)	49 (76.56)	39 (60.94)
Sadness	39 (60.94)	57 (89.06)	51 (79.69)	39 (60.94)
Experiencing pain and/or physical symptom(s) that have not been diagnosed or are resistant to treatment	10 (15.63)	45 (70.31)	43 (67.19)	34 (53.13)

Table 6: Number of Symptoms reported as currently experiencing during full implementation of the Polyvictimization Assessment Tool

Number of Symptoms	Number of Clients	%
0	4	6.25
1	4	6.25
2-5	8	12.50
6-9	23	35.94
10-14	24	37.50
Missing	1	1.56

Average: ~8 Symptoms reported as "current"

Assessing Events

In the analysis of the national full implementation data, the events “natural and/or man-made disaster” and “chronic or repeated discrimination” were in the top five events that were commonly marked as “user did not ask” by Assessment Tool users. Yet, these two events proved to be highly relevant to the NOFJC population and New Orleans at large with 50 (78.1%) clients reporting to have experienced chronic or repeated discrimination as an adult and 42 (65.6%) clients reporting to have experienced a natural and/or man-made disaster as an adult. Table 7 features adverse events, ranked in descending order of most abundantly reported adverse events experienced within the last year. On average, eight, although as many as 19 events were reported to be experienced within the last year (Table 8).

Table 7: (Selection) Adverse Events reported as experienced over lifetime among NOFJC clients [N=64] during full implementation of the Polyvictimization Assessment Tool

Event Experienced…	…as a Child/Teen	…as an Adult	…In the last year
	n(%)	n(%)	n(%)
Emotional/verbal abuse by parent, caregiver, partner, relative, friend, or other	54 (84.83)	62 (96.88)	44 (68.75)
Chronic or repeated discrimination	38 (59.38)	50 (78.13)	39 (60.94)
Financial abuse	15 (23.44)	46 (71.88)	32 (50.00)
Stalking/inappropriate pursuit by parent, caregiver, partner, relative, friend, or other	12 (18.75)	48 (75.00)	32 (50.00)
Assault/battery by parent, caregiver, partner, or relative	37 (57.81)	48 (75.00)	28 (43.75)
Poverty	39 (60.94)	40 (62.50)	27 (42.19)
Strangulation and/or positional asphyxia	10 (15.63)	42 (65.63)	18 (28.13)
Natural and/or man-made disaster	18 (28.13)	42 (65.63)	5 (7.81)

Table 8: Number of Adverse Events reported as experienced within the last year during full implementation of the Polyvictimization Assessment Tool

Number of Events	Number of Clients	%
0	1	1.56
1	3	4.69
2-5	13	20.31
6-9	24	37.50
10-13	15	23.43
14-19	8	12.50

Average: ~8 Events experience within last year

Lessons Learned from Piloting and Full Implementation

Pilot

Piloting the Polyvictimization Assessment Tool was a fruitful experience in envisioning and determining how NOFJC will use the Assessment Tool to better serve clients. One overarching lesson learned was that there is a delicate balance between asking all questions in the Assessment Tool in order to have a complete picture of what the Assessment Tool is intended to measure while also remaining trauma-informed and respecting the relationship building process between advocates and clients. NOFJC's commitment to this approach facilitated a space where clients expressed feeling supported and even emboldened to share, allowing NOFJC case managers and counselors to provide further support and psychoeducation back to clients in return.

Another elevated priority after pilot testing was the need to carefully delineate action plans for individuals experiencing multiple forms of trauma. As expected, the Assessment Tool brought up a lot of strong feelings in clients and the case management staff needed to be trained and prepared to respond effectively. There was a heightened realization after piloting that if clients were asked to bare their deepest pains, case management staff also needed to know how to witness that pain, acknowledge the courage it takes to share, and provide comfort to soothe in multiple ways. Even counselors who may have been more prepared for the depth of emotional sharing were not always prepared to need multiple sessions to cover just one traumatic event. Once trust and bonds were formed, clients went even deeper with counselors. The Assessment Tool not only increased the level of information that is known about clients, but in turn strengthened communication between teams and improved timeliness of sharing pertinent client information. As a result, case managers could advocate more effectively for an individual that they know to be in immediate need of

mental health counseling or other intensive services, especially in times of limited availability.

Full Implementation

Towards the end of full implementation, the NOFJC realized that passing the Assessment Tool between the case management and counseling teams was not an entirely effective strategy for reaching the goal of 75 complete Assessment Tools. It affirmed that the strategy was effective in sharing information between the teams and for improving client advocacy. However, two factors inhibited the completion of the Assessment Tool within the six month timeframe. First, staff turnover within the case management team considerably slowed progress towards implementation at intake. Three new case managers were brought on and trained half way through full implementation. Secondly, the long waitlist for counseling services meant that Assessment Tools stayed partially complete for a long time. The waitlist for individual counseling remained at four to eight weeks throughout the entire implementation period, making it difficult to finish the Assessment Tools in this manner for any client starting in March or after. Once the teams realized this, case managers attempted to finish the partially complete Assessment Tools on their own, rather than wait for the counseling to begin.

The IWES research team facilitated a provider focus group with multiple NOFJC staff to discuss and document challenges and lessons learned from full implementation of the Assessment Tool. In attendance were the Director of Trauma Recovery mental health counseling, the Director of Children's Counseling, the Director of Data Management, and the Director of Client Services, along with two mental health counselors and two case managers.

From the discussion, manifold strategies emerged as ways to successfully utilize the tool with clients. First, NOFJC case managers expressed needing to be selective in introducing and administering the Assessment Tool given the unique circumstances of each client seeking services at NOFJC. There were instances, especially with new clients, when individuals were in crisis, in immediate need of services, or explicitly stated that they did not want their past information collected. In these cases, introducing the Assessment Tool was deemed inappropriate. A few clients were given the Assessment Tool to review at home but never returned. This was interpreted as a passive refusal of the Assessment Tool. Requesting informed consent for a research project was not ideal at all intakes. However, the process of informed consent felt important to the NOFJC and IWES. Fortunately, for the continued use of the Assessment Tool locally, it will no longer need to be introduced in such a manner. Staff and partners can utilize the Assessment Tool as a way to increase relationship building and information integration.

Providers also expressed feeling pressed in reaching the site goal to complete a certain number of Assessment Tools within the full implementation period. Despite the pressure, providers expressed that they felt supported by the Center if they refused to ask a question or broach a topic that may not have been most appropriate to discuss at certain points in time. Prioritizing a trauma-informed approach above all else, NOFJC providers let the client guide their questioning and implementation.

Beyond considerations for the timing and appropriateness of introducing the Assessment Tool to clients, providers reported needing to exercise discernment in deciding if, when, and how the experience of certain events and/or symptoms were asked. Similarly, many needed to make the language more accessible and conversational, providing examples to help clients understand the questions. This proved especially challenging in translating symptoms for Spanish-speaking clients. One bilingual case manager started introducing the concept of polyvictimization by asking clients, “Have you experienced multiple bad things in your life?” This revealed to be a more relatable and applicable way to ask clients about life experience instead of presenting the term “polyvictim.”

Discussion

All in all, incorporating the Assessment Tool proved to help institutionalize crucial decision-making processes in providing services to clients. The Initiative transformed the Center’s appearance, policies, and approach to client’s lived experience. It added knowledge of trauma to the greater community by rippling out from the Center in a myriad of ways. Most notably, it added depth to the NOFJC’s work. The NOFJC could not continue to function as a crisis center which only attended to the immediate needs of clients. While many case managers (and others) built excellent rapport with their clients and developed long-term relationships, the bulk on that long-term work fell on the shoulders of the mental health counselors. Thanks to the changes brought on by the Initiative, many more staff feel capable of providing therapeutic experiences to clients without being therapists.

The NOFJC staff were surprised by how many clients wanted to tell their whole story, but not surprised that many clients did not want to tell it right away. The staff were surprised by what clients resonated with and what they did not. For instance, many survivors liked the term “polyvictim” despite worries that it may feel too stigmatizing. Many survivors resonated deeply with reiki, despite staff reservations, but many did not resonate with yoga, despite assumptions that it would be popular. Staff learned that they must continually put their own assumptions aside and check-in with survivors. The Initiative confirmed that survivors are an essential part of the decision making process at the Center, including determinations about what new services are needed.

If the NOFJC team could do it all over again, it would engage the full case management team earlier before final implementation for increased buy-in. The team agreed that the decision to not engage other partners in completion of the Assessment Tool was sound, but that they would implement more regular trainings with staff on trauma informed care throughout the Initiative. In addition, the team concluded that more conversations about the Initiative and its impact on the Center’s systems would have been helpful. Providing staff with more regular updates about the changes made as a result of the Initiative would have created a more collective spirit and increased buy-in for change. As an instrument for cross-pollination and communication, the NOFJC will continue to use the Assessment Tools between the case management and counseling teams.

For others sites considering implementation of the Assessment Tool: build capacity first.

If not used well, the Assessment Tool is, at best, a source of data. At worst, the Assessment Tool is harmful to clients. The more important adaptation is to make use of the polyvictimization framework to guide reflection and transformation. Use the knowledge gained through the six sites and ask the deeper questions: *Are you really ready to transform your whole system if need be? Do you have the trust and flexibility of your leadership to dramatically change things?* A center doesn't need the Assessment Tool in order to transform, but it does need willingness to go deeper with clients, and that comes with more time and energy regardless.

Because of the increased capacity required for implementation, there is also the need for increased commitment to establishing a polyvictimization framework. Having competent, well trained front line staff who also have the spaciousness and autonomy to work more intensively with clients is critical. Whether they are shelter advocates, legal advocates, social workers, intake staff or hotline staff, one has to have the time for longer conversations. Beyond that, any center without a mental health partner on site must seek one out or create a meaningful relationship with one. Becoming comfortable with discussing trauma symptoms and helping clients identify them requires a level of professional expertise. However, even those without an advanced degree can provide incredibly therapeutic interventions just through non-judgmental support, de-escalation training, and compassion.

Impacts of the Assessment Tool

The Assessment Tool is sure to live on at NOFJC. Providers agree that the Assessment Tool fostered an internal feedback loop, which allowed for NOFJC case managers and counselors to stay in communication and agreement with best practices for client engagement. Moreover, NOFJC staff, partner, and individual trainings were an organization wide strategy to cultivate a deep understanding of polyvictimization. The training created space to dive into varied approaches to complex trauma. They expanded the vision of what was possible if the Center operated as a place for trauma healing, rather than a place only for domestic violence and sexual assault crisis intervention. Further, the Assessment Tool helped to deepen and foster rapport between NOFJC staff and clients on the next level.

Providers expressed that the Assessment Tool helped broach topics with survivors that they had never discussed before. Overall, reactions from clients were positive in being able to self-identify with polyvictimization as both a concept and term that sums their life experiences. NOFJC is dedicated to continue fostering an environment where clients feel empowered and supported to talk about their lives completely.

> ""We want a space where clients can feel that they can share everything here instead of what society tells them they can or cannot share."
> **-Walesa Kanarek [Trauma Recovery Counselor]**

Moving forward, providers agreed on the importance of ensuring ongoing discussions about polyvictimization as a whole agency at the NOFJC. The process encouraged staff

to understand and empathize more with clients when advocating for their needs and shifted their view towards holistic solutions. The Initiative created an organization wide cultural shift at the NOFJC and now there is no going back.

> "This approach needs to be a part of our elevator pitch when speaking about what we do at this center."
> **-Ashley Ponson [Director of Data Management]**

Acknowledgements

The NOFJC would like to express their heartfelt thanks and deepest gratitude for the many people who made this Initiative come alive over the past three years. Working together and separately, every person gave a piece of themselves towards healing and hope in survivors. The Center could not have done this without them!

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The NOFJC project leads: Walesa Kanarek, Ashley Ponson, Veronica Martinez, Carly Smith, Eva Lessinger, and Mary Claire Landry.

All of the incredible staff and partners who do the hardest work every day. And most importantly, the survivors who spoke their truths and their deepest traumas - it was an honor to hear your stories and accompany you on your healing journey.

Chapter 6

Family Justice Center Sonoma County

Sonoma, California

Authors: Sophie Lyons, MPH, MSW; Danielle Toussaint, PhD; and Kelsey Price

CHAPTER 6: Family Justice Center Sonoma County

Family Justice Center Sonoma County Overview

Sonoma County Demographic Snapshot

POPULATION	MEDIAN HOUSEHOLD INCOME	POVERTY RATE	EMPLOYMENT RATE
500,943	$71,769	10.7%	60.7%

Source: U.S. Census Bureau, ACS 5-Year Estimates. (2013-2017). Tables DP02, DP03, DP05. Sonoma County, California Census Profile.

Sonoma County is the 29th largest county in California and is situated approximately 65 miles north of San Francisco. The median age in the county is 41 years, slightly older than the United States median age of 38 years. The percentage of foreign born residents is also higher than that of the United States (U.S.), at 17% in Sonoma County compared to 13% in the U.S with 26% of residents speaking a language other than English at home. Spanish is the most common non-English language, with 20% of residents reportedly speaking Spanish at home. The majority of Sonoma County residents are Non-Hispanic White (62%), and 27% of residents are of Hispanic or Latinx ethnicity (see Figure 2) (U.S. Census Bureau, 2013-15, Tables DP02, DP03, DP05).

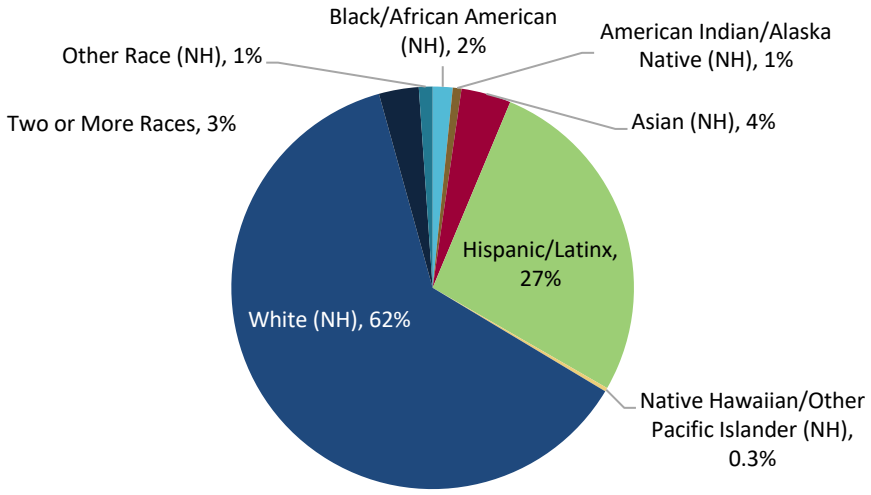


Figure 1: Race/Ethnicity, Sonoma County, 2017

Source: U.S. Census Bureau, ACS 5-Year Estimates. (2013-2017). Table DP05.

Note: NH = Non-Hispanic/Latinx

History and Current Governance Structure

The Family Justice Center Sonoma County (FJCSC) operates under the Sonoma County District Attorney's Office (DA's Office) with all FJCSC staff operating as employees of the DA's Office. Prior to the FJCSC's opening, a victim in Sonoma County needed to visit up to 23 different locations to receive basic services and participate in criminal prosecution. The FJCSC was created in order to address this issue of dispersed service delivery and to provide coordinated support services to victims of violence, initially collocating staff from partner organizations at the Santa Rosa Police Department in April 2010. Soon after this initial opening, the Sonoma County Board of Supervisors unanimously approved the purchase of a building in Santa Rosa for use by the FJCSC and the new Center's official grand opening was in October 2011.

Michelle Carstensen is currently the FJCSC Interim Executive Director, having started this position on June 20, 2019. Ms. Carstensen was previously the Director of Victim Services in the DA's Office and is a Licensed Marriage and Family Therapist. The previous FJCSC Executive Director's tenure was from 2013 until February 1, 2019, and he oversaw the Polyvictimization Demonstration Initiative from the initial grant application through the beginning of the implementation phase. Between February 1, 2019 and June 20, 2019, the FJCSC was overseen by a temporary Interim Executive Director. Kelsey Price, the Polyvictimization Grant Coordinator and former FJCSC Navigator with the YWCA Sonoma County, oversaw the Polyvictimization Demonstration Initiative at the FJCSC since September 2018.

At the start of the Polyvictimization Demonstration Initiative ("Initiative") in 2016, there were two FJCSC employees - an FJC Coordinator and the FJC Executive Director - and one full-time navigator employed by the YWCA. At the end of the Initiative's implementation period (May 31, 2019), there were four FJCSC employees - the FJC coordinator, interim FJC Executive Director, Client Services Coordinator, and FJC Receptionist. The client services coordinator is a full-time position that was expanded to ensure greater oversight of the client intake process and trauma-informed care implementation. In addition, the FJCSC added a full-time navigator, employed by the YWCA, and a part-time navigator, employed by Verity. A key expansion in FJCSC staffing during the Demonstration Initiative was the addition of the bilingual receptionist position, initially hired on a part-time basis in August 2017 and transitioning to full-time in September 2018. As the first line of contact for clients, employing

Family Justice Center Sonoma County Mission Statement

The Family Justice Center Sonoma County empowers family violence victims to live free from violence and abuse by providing comprehensive services, centered on and around the victim through a single point of access. Building on strong interagency collaboration, we protect the vulnerable, stop the violence and restore hope.

Family Justice Center Sonoma County Vision Statement

The Vision of the Family Justice Center Sonoma County is creating a future where our community has ended the cycle of family violence, our homes are places of safety, and children, families, and elders live free from the fear and presence of abuse in our rural, suburban, and urban neighborhoods.

someone who understands the FJCSC protocols and services in this position full-time is crucial to ensuring smooth client flow.

Partner Organizations

Currently, the FJCSC has 44 partners, including 15 onsite, co-located agencies. Over the course of the three year Polyvictimization Demonstration Initiative, the list of partner organizations expanded to meet client needs, with the FJCSC adding 11 new partners. The collocation of onsite partners provides key victim support and advocacy services (including bilingual and bicultural services), and enhances collaboration, coordination, communication, and integrated service delivery for clients. New and pre-existing onsite and offsite partners are identified in Table 1 below.

Table 1. Family Justice Center Sonoma County On-Site Partners

On-Site Partners 2016-2019	Off-Site Partners 2016-2019
At Initiative Start ● Catholic Charities of the Diocese of Santa Rosa* ● City of Santa Rosa Police Department* ● Council on Aging* ● County of Sonoma Sheriff's Office* ● Legal Aid of Sonoma County* ● Redwood Children's Center* ● Sonoma County District Attorney's Office/Victim Services Division* ● Verity* ● YWCA of Sonoma County*	**At Initiative Start** ● Becoming Independent ● Child Support Services ● CHOPS Teen Center ● Commission on the Status of Women ● Community Child Care Council of Sonoma County* ● County of Sonoma Department of Health Services Behavioral Health Division* ● Disability Services and Legal Center ● Family Service Agency ● Inter-Tribal Council of California* ● Jewish Family and Children's Services ● Kaiser Permanente* ● Living Room ● North Bay Regional Center ● Probation Department ● Redwood Community Health Coalition ● Redwood Covenant Church ● Redwood Empire Chinese Association ● Santa Rosa Community Health Centers* ● Sebastopol Police Department ● Social Advocates for Youth ● Sonoma County Human Services Department* ● South West Community Health Center ● St. Joseph Community Health Clinics at Memorial ● Sutter Santa Rosa Regional Hospital
Added During Initiative ● Empowerment Group* ● Healdsburg Holistic* ● Homeless Outreach Team ● Licensed Marriage and Family Therapist* ● SonomaWorks	**Added During Initiative** ● Child Parenting Institute* ● Lindsey's Yoga Lifestyle* ● Sonoma County Bar Association ● Sonoma County Office of Education ● Sonoma Yoga Therapy* ● Forget Me Not Farms

Note: An asterisk (*) indicates a partner who participated in the Polyvictimization Demonstration Initiative.

Clients at the FJCSC

The FJCSC serves any and all clients who have experienced or are currently experiencing domestic violence, dating violence, human trafficking, sexual assault, child abuse, elder abuse, and stalking. Clients access services that are free, confidential, and safe. Upon arrival at the Center, clients complete an intake form in the lobby which captures demographics, contact information, and general information about their reason for seeking services. A navigator then welcomes the client in the lobby and escorts them back to the "Nest." The Nest is a secure location within the FJCSC that serves as the hub of all client services. Within the Nest are four confidential interview rooms, a lounge, and a children's area. The navigator conducts the intake process within one of the four interview rooms, and creates a service delivery plan for onsite partners. The navigator then coordinates with any onsite partners identified in the service delivery plan and provides a warm hand-off, with staff from identified partner organizations coming to the interview room in the Nest to continue services. The interview room serves as a centralized location for all service provision, with staff moving through the Center to meet with the client, rather than the client moving from office to office. For a more detailed explanation of the client flow process, see the "Client Mapping Process" section.

Clients Served During the Initiative

From January 1, 2016 to May 31, 2019, a total of 3,363 unduplicated clients visited the FJCSC. During the Polyvictimization Demonstration Initiative (October 1, 2016 – May 31, 2019), 2,692 unduplicated clients were served at the FJCSC. If current rates continue through the end of the year, the FJCSC would expect to see approximately 1,176 clients by the end of 2019. It is important to note that the actual client numbers for 2017 were much higher, but there were a number of duplicate clients from 2016 who returned for additional services in 2019. In addition, these numbers do not include clients who returned after a year or longer hiatus from FJC services, or those that came back for a different victimization than that of their initial FJCSC visit.

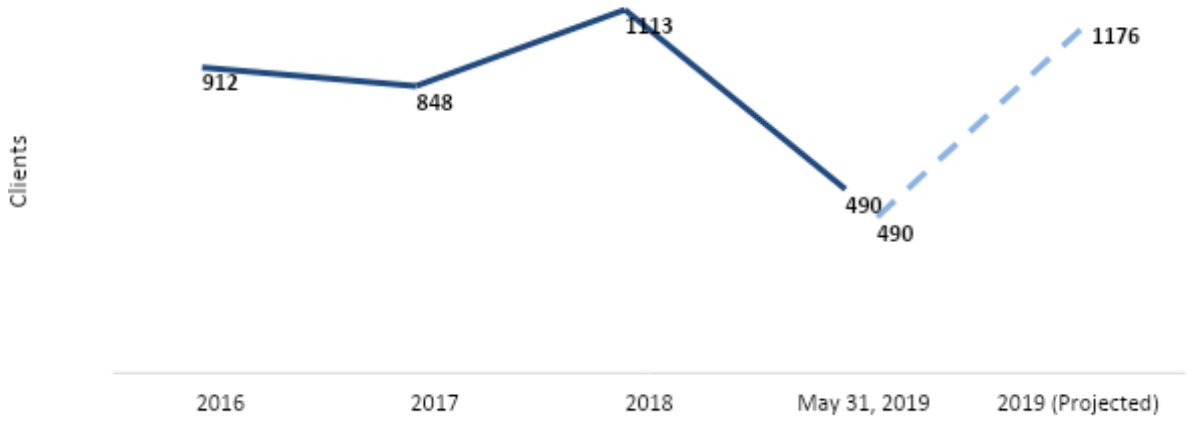


Figure 2: Unduplicated FJCSC Clients by Year

Source: FJCSC *Efforts to Outcomes* platform, January 1, 2016 - May 31, 2019

Impact of the 2017 Sonoma County Fires

In the midst of the Polyvictimization Demonstration Initiative, Sonoma County was devastated by the raging October 2017 wildfires that destroyed over 5,000 structures in Sonoma and Napa Counties alone. The wildfires took the lives of 44 individuals throughout Northern California, including 22 people in Sonoma and Napa Counties, making it the deadliest wildfire in California's history at the time (Cal Fire, 2019; "October Fires' 44th Victim," 2017). The FJCSC shut its doors for two weeks, as the fires came within half a mile of the Center, and residual smoke made it unsafe to occupy the building. Recovery efforts began immediately throughout the county. The FJCSC found that the number of clients seeking services at the Center dropped notably in the immediate aftermath of the fires, but by May of 2018, client visits were up 33% compared to the year before. The YWCA Sonoma County reported a 21% increase in calls to their 24/7 Domestic Violence Hotline following the tragedy.

Months after the crisis, it became clear that the pre-existing victimizations that individuals faced prior to October 2017 were exacerbated by the trauma and uncertainty that followed in the wake of the catastrophic fires. Anecdotally, FJCSC staff noticed that the rate of polyvictimization had risen amongst clients as many had lost homes, family members, wages, and experienced health complications associated with smoke exposure. Many in the community were already experiencing housing insecurity due to a lack of affordable housing in the county, and the stress and insecurity only became more tenuous due to the massive loss of housing structures.

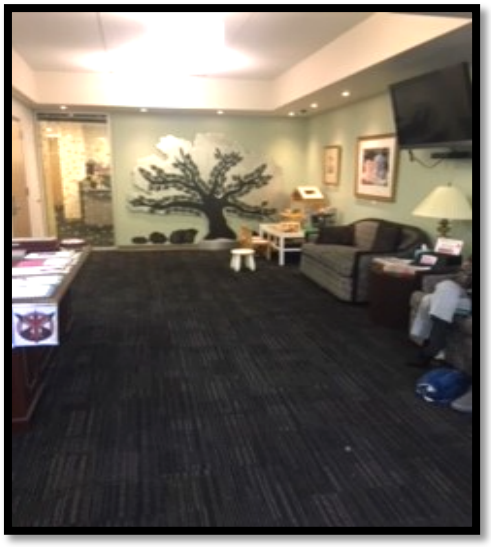
While there is not yet data on the impact that the fires had on victimization in Sonoma County, prior research found that natural disasters can have a substantial impact on the rate of victimization of women. There was a 98% increase in physical victimization of women after Hurricane Katrina (Schumacher et al., 2010) and a 300% increase in reports of sexual assault after the Loma Prieta earthquake (Gender and Disaster Network, 2006). Victims may be easier to find for an abuser if the victim is seeking refuge in a shelter. Victims are more likely to return to an abuser who can provide access to housing, and can suffer from reduced access to services as community resources are often more limited following a disaster (Glen Price Group, 2018)

Creating a Trauma-Informed Center

In 2017, the Project Coordinator attended a two day Train-the-Trainer workshop on trauma-informed care in San Diego, facilitated by Dr. Raul Almazar and organized by Alliance for HOPE International. This experience reinvigorated FJCSC leadership, which led to the adoption of trauma-informed policy adaptations within the Center. The Project Coordinator began facilitating trauma-informed care trainings for all FJCSC staff, as well as partner staff, volunteers, and Camp HOPE America counselors. The FJCSC and partner staff revisited Adverse Childhood Experiences (ACEs) trainings, and began brainstorming additional trauma-informed services that could be offered at the FJCSC. Most notably, the Project Coordinator began to roundtable with frontline staff, the staff working directly with clients, to discuss cost-effective changes to the physical space of the Center to integrate the teachings of the trauma-informed care training into the

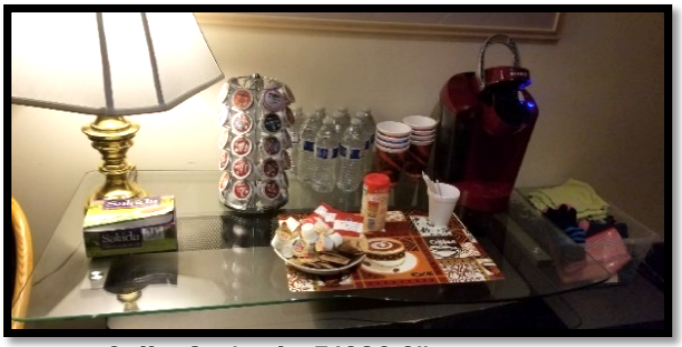
service delivery environment. Guided by the principle of providing thoughtful stimulation and comfort to all five senses, staff determined that a space filled with warm lighting, rugs, blankets, adult coloring books, coffee service and snacks, soothing sounds, aromatherapy, and art would physically transform the Center into a more trauma-informed space.

The Project Coordinator found funding for these physical changes through the Grateful Garment Project, a San Jose based non-profit organization whose mission is, “to ensure that every victim of a sexual crime who crosses the threshold of a Sexual Assault Response Team facility, or who seeks medical attention and/or law enforcement involvement, is provided with whatever new clothing, toiletries, snacks, and other miscellaneous items that he or she may require to reduce further negative impact against their being”(“The Grateful Garment Project,” n.d.; “The Grateful Garment Project - GuideStar Profile,” n.d.). One of the Grateful Garment Project’s core programs is the “Beautification Project”, which provides funding to approved service providers for transformation of atmospheres that may be conducive to healing. The FJCSC was selected to receive funding from the Grateful Garment Project for lamps, rugs, blankets, pillows, new sofas, coffee makers, anti-anxiety toys, adult coloring books, educational materials, artwork, and more. Thanks to the Grateful Garment Project, the client services area known as the “Nest” became a space that truly fostered a sense of safety, empowerment, and healing.

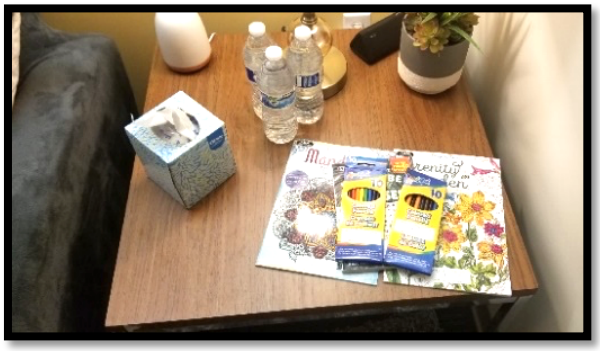


FJCSC Lobby before Trauma-Informed Transformation

FJCSC Lobby after Trauma-Informed Transformation



Coffee Station for FJCSC Clients



Coloring Materials for FJCSC Clients

FJCSC Interview Room

FJCSC Interview Room

Original Site Goals and Focus for the Demonstration Initiative

Site Goals and Partner Involvement

At the outset of the Initiative, the FJCSC was invested in developing and implementing a model screening tool (eventually called the Polyvictimization Assessment Tool) to identify clients who have experienced polyvictimization and determine services needed by those who identified as polyvictims. The FJCSC sought to then use that information to collaboratively enhance the range of coordinated services available to FJCSC clients experiencing polyvictimization.

The FJCSC determined that a coordinator would be integral to the Center's success in achieving the desired goals through the Initiative. A Polyvictimization Grant Coordinator was hired through the Sonoma County DA's Office in March 2017, a position that she maintained through August of 2018. In this time, the Grant Coordinator initiated the process of strategic and evaluation planning, in addition to convening several partner meetings to determine services already in place for polyvictims through the FJCSC. The five founding non-profit partners of the FJCSC (Catholic Charities of the Diocese of Santa Rosa, Council on Aging, Legal Aid of Sonoma County, Verity, and YWCA Sonoma County) were selected as the victim service providers for the purposes of this Initiative. These community-based organizations (CBOs) were also tasked with ensuring successful implementation of the plan of action and long-term planning for sustainable systems, as they related to both FJCSC activities and the Initiative's goal fulfillment. During Year 3 of the Initiative, representatives from each of these agencies participated in implementation of the Screening and Assessment Tools and accompanying training, case management, and service delivery. Additionally, the City of Santa Rosa Police Department, Community Child Care Council of Sonoma County (4Cs), Inter-Tribal Council of California, Kaiser Foundation Health, Santa Rosa Community Health Centers, County of Sonoma Department of Health Services Behavioral Health Division, Sonoma County Human Services Department, County of Sonoma Sheriff's Office, and Sutter Santa Rosa Regional Hospital collaborated with the FJCSC and the Sonoma County DA's Office to unite their resources to create better outcomes for victims. The Glen Price Group (GPG) was contracted to provide strategic planning support, and Hatchuel Tabernik and Associates (HTA) was contracted as the independent evaluation and research partner.

The FJCSC and its participating partners initially focused on developing a site-specific Assessment Tool to 1) identify which clientele were experiencing polyvictimization, 2) obtain a more thorough understanding of which victimizations they experienced, and 3) determine the necessary accompanying action steps for advancing client outcomes through both prevention and intervention services. The intent was that each partnering CBO would have access to the developed Assessment Tool for use in their work - both in and outside of - the FJCSC. As the coordinator and the evaluation and research partner began regularly communicating with Alliance for HOPE International, the Initiative's Technical Assistance (TA) Provider, it became clear that the scope of the project would be moving away from localized control and responsibility to a process led by the Alliance, who held responsibility for the development and rollout of an identical

Assessment Tool across all six sites, with some flexibility given to the Centers in how the Assessment Tool was administered. Staff from the six participating sites virtually convened on an ongoing and regular basis through Learning Exchange Team (LET) calls, which were facilitated by the Alliance. These convenings led to greater clarity around the overall vision of the project, provided updates on specific steps taken by the Alliance on developing a shared Polyvictimization Assessment Tool on behalf of the six sites, and included instructions on how each site could prepare to pilot the Assessment Tool at the designated time.

Following the pilot phase (March 1 to May 31, 2018), but before the implementation phase (December 1, 2018 to May 31, 2019), the FJCSC's goals dramatically shifted as several needs were identified as a result of the in-depth inquiry of client experiences associated with the Assessment Tool. Frontline staff felt that many of the needs identified by the Assessment Tool were not being met by the available services provided at the FJCSC. Clients were eager to continue their healing journeys after discussing their victimizations and receiving psychoeducation, but waitlists were long and the Center had not adequately diversified the types of services available for clients. In addition, frontline staff reported increased levels of secondary trauma and burnout as a result of holding space for the complicated, traumatic stories of clients. As a result of these findings, the goals of the FJCSC soon transitioned to prioritizing trauma-informed, hope-centered care by integrating additional holistic services outside of the traditional purview of Family Justice Centers. This shift was necessary to address the holistic needs of polyvictims and the staff interfacing with this vulnerable population.

Evaluation Goals and Role

HTA, the external evaluation and research partner, worked with the FJCSC throughout the Initiative to support all phases of the project, development of the Assessment Tool, and site level evaluation. This included participating in the process to review existing polyvictimization assessments (see section VI) and participating in quarterly Learning Exchange Team (LET) and research partner calls with the national technical assistance provider and other demonstration sites. HTA's role throughout the Initiative developed over time to also include technical assistance regarding data collection in the *Efforts to Outcomes (ETO)* platform*,* assistance with developing and implementing a short Screening Tool ("Screener"), and assistance with developing a Client ID system for data tracking, analysis, and reporting.

During the Strategic Planning Phase, the FJCSC, along with partner organizations, HTA and GPG, developed 24 learning questions (see Appendix 1), which were later revised and condensed to develop a clear and concise evaluation plan for the implementation phase. In October of 2018, HTA revised the evaluation plan to address overall changes and the clearer understanding of the implementation phase that had developed throughout and after the pilot phase. Table 2 outlines the resulting evaluation goals and questions used to guide the final implementation phase.

Table 2. Final Evaluation Goals and Questions.

Evaluation Goal	Evaluation Questions
Goal 1. Develop a short polyvictimization Screening Tool.	N/A
Goal 2. Evaluate the implementation and use of the Polyvictimization Screening and Assessment tools during the project period.	1. What training did frontline staff receive to administer the Assessment Tool? 2. Is it perceived to be sufficient for successful implementation by frontline staff? 3. Do frontline staff and program administrators understand the vision/purpose of the Screener and how the collected data is to be used? 4. What is the value of using a Polyvictimization Assessment Tool during intake? 5. How are the Screener and Assessment Tool perceived by clients? What is the perceived value of the Assessment Tool by clients?
Goal 3. Evaluate the clientele of the Family Justice Center Sonoma County.	1. What is the prevalence of polyvictimization among clients at the FJC Sonoma County? 2. What is the demographic profile of clients experiencing polyvictimization? Does this profile differ from other clients of the Family Justice Center? 3. What is the prevalence of victimizations, traumatic events, and symptoms among polyvictims? 4. Did hope and empowerment among clients change over the project period?
Goal 4. Assess the expansion of strategies and coordinated services for serving polyvictim clients in Sonoma County.	1. What services/referrals are clients provided? Do these differ between polyvictim and non polyvictim clients? 2. What is the level of client satisfaction with services received? 3. Has the use of a polyvictimization Assessment Tool changed what resources are offered to clients? How? 4. What additional or alternative resources do polyvictim clients in Sonoma County need compared to other clients? 5. What are the gaps in services for polyvictim clients in Sonoma County? 6. What strategies have been proposed to better serve polyvictim clients? 7. What is the potential impact of these proposed strategies on polyvictim clients' outcomes?

Client Mapping Process

To better plan out the implementation of the Polyvictimization Assessment Tool, HTA and the FJCSC Project Coordinator determined that it was necessary to better understand how clients enter and receive services from the FJCSC. To this end, HTA facilitated a client flow mapping process starting in July 2017. It began with a series of one-on-one phone calls or in-person meetings with representatives from the FJCSC and partner organizations, during which the informant would outline the sequence of steps that staff take with each client from intake to completion of service with their particular organization. During this conversation, the "touchpoints" where clients were provided a warm hand-off or referral to another organization were documented, as well as the type and frequency of data (quantitative and qualitative) that was gathered at each step. Quantitative data on the number of individuals who had been processed at the FJCSC was also compiled from internal databases and partner organization records, and analyzed for patterns.

A summary of this client flow information was then presented by HTA at a Strategic Planning meeting held with partner organizations at the FJCSC on August 8, 2017. As the client pathway flowcharts were presented, feedback and corrections were solicited from the participating members. Members actively discussed what the data revealed about the FJCSC client base, how they were passed through the system, and implications for implementation of the Polyvictimization Assessment Tool. This meeting revealed the following areas needing to be addressed in order to move forward with the implementation of a polyvictimization framework:

- Many individual client assessments conducted by partner organizations were not being entered into the FJCSC *ETO* database. As a result, other partners could not benefit from what was being learned, and/or clients were being repeatedly asked the same questions.
- The FJCSC intake forms were hard to complete, as they were printed out on paper with very small boxes for data entry. Subsequently, clients were leaving items blank and/or intake personnel were skipping over illegible entries. The forms also did not allow for details on polyvictimization.
- Clients were being prompted to complete forms by themselves and service providers were not checking that the forms were being completed in full.
- Some clients were illiterate and/or non-English/Spanish speakers, and translations or alternative versions of the forms were not being provided to collect data from these clients.
- Some clients were afraid to complete forms due to immigration concerns, and alternatives were not being provided to collect data from these clients in an anonymous and safe way.
- Partner organizations agreed that clients should not be asked to self-complete a Polyvictimization Assessment Tool, as it could further traumatize the individual.
- Partner organizations agreed that the main intake form should be more general in nature followed by a more in-depth intake, which would include trained personnel administering the Assessment Tool once clients entered the secure

and safe “Nest” of the Center. It was also agreed upon that there should be flexibility in completing the Assessment Tool items over time as the client built a relationship with the service provider(s) and had their acute issues addressed.
- Partner organizations expressed the need for development of outreach and tailored service provision for individuals who “screened in” as polyvictims. At the time of the meeting, no such services existed in a consistent way.
- For the most part, follow-up services are client driven, meaning that clients who returned for additional visits or services for the same victimization did so of their own volition and were not necessarily prompted by staff to do so.

Following the meeting, HTA worked with the coordinator to create a one page summary graphic of client flow through FJCSC with accompanying data collection points and decisions. A copy is included in Appendix 2. Based on the process and development of a client flow chart, the following determinations were made:

- Polyvictimization Assessment Tools would be completed in the Nest with clients, and over multiple sessions (either in one day or across multiple visits to the FJCSC) with more than one staff member if necessary.
- The intake forms and coinciding data entry portion of the *ETO* database were updated to be clearer, more readable, and to include only necessary information.
- As follow-up services are primarily client driven, staff continued to explore the need for integration of a case management system.

Tool Development and Implementation

Reviewing and Developing Assessment Tools

An Assessment Tool subcommittee formed from the larger Strategic Planning committee gathered for a 90-minute work session at the FJCSC on August 18, 2017, with the goal of recommending three screening tools from a detailed list provided by the Alliance, along with their reasons for selecting these tools and not others. The subcommittee consisted of five victim advocates/navigators, one researcher, and the project coordinator. Prior to the meeting, all of the tools were sent out to the Assessment Tool subcommittee and each member was assigned an average of five to six tools to evaluate and present to the group. All Assessment Tools were thoroughly evaluated using an evaluation rubric by at least two people prior to the work session.

During the work session, the group agreed that the main goal of implementing any Screener or Assessment Tool at FJCSC was to better inform service providers in their work with clients. The group discussed how individuals will have varied responses to traumatic events, and that there could be risks of “re-traumatizing” or causing further harm to an individual by asking them to discuss past events of trauma when they are seeking services related to a specific and recent episode of violence. Therefore, it was decided that, for whichever tool they would recommend, the timing and the method of delivery of the Assessment Tool was critical. The group proceeded to present summaries and conclusions on each of the evaluated Assessment Tools in a round-robin fashion. Most feedback was related to the length of the Assessment Tool (brevity

was preferred, especially by advocates/navigators), the openness of questions in terms of being able to facilitate a discussion, and whether or not someone who was not a clinician could administer the Assessment Tool. Group members, most of whom provide direct services to clients, preferred the Assessment Tools that focused on symptoms rather than past traumas, as knowledge of extent and severity of symptoms was "actionable," whereas knowledge of past traumas was "interesting to know."

The group chose the top three assessment instruments to recommend to the Alliance by an almost unanimous vote: the PCL-C (Weathers et al, 2013), the NSLIJHS Trauma History Checklist and Interview (North Shore-Long Island Jewish Health System, 2006), and the Polyvictimization/ Trauma Symptom Checklist (Pilnik & Kendall, 2012). Based on discussion and the client mapping process, the group recommended that the Assessment Tool be administered at the FJCSC in two phases to ease the burden on both client and staff: 1) a symptoms section could be self-administered at intake in the front lobby, and 2) a trauma history section would be administered during the initial interview by the FJCSC Navigator. In addition, the group identified a specific need to include past events about homelessness, family separation, and deportation, given the special importance of these issues in Sonoma County. Ultimately (and as described below) due to the inclusion of a short Screener administered at intake, further discussion with frontline staff, and the final determination that the Alliance would create a Polyvictimization Assessment Tool, administration of the Assessment Tool did not happen in two distinct parts but rather over time by multiple staff members.

Piloting the Assessment Tool

Pilot Process

Through the quarterly LET calls with the Alliance and five other participating demonstration sites, it was determined that each site would select one or two frontline staff to begin piloting the Assessment Tool within an intake setting. FJCSC designated the two, navigators to be responsible for piloting the Assessment Tool with clients who were not in crisis upon their visit to the FJCSC. Based on client numbers and visits reported at the beginning of the Initiative, the Alliance requested that the FJCSC complete a minimum of 25 Assessment Tools over a three-month period (12 of which were to be completed with clients new to the FJCSC, and 13 to be completed with clients returning to the FJCSC). The navigators familiarized themselves with the Assessment Tool through concentrated review and mock interviews.

Navigators incorporated the Assessment Tool into client intake as a guide for conversation in concurrence with service delivery. If a client was receptive to conversation regarding their life experiences and symptomology beyond the scope of typical service delivery, navigators introduced the Assessment Tool to the client and asked their permission to continue. The navigators completed the Assessment Tool itself at a later time using the information gathered over the course of the intake. If the client consented to information sharing amongst partners, navigators would complete the Assessment Tool after gathering data from other agencies that provided services to the client. Navigators also made follow-up calls to clients to complete the remaining questions when necessary.

Each site was given the option of utilizing a paper or electronic version of the tool. The FJCSC found success utilizing the paper version, as it was more accessible throughout the intake for FJCSC navigators to use as a guide.

Pilot Research Findings

In total, the two FJCSC navigators completed pilot Assessment Tools with 25 clients. Navigators worked with clients individually to complete an Assessment Tool. On average, it took two sessions to complete the Assessment Tool with clients, and 48% of the clients were new to the FJCSC. As the most complete data on the Assessment Tool fell into the "in the last year" category, the analysis focused only on this time period. Clients experienced an average of 13.28 events and 12.24 symptoms in the last year. The top five most prevalent events experienced by clients in the last year were:

- Fear of physical violence (92%)
- Assault/battery by parent, caregiver, partner, or relative (84%)
- Emotional or verbal abuse by parent, caregiver, partner, or relative (83%)
- Justice system involvement of the client or a family member (74%)
- Financial abuse / Stalking or inappropriate pursuit by partner, friend, etc. (tied at 71%)

Lessons Learned from the Pilot Phase

Several lessons were learned by the FJCSC staff and navigators as a result of the pilot phase:

1. Clients reported feeling eager to tell their stories and were empowered by the opportunity to talk about their trauma.
2. Returning client visits rose by 35% compared to the same time period in 2017, though it is unknown whether this was directly related to the pilot phase or due to other factors.
3. Building a strong rapport with clients was necessary to begin and complete the Assessment Tool in a trauma-informed manner.
4. The intake process became longer when administering the Assessment Tool, which led to longer client wait times and an added burden for navigators. Therefore, staff determined that the Assessment Tool should not be confined only to intake, but should be completed using a team based approach and/or at other points of service delivery.
5. Administration of the Assessment Tool resulted in deeper relationships between staff and clients.
6. Navigators reported an increase in secondary trauma symptoms and increased feelings of burnout, also expressing that increased agency/leadership buy-in and knowledge of the project would have led to more support and less secondary symptoms.
7. Navigators and clients identified a need for a full-time trauma-informed receptionist, a wider range of resources and healing modalities, increased

hours for the onsite mental health practitioner, ongoing client support through community building activities, and additional Spanish-speaking bilingual staff and services.

Implementation of the Polyvictimization Screening and Assessment Tools

Staff Training

Seven staff were trained on the use of the revised Assessment Tool before the implementation phase began in December 2018. Training consisted of presentations by the Polyvictimization Grant Coordinator, webinars, and mock interviews using the Assessment Tool. Topics covered included overviews of polyvictimization and an introduction to the Assessment Tool. As the implementation phase progressed, continuous training came in the form of weekly group check-ins, additional webinars on polyvictimization related topics, and a one-day Hope Training with Dr. Chan Hellman, Professor of Social Work and Director of the Hope Research Center at the University of Oklahoma, who is also the Polyvictimization Initiative National Research Partner with the Alliance.

In a series of group and individual interviews, frontline staff reported feeling that the training they received was sufficient in order to use the Assessment Tool with clients, though some staff would have liked additional trainings or webinars on practical topics such as domestic violence or strangulation, even as a refresher. Many staff members found the weekly check-ins to be helpful as they provided a space to learn from their colleagues, trade tips on how to best administer the Assessment Tool, and provide case consultation when needed. Staff reported that the Hope Training with Dr. Hellman was especially useful, as it provided staff with more context for why considering polyvictimization is important to the work they do; however, they also expressed that they would have preferred to receive this training before or earlier in the final implementation phase. Finally, in addition to formal training, staff reported that simply using the Assessment Tool with clients over time aided in their increased level of comfort with the Assessment Tool.

Development and Implementation of the Screening Tool

Concern across all six demonstration sites regarding the length of the Assessment Tool, the increased burden on staff members, and the lack of a systematic way to quickly filter out clients who were not polyvictims led to the decision that each site should have a short Screening Tool (“Screener”) designed specifically to meet the needs of that site.

Results from the pilot Assessment Tool data were used to inform the development of a Sonoma County specific short Screener to identify potential polyvictims. Statistical correlations between event items were assessed in conjunction with their prevalence in order to determine which questions would be more likely to capture additional events over the course of a client’s life. For example, among the pilot participants, “Assault/battery by parent, caregiver, partner, or relative” was highly correlated with

"Fear of physical violence,"[1] "Financial Abuse,"[2] "Justice-system involvement of the client or a family member,"[3] and other items. Therefore, given the significant correlations and high prevalence of this item, assault/battery was included on the short Screener with the idea that a client who responds "Yes" to this question on the short Screener will likely have experienced other events as well. In addition to using the pilot Assessment Tool data, qualitative data based on the navigators' experiences conducting assessments during pilot testing, as well as their general knowledge of the FJCSC client population, informed decision making around Assessment Tool items. Finally, due to the recent history of fires in Santa Rosa, California, a question regarding experiencing manmade or natural disasters was added to the Screener.

The final FJCSC Screener (see Appendix 3) consisted of seven event questions that are a mix of victimizations and adverse life events. It was included in the intake packet that clients complete upon arrival at the FJCSC and was self-administered. Clients could respond "Yes," "No," or "Decline answer." Clients who screened in as possible polyvictims were eligible to complete the full Assessment Tool if they met either of the screening criteria (see Table 3 below) or if a staff member determined the client to be a polyvictim at a later point in time. Criteria for screening an established polyvictimization threshold was determined based on conversations with other Initiative sites and on staff knowledge of the FJCSC clientele. However, 19 days into the implementation phase, the screening criteria needed to be revised (see Table 3 below), as almost 100% of clients were screening in based on the initial criteria.

Table 3. Initial and Revised Screening Criteria.

Initial Screening Criteria *Used December 1 – December 18, 2018*	**Revised Screening Criteria** *Used December 19, 2018 – May 31, 2019*
Criteria #1: The client answered "Yes" to any three of the screening questions. **Criteria #2:** The client answered "Yes" to one of the following questions and any one other screening question: 1) Have you ever experienced any physical harm or assault? Or 4) Have you ever experienced any type of sexual abuse? Or 5) Have you ever felt threatened? **Post-Screener determination:** Client did not screen in using criteria #1 or #2, but you (the navigator) have determined that the client may be a polyvictim based on conversations with the client.	**Criteria #1**: The client answered "Yes" to any **four** of the screening questions. **Criteria #2**: The client answered "Yes" to one of the following questions and any **two** other screening questions: 1) Have you ever experienced any physical harm or assault? Or 4) Have you ever experienced any type of sexual abuse? Or 5) Have you ever felt threatened? **Post-Screener determination**: Client did not screen in using criteria #1 or #2, but you (the navigator) have determined that the client may be a polyvictim based on conversations with the client.

[1] Pearson correlation=0.798, p<0.01

[2] Pearson correlation=0.697, p<0.01

[3] Pearson correlation=0.519, p<0.05

Implementation of the Assessment Tool

Upon screening in and starting the FJCSC navigation service process, clients were informally assessed by navigators in the Nest to determine if administering the full Polyvictimization Assessment Tool would be appropriate. Many clients coming to the FJCSC are in immediate crisis and therefore starting an Assessment Tool before their immediate needs have been met would not be the appropriate course of action. For clients not in crisis, navigators used their initial conversation to build rapport and lay the groundwork for beginning the full Assessment Tool. Navigators used their clinical judgement to determine which clients would benefit from the Assessment Tool and, if the client was amenable, navigators reviewed the Polyvictimization Initiative consent forms with them. Some clients who did not complete a Screener were later determined to likely be polyvictims and were therefore asked if they wanted to participate in the Initiative by navigators.

After clients gave consent, navigators began the Assessment Tool during the initial client interview. Most navigators used the Screener as an initial jumping off point for what to ask the client about and then continued with other Assessment Tool questions from there. Navigators tended to weave the Assessment Tool questions into the conversation and fill in the Assessment Tool retrospectively, though some reported keeping the Assessment Tool with them during the conversation as a reference point. Based on the lessons learned from the pilot phase, Assessment Tools were not necessarily completed by one staff member, but followed the client through their service delivery flow at the FJCSC. As clients met with partner organizations, those staff would add to the Assessment Tool until it was complete.

Assessment Tool Implementation and Service Delivery

> "[The assessment tool] has actually helped a lot because I get to learn more about their story, not specifically just one case or one incident and so it makes me, it actually pushes me to provide them with better services or the most services needed."
>
> ***- FJCSC Partner Staff***

Staff reported that both the Screener and Assessment Tool enhanced their rapport building and service delivery with clients. Staff continued to provide the appropriate services for a client's primary victimization (that which they came to the FJCSC to address), but also learned about other needs a client had through their Screener and Assessment Tool responses. Staff all reported that the Screener and Assessment Tool helped them learn history and context about clients that they otherwise would not and offer them additional services, thus beginning the intended FJCSC shift from crisis intervention to holistic service provision.

Given that the vast majority of clients completing a Screener screened in as a possible polyvictims (91%, also see the Results section), the Screener did not completely serve its intended purpose of helping staff determine which clients with whom to start an Assessment Tool. However, the Screener served another valuable purpose. The majority of frontline staff reported using the Screener as a guide to help open up conversation with the client. Almost all new clients completed a Screener, but

significantly fewer completed an Assessment Tool. Therefore, with most clients, staff had only the screening tool to use when working with a client. A client's Screener results pointed staff to ask about experiences that the client may not bring up in conversation, helping staff determine client needs for service delivery outside of the primary victimization-related needs.

Similarly, for those clients completing an Assessment Tool, navigators were able to use their conversations with the client, as well as subsequent Assessment Tool results, to discover needs that may not have been otherwise identified. Staff reported that the Assessment Tool provided them with a more holistic understanding of the client's experience and needs. In addition, clients expressed positive feedback regarding their experiences with the Assessment Tool. Though it was challenging for some clients to think about so many negative life events, it also validated their experiences, helped them identify and highlight events in their lives that they may not have previously considered victimizations/adverse events, and opened the door to discussions about how past experiences affect them now and into the future.

> "There was one client in particular who was really intrigued by the [Assessment Tool] questions…that we were talking about, and who after having gone through them, she kind of put the dots together and realized that she needed to go back to therapy because she had stopped going to therapy. But after doing the tool she actually said that the wanted to go back to therapy and really does need it."
>
> ***- FJCSC Partner Staff***

In response to lessons learned from the pilot phase of the Initiative, the FJCSC added a variety of holistic service providers to the Center during the implementation phase. The intention was for clients to have the opportunity to access additional healing opportunities, especially after recalling traumatic events or symptoms while completing the Assessment Tool. The Center developed monthly Empowerment Groups that included yoga in each meeting, as well as onsite Reiki and massage therapy, coping skills groups, parenting workshops, and increased hours for the onsite Licensed Marriage and Family Therapist. During the implementation phase, referrals for these services were targeted towards clients who completed an Assessment Tool, though some other clients participated as well. The roll-out of these "polyvictim services," as they are referred to for the purposes of this Initiative, began late in the implementation phase, but the Center plans to continue offering them post-Initiative.

Benefits of Using the Assessment Tool

- Overall, staff reported having positive experiences using the Assessment Tool with clients.
- The Assessment Tool validated client experiences and helped the client make valuable connections between their lifetime experiences and symptoms.
- The Assessment Tool gave staff additional and deeper perspective on the client's experience and needs.
- The symptoms portion of the Assessment Tool helped lead staff to provide psychoeducation and coping skills to clients, and helped them better determine the level of need for the limited onsite counseling.
- Passing the Assessment Tool between partners strengthened relationships amongst staff and provided space for them to discuss cases and service delivery.

Challenges with Using the Assessment Tool

- The Assessment Tool could be time consuming, creating an additional burden for navigator and other FJCSC staff.
- It took time for staff to acclimate and become comfortable with using the Assessment Tool.
- Asking about past events can be hard for clients, even if they see it as beneficial in the end. Staff struggled with resource constraints that made them unable to provide immediate counseling to clients who needed it.

> "We're here to walk the path with you and to help you in whatever you need to be successful, whatever that looks like. So, doesn't the Tool give us that ability to look at what they need and help them be successful? ... That Tool has allowed us to look at people's needs and help them be successful based on their life experience… That's actually how I do think about it."
>
> ***– FJCSC Partner Staff***

Results

Evaluation and Research Methods

Evaluation Data Sources

The following data sources were analyzed in order to evaluate the Polyvictimization Demonstration Initiative at the FJCSC:

1. *Efforts to Outcomes (ETO) platform*: Programmatic data on client demographics, referrals provided, and services received was pulled from the *ETO* database for all clients (Initiative participants and non-participants) who received services during the implementation phase (December 1, 2018 – May 31, 2019).
2. *FJCSC Polyvictimization Screening Tool ("Screener")*: See section VI for further description of this tool.
3. *Polyvictimization Assessment Tool ("Assessment Tool")*: The full Polyvictimization Assessment Tool, as developed during the Initiative, which tracks: 1) victimizations and adverse life events experienced during childhood (0-17 years), adulthood (18+ years), and within the last year; and 2) symptoms experienced during childhood (0-17 years), adulthood (18+ years), within the last year, and currently (at the time of assessment).
4. *Staff Interviews*: During final implementation, the research and evaluation team conducted two sets of interviews with frontline FJCSC staff, including navigators and other partner staff responsible for completing the Assessment Tool with clients. In February of 2019, seven staff members were interviewed by HTA and

the Alliance, and in May of 2019, six staff members were interviewed by HTA. Staff were asked about the following:

   a. Training received and additional training needs;
   b. Experience using and perceived value of the Screener;
   c. Experience using and perceived value of the Assessment Tool;
   d. Perceived impact of the Screener and Assessment Tool on service delivery; and
   e. Feedback received from clients about the Screener and Assessment Tool.

5. *Client Focus Groups*: HTA conducted three focus groups with clients who had completed the Assessment Tool. In January/February 2019, an English (three clients) focus group and a Spanish (one client) focus group were conducted with clients who participated during pilot testing. In June 2019, an English focus group (two clients) was conducted with clients who participated during final implementation. Additional clients were invited to each of the focus groups, though many were unable to attend. Clients were asked about the following:

   a. General experience at the FJCSC;
   b. Experience completing and perceived value of the Screener *(June focus group only)*;
   c. Experience completing and perceived value of the Assessment Tool; and
   d. Perceived impact of the Assessment Tool on service delivery and other feedback on services or referrals received.

6. *FJCSC Documents*: Institutional and program documents, such as the original grant application, reports, and meeting notes were reviewed in order to evaluate the process of implementing a polyvictimization framework at the FJCSC.
7. *Professional Quality of Life Scale (*ProQOL; Hundall Stamm, 2010): The ProQOL is a self-administered, 30-item scale that measures two elements of secondary or vicarious trauma: Compassion Satisfaction and Compassion Fatigue (broken into two parts: Burnout and Secondary Traumatic Stress). The scale was completed by FJCSC frontline staff in November 2018 (before implementation began) and June 2019 (after implementation was complete).

Analyses

Consistent with the use of mixed methods, a variety of analyses (both statistical and non-statistical) were employed to answer the evaluation questions. The choice of analysis primarily depended on whether quantitative or qualitative data was examined, as well as the specific question being addressed. For quantitative data, frequencies, chi-square tests, and Pearson correlations were the most often used analyses. Statistical analysis included the calculation of *p*-values, which is used to ensure, as much as possible, that the finding is not due to chance. For these analyses, a *p*-value of 0.05 or less was considered to represent a statistically significant finding, or whether the

difference has any practical or theoretical significance. The following guidelines were used to interpret the strength of statistically significant Pearson correlation values:

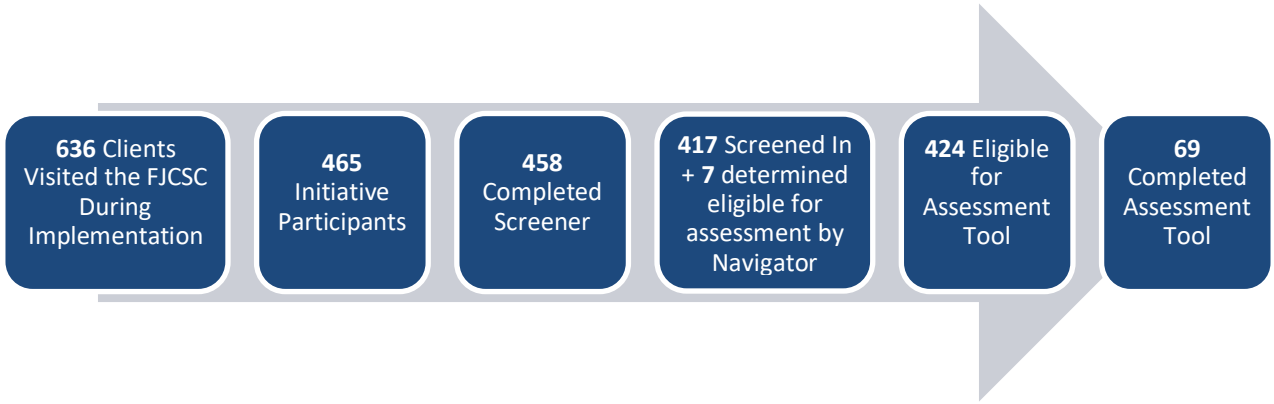
- (+/-)0.10 to (+/-)0.29 = weak;
- (+/-) 0.30 to (+/-)0.49 = medium;
- (+/-)0.50 to (+/-)1.0 = strong (Cohen, 1988).

Qualitative data was analyzed inductively for common themes. Quotes were also pulled out from interviews to highlight themes found throughout the data.

Specific to the Polyvictimization Assessment Tool, responses were considered "valid," and therefore included in the prevalence results and other analyses, if the client responded either "yes" or "no" to the event or symptom item. Responses of "client did not respond", "user [the staff member] did not ask due to time constraints or other limitations", "user did not ask as it was not appropriate to ask", and items left blank were coded as missing in the dataset. For all results, total sample size (N) is reported.

For the ProQOL, data was coded following instructions from the ProQOL Manual (Stamm, 2010) and mean scale scores for the three subscales, rather than sum scores were calculated in order to account for missing data. Significant differences in mean scores from pre to post were determined using paired t-tests, and Cohen's *d* was calculated to determine effect sizes.

Polyvictimization Initiative Participation Overview



In total, the FJCSC served 636 clients from December 1, 2018 to May 31, 2019 (the Initiative implementation phase). Four hundred and sixty-five of those clients participated in the Polyvictimization Initiative through completing a Screener (458 clients) and/or completing an Assessment Tool after a staff member determined their eligibility (69 clients). Of those 458 clients who completed the Screener, 417 (91%) screened in using the criteria outlined in section VI, and 7 additional clients who did not complete a Screener were determined through clinical judgement by a navigator to potentially be polyvictims and therefore eligible for the Assessment Tool. In total, 424 clients were eligible to complete the Assessment Tool, of which 69 (16%) did.

Multiple groups of FJCSC clients were considered when analyzing the data:

- Initiative non-participants: clients who came to the FJCSC for services during the implementation phase, but did not complete a Screener or Assessment Tool.

- All Initiative participants: clients who came to the FJCSC for services during the implementation phase who completed a Screener and/or Assessment Tool
- Participants screening out: clients who completed a Screener, but were determined to not be potential polyvictims using the screening criteria (described in section IV)
- Participants screening in: clients who completed a Screener and were determined to be potential polyvictims using the screening criteria (described in section IV), and therefore eligible for the Assessment Tool
- Eligible participants with no Assessment Tool: clients who screened in as a potential polyvictim, but did not complete an Assessment Tool
- Participants Completing Assessment Tool: clients who completed the full Assessment Tool

Client Demographics

Table 4 shows the demographic characteristics for clients not participating in the Polyvictimization Demonstration Initiative, clients participating in the Initiative, clients who screened in and out using the Screener, clients who completed the Assessment Tool, and eligible clients who did not complete the Assessment Tool.

In total, 465 clients participated in the Polyvictimization Initiative by completing a Screener and/or a full Polyvictimization Assessment Tool. The average age of participating clients was 40 years old. Eighty-four percent (84%) of participating clients identified as female and 16% identified as male. The majority of clients identified as white (52%), with the second most common race/ethnicity being Hispanic/Latinx (33%). Over half (55%) of clients reported a household income of less than $20,000 per year. One fifth (20%) of clients reported Spanish as their primary language. Though likely an under-representation due to underreporting, 14% of clients identified as an immigrant, refugee, or asylum seeker. One quarter (23%) of clients reported having a disability. Over half (55%) of clients had a child or children under the age of 18, and 18% of clients had minor children with them at the Family Justice Center on the day of their intake visit. Almost half (42%) of clients were single at the time of intake (not shown in table). Just 4% of clients identified as LGBTQ.

There were some statistically significant demographic differences between clients who screened in and screened out as potential polyvictims. **A higher proportion of clients who screened in were female, had a disability, or reported English (rather than Spanish) as their primary language.**

There were also statistically significant demographic differences between those eligible participants with no Assessment Tool and participants who completed an Assessment Tool. **A higher proportion of those with a completed Assessment Tool had a disability or identified as an immigrant, refugee, or asylum seeker.**

Table 4. Demographic Characteristics of Polyvictimization Participants and Non-Participants

Demographic Characteristic		Initiative Non-Participants (N=171)	All Initiative Participants (N=465)	Participants Screening Out (N=41)	Participants Screening In (N=417)	Eligible Participants with no Assessment (N=355)	Participants Completing Assessment (N=69)
Average Age (mean years)		41	40	41	40	40	42
Gender	Female	79%	83%	71%	84% *[4]	83%	90%
	Male	21%	16%	29%	15%	16%	9%
	Missing	0%	1%	0%	1%	1%	1%
Race/ Ethnicity	Native American/Alaska Native	3%	3%	0%	3%	3%	3%
	Asian/Pacific Islander	5%	3%	7%	2%	2%	3%
	Black/African American	5%	2%	2%	2%	2%	3%
	Hispanic/Latinx	41%	33%	61%	31%	30%	35%
	Multi-Racial	1%	2%	0%	2%	2%	1%
	White	41%	52%	24%	55%	56%	51%
	Other	4%	2%	2%	2%	2%	3%
	Missing	1%	3%	2%	3%	3%	1%
Household Income	$0-$20,000	56%	55%	37%	57%	55%	65%
	$20,000-$35,000	11%	11%	17%	10%	10%	13%
	$35,000-$50,000	8%	8%	7%	8%	8%	9%
	$50,000+	4%	9%	15%	9%	10%	1%
	Missing	21%	17%	24%	16%	17%	12%
Primary Language	English	71%	77%	46%	82% *[5]	82%	78%
	Spanish	26%	20%	54%	17%	17%	20%
	Other	3%	0%	0%	0%	0%	0%
	Missing	0%	2%	0%	1%	2%	1%
Client Has a Disability		22%	23%	7%	25% *[6]	22%	38% *[7]
Client is Pregnant		1%	3%	2%	3%	3%	3%
Client Has Minor Child(ren)		60%	55%	49%	55%	56%	51%
Minor Child(ren) were with Client at FJCSC		21%	18%	15%	18%	18%	17%
Client Identifies as LGBTQ		2%	4%	2%	4%	3%	6%
Client is an Immigrant, Refugee, or Asylee		15%	14%	24%	13%	12%	22% *[8]

Source: FJCSC *Efforts to Outcomes* platform, December 1, 2018 – May 31, 2019

Note: Percentages may not add up to 100% due to rounding. The following groups were compared for statically significant differences on demographic characteristics: Initiative Non-Participants and Participants; Participants Screening In and Out; Eligible Participants Completing and Not Completing an Assessment. Statistically significant differences between groups at the $p<0.05$ level are noted with an asterisk (*).

[4] Chi-Square (χ^2) = 4.5, p=0.03
[5] $\chi^2 = 28.63$, $p<0.001$
[6] $\chi^2 = 4.3$, p=0.04
[7] $\chi^2 = 5.9$, p=0.02
[8] $\chi^2 = 8.1$, $p<0.001$

As seen in Table 5, **the vast majority of Polyvictimization Demonstration Initiative participants (71%) reported domestic violence as their primary victimization or reason for seeking services at the FJCSC, while only 60% Initiative non-participants reported domestic violence as their primary victimization.** When comparing clients who screened in and screened out, domestic violence continues to be the most prevalent primary victimization, though far less so for clients who screened out. While not the only indicator of need, understanding a client's primary victimization is a key piece of information for staff in determining client needs and appropriate services.

Table 5. Primary Victimization of Polyvictimization Initiative Participants and Non-Participants

Primary victimization	Initiative Non-Participants (N=171)	All Initiative Participants (N=465) *[9]	Participants Screening Out (N=41)	Participants Screening In (N=417)	Eligible Participants with no Assessment (N=355)	Participants Completing Assessment (N=69) *[10]
Domestic Violence	60%	71%	51%	73%	73%	70%
Sexual Assault	12%	9%	17%	8%	7%	13%
Elder Abuse	8%	9%	15%	8%	7%	15%
Stalking	5%	4%	7%	4%	5%	0%
Other	12%	4%	5%	4%	4%	1%
Missing	3%	4%	5%	3%	4%	1%

Source: FJCSC *Efforts to Outcomes* platform, December 1, 2018 – May 31, 2019; Polyvictimization Screening Tool, December 1, 2018 – May 31, 2019

Note: "Other" encompasses the reasons for visiting the FJCSC: civil harassment, custody, homelessness, and others. Percentages may not add up to 100% due to rounding. The following groups were compared for statically significant differences: Initiative Non-Participants and Participants; Participants Screening In and Out; Eligible Participants Completing and Not Completing an assessment. Statistically significant differences between the groups at the $p<0.05$ level are noted with an asterisk in the column header (*).

In total, one fifth (20%) of Initiative participants were returning clients (see Figure 3), meaning that they had come to the Family Justice Center for services prior to the start of the six-month implementation phase (December 1, 2018). **This prevalence increases when considering only those who completed an Assessment Tool, with 36% of these clients having visited the FJCSC prior to implementation, compared to only 17% of eligible participants with no Assessment Tool.**[11] Whether a client was new to the FJCSC or not, could have played a factor in whether they completed an Assessment Tool. Given that the vast majority of clients screened in as potential polyvictims, making them eligible to complete the full Assessment Tool, staff had to use

[9] $\chi^2 = 19.05$, $p=0.001$

[10] $\chi^2 = 10.19$, $p=0.04$

[11] $\chi^2 = 11.81$, $p=0.001$

clinical judgment to help them decide with whom to start an Assessment Tool. Staff may have been able to build rapport more easily with returning clients than with new clients. The importance of building a relationship with clients was reflected in staff interviews where they identified it as a key factor in whether they chose to complete an Assessment Tool with a client.

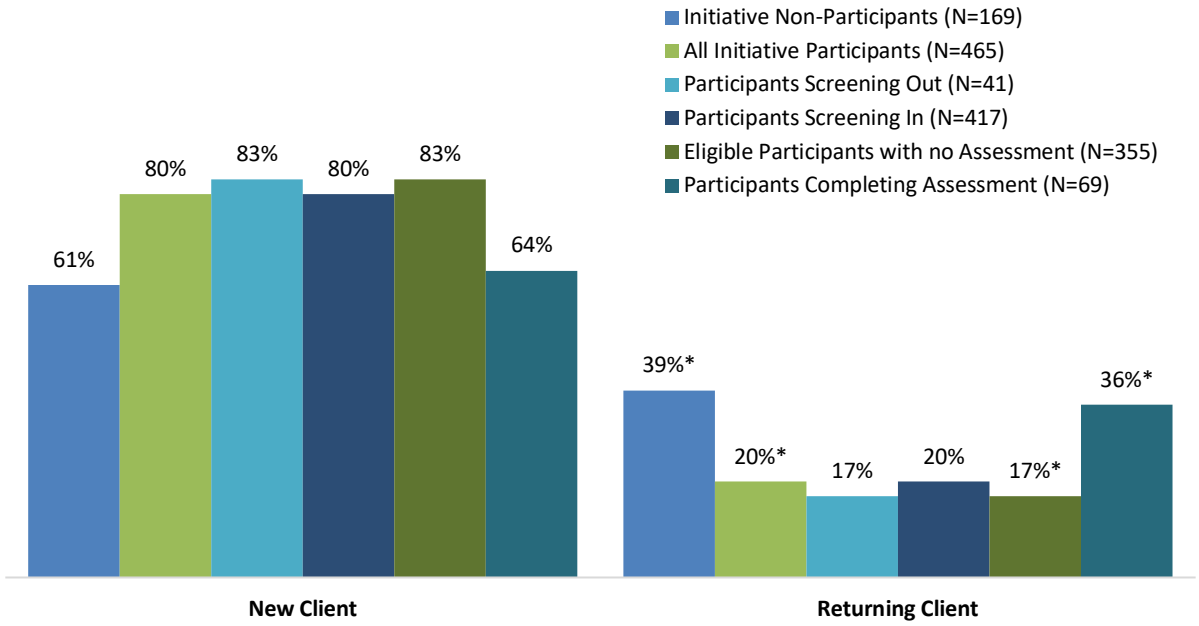


Figure 3: Returning and New Client Status of Participants and Non-Participants

Source: FJCSC *Efforts to Outcomes* platform, December 1, 2018 – May 31, 2019

Note: Percentages may not add up to 100% due to rounding. The following groups were compared for statically significant differences: Initiative Non-Participants and Participants; Participants Screening In and Out; Eligible Participants Completing and Not Completing an assessment. Statistically significant differences between the groups at the p<0.05 level are noted with an asterisk (*).

As can be seen in Figure 4 below, **only one third (38%) of Polyvictimization Demonstration Initiative participants returned to the FJCSC for more than one visit during the six-month implementation phase. However, when considering the subset of participants who completed an Assessment Tool, the percentage who returned for two or more visits to the FJCSC increases to 64%**, and is a statistically significant difference compared to those eligible participants who did not complete an Assessment Tool.[12] Staff reported building strong relationships with and learning more about clients who completed an Assessment Tool. This may be associated with clients returning for more follow-up, though we do not know what other factors influenced these clients to return multiple times to the FJCSC throughout the implementation phase.

[12] $\chi^2 = 20.96$, $p<0.001$

The average number of visits to the FJCSC during the implementation phase was 1.30 for Initiative non-participants, 1.38 for all Initiative participants, 1.37 for participants who screened out, 1.76 for participants who screened in, 1.65 for eligible participants with no Assessment Tool, and 2.38 for eligible participants with a completed assessment.

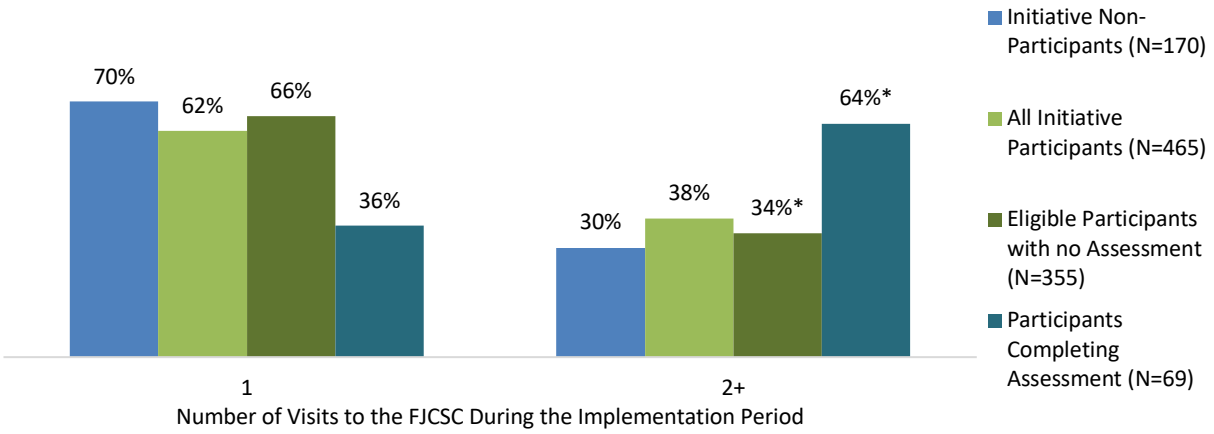


Figure 4. Number of Visits to the FJCSC During the Implementation Phase (December 1, 2018 – May 31, 2019)
Source: FJCSC *Efforts to Outcomes* platform, December 1, 2018 – May 31, 2019

Polyvictimization Screener

The significant majority (91%) of the 458 participants who completed a Screener at intake screened in as potential polyvictims using the criteria described in a previous section. Though frontline staff reported being unsurprised by this high prevalence, having this concrete number reinforces and supports patterns that staff see every day with clients. Table 6 shows the percentage of participants who said "Yes" to each Screener question – first, amongst all who completed a Screener and, second, amongst only those who screened in.

The most skipped questions on the Screener were "natural and manmade disasters" (32 skipped) and "experienced long-term loss" (28 skipped). Staff reported that some clients had difficulty understanding what a "natural or manmade disaster" refers to and would have benefited from a clearer phrasing and/or examples on the Screener. This finding led to an adjustment on the Screener after the implementation phase so that clarification and examples are now provided on the Screener for the question regarding natural or manmade disasters.

Table 6. Participant Responses to Screening Tool Items

Screening Tool Item	All with a Completed Screener		Participants Screening In	
	N	%	N	%
Ever experienced any physical harm or assault	445	76%	408	82%
Ever experienced any type of emotional or verbal abuse	454	93%	417	97%
Ever experienced any natural or manmade disasters	433	51%	397	54%
Ever experienced any type of sexual abuse	446	49%	407	54%
Ever felt threatened	449	91%	411	97%
Ever experienced the long-term loss of someone close to you	437	68%	403	71%
Ever experienced any financial difficulties	447	86%	412	89%

Source: Polyvictimization Screening Tool, December 1, 2018 – May 31, 2019

Note: In this table, N represents the number of clients who responded to the item on the Screening Tool, and the percentage is a valid percent.

Polyvictimization Assessment Tool

A total of 69 of the 424 eligible Initiative participants completed an Assessment Tool with frontline staff. Slightly more than half (57%) of the assessments were completed by one staff member, and a quarter by two staff members (28%). On average it took 1.74 sessions to complete the full Assessment Tool, with half (51%) the clients completing it in one session.

The minimum, maximum, and average number of event types and trauma related symptoms experienced at each time period is shown in Table 7. Given that the Assessment Tool asks participants about whether they experienced an event type during the time period, not the number of times they experienced that event, we are able to report only on the number of event types. Therefore, this data captures the number of event **types** experienced, rather than the total number of individual events experienced (for example, if an event was experienced more than once during a time period).

On average, clients experienced 15.93 event types at least once over the course of their life, and 10.68 event types within the last year. At the time of completing the Assessment Tool (labeled "Current" in Table 7), clients were experiencing an average of 9.30 trauma related symptoms.

Table 7. Number of Event Types, Victimization Types, and Symptoms Experienced by Participants Completing an Assessment Tool

	Childhood (0-17)	Adulthood (18+)	Last Year	Current	Lifetime
Event Types					
Minimum	0	3	2	*N/A*	3
Maximum	18	24	22	*N/A*	24
Average	6.98	14.68	10.68	*N/A*	15.93
N	65	69	69	*N/A*	69
Symptoms					
Minimum	0	0	1	1	*N/A*
Maximum	16	18	17	16	*N/A*
Average	4.94	10.73	10.07	9.30	*N/A*
N	53	67	67	67	*N/A*

Source: Polyvictimization Assessment Tool, December 1, 2018 – May 31, 2019

Note: In this table, N represents the number of participants completing an Assessment Tool who responded at least one item in the corresponding time period.

Table 8 shows the top five most prevalent event types over the lifetime and in the last year for participants who completed the Assessment Tool and answered that item. **Every client who completed an Assessment Tool experienced emotional or verbal abuse at some point in their life, and 91% experienced it in the last year, making this event type the most common for participants.** For a complete table of prevalence for all Assessment Tool event types (including more detailed descriptions of the event types) in all four time periods (lifetime, childhood, adulthood, and in the last year), see Appendix 4.

While the FJCSC is a place for people who have been victimized, learning about the adverse life experiences[13] that clients have experienced is key to the intentional shift from crisis intervention to holistic service provision. Three adverse life experiences – substance use, permanent or long-term loss, and justice system involvement – were found to be in the top five most prevalent events among those clients who completed an Assessment Tool (Table 8). Of particular interest, **substance use (for the client or a family member) was common both across the lifetime and in the last year, though few clients received referrals for related substance use disorder services** (see "Referrals and Services" section below). In addition to these, over their lifetimes, a large proportion of clients also experienced poverty (76% of clients), homelessness (65%), natural or man-made disasters (63%), chronic discrimination (60%), and immigration related trauma (45%). These adverse life experiences impact clients in many ways and are crucial for staff to know about in order for them to provide well-rounded and comprehensive services.

[13] Adverse life experience is defined as an event other than one where a crime or other victimizing offense has been committed by another person. It refers to stressful experiences that are distinct from ordinary life stressors, and can be traumatic for some people.

Table 8. Top Five Most Prevalent Events Over the Lifetime and in the Last Year Among Participants Completing an Assessment Tool

Lifetime			Last Year		
Event Type	%	N	Event Type	%	N
Emotional or verbal abuse by a parent, caregiver, partner, relative, friend, or other person	100 %	69	Emotional or verbal abuse by a parent, caregiver, partner, relative, friend, or other person	91 %	69
Assault or battery by a parent, caregiver, partner, or relative	94%	69	Substance use (client or family member)	72 %	65
Permanent or long-term loss	90%	62	Financial abuse	71 %	62
Justice system involvement (client or family member)	90%	59	Neglect	68 %	66
Substance use (client or family member)	89%	65	Bullying / Stalking or inappropriate pursuit (*tie*)	67 %	58 / 65

Source: Polyvictimization Assessment Tool, December 1, 2018 – May 31, 2019

Note: N represents the number of participants completing an Assessment Tool who responded to the corresponding event item.

Table 9 shows the top five most prevalent trauma related symptoms in the last year and at the time of the Assessment Tool completion (current) among those who completed the Assessment Tool and answered those items. The five most prevalent symptoms were the same for participants in the last year and at the time of the Assessment Tool and **between 75% and 98% of participants experienced each of the top five symptoms.** For a complete table of symptom prevalence with all Assessment Tool symptom items in all four time periods (childhood, adulthood, last year, current), see Appendix 5.

Table 9. Top Five Most Prevalent Symptoms in the Last Year and at the Time of Assessment Tool Completion

Symptom	Last Year		Current	
	%	N	%	N
Repeated disturbing memories, thoughts, or images	98%	57	96%	56
Sadness	97%	64	97%	64
Avoidance	88%	56	84%	56
Anxiety	87%	62	87%	61
Feeling cut off (e.g. feeling distant or isolated)	82%	56	75%	56

Source: Polyvictimization Assessment Tool, December 1, 2018 – May 31, 2019

Relationship Between Event Types and Symptoms

Among clients who completed the Assessment Tool, there is a correlation between the total number of event types experienced and the total number of trauma related symptoms experienced, as can be seen in Table 10. Though the sample size is relatively small and there is some variation, **we see a slight upward trend in the number of current symptoms as the number of event types experienced over the lifetime increases** (Figure 5). Due to the small sample size, we cannot conclusively ascertain any particular trends. However, this general finding is as expected given the large body of literature connecting traumatic events to PTSD related mental health symptoms; in particular, a significant amount of research has shown that polyvictimization is a strong predictor of distress and traumatic symptoms[14] in youth (Turner, Finkelhor, Ormrod, 2010; Finkelhor, Ormrod, & Turner, 2009; Finkelhor, Ormrod, & Turner, 2007; Finkelhor, Ormrod, Turner, & Hamby, 2005).

Staff reported that better understanding the symptoms experienced by participants helped them determine need for counseling and prioritize higher-needs clients for the onsite counseling services. In addition, clients reported that the Assessment Tool helped them gain insight into their lives and see the connection between the events that occurred over their lifetimes and the symptoms they experienced. Clients felt that having a space where they could connect everything was a challenging, yet helpful part of their healing process.

Table 10. Pearson Correlation Between Event Types and Symptoms

	# of Event Types in the Last Year	# of Lifetime Event Types
# of Symptoms in the Last Year	0.388**	0.576**
# of Symptoms Currently (at time of Assessment)	0.337**	0.539**

** p<0.01; * p<0.05

Source: Polyvictimization Assessment Tool, December 1, 2018 –May 31, 2019.

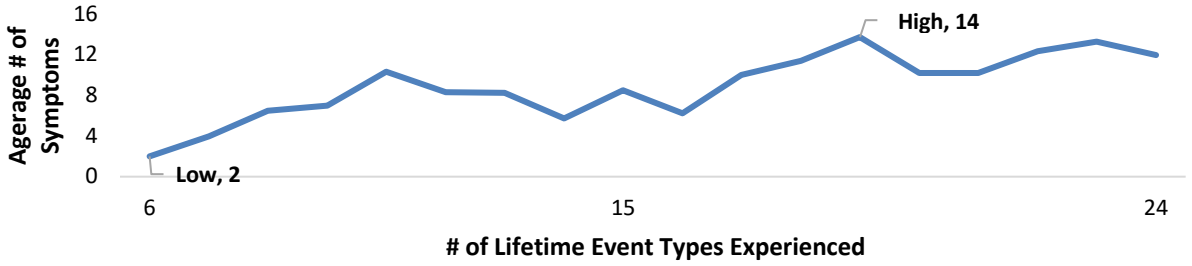


Figure 5: Relationship Between Number of Lifetime Event Types Experienced and Number of Current Symptoms (at the Time of Assessment)

Source: Polyvictimization Assessment Tool, December 1, 2018 – May 31, 2019

[14] Traumatic symptoms include depression, anger, and anxiety.

Referrals and Services

Referrals Provided by Navigators

A key part of the navigation process at the FJCSC is the provision of referrals for relevant services.[15] Navigators work with clients in the Nest at the FJCSC to determine which onsite and offsite referrals to provide clients. Onsite partners provide additional referrals to clients as determined through their agency's intake processes. It was hypothesized that by completing the Assessment Tool with clients, staff would learn more about client needs and subsequently provide them with more extensive and/or more appropriate services.

As is outlined below, **there is evidence to show that Initiative participants who completed the** Assessment **Tool received more extensive service referrals (in quantity) compared to eligible participants that did not complete the** Assessment **Tool. In addition, there is some evidence that Initiative participants received more referrals overall compared to clients not participating in the Initiative.** However, there is no evidence to show that any group received more appropriate services (in quality). This may speak to the utility of both the Screener and Assessment Tool in service delivery, and especially to the Assessment Tool given that those participants received the highest number of referrals on average. Even with these preliminary findings, at this time, there is not enough information to conclusively determine whether all clients received appropriate services that met all of their needs or if there are remaining gaps in referrals and services.

It is important to note that during the process of gathering the referral data, FJCSC administrative staff identified that the *ETO* platform touchpoints were not accurately capturing all of the referrals and services provided, so it is possible that the entirety of referrals and services provided to clients is not reflected here. Due to this discovery, changes were made to the *ETO* touchpoints after implementation to ensure thorough information gathering in the future.

As can be seen in Table 11, **the average number of referrals provided to Initiative participants was 3.29, compared to 2.80 for Initiative non-participants, a statistically significant difference.** It is important to note that 33 non-participants received their referrals before the implementation start date of December 1, 2018, but subsequently returned to the FJCSC during implementation for follow-up.

When considering only Initiative participants who were eligible to complete an Assessment Tool, those who completed an Assessment Tool received on average one additional referral compared to those with no Assessment **Tool. Those who completed an Assessment Tool received, on average, 4.10 referrals compared to**

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[15] If a client was not marked in the FJCSC *Efforts to Outcomes* platform as having received a referral or service, it was assumed that they did not receive that referral or service. As it is possible clients received referrals that were not entered into the *ETO* platform, the results in this section could be underestimates.

eligible participants with no Assessment Tool who received 3.19 referrals. This difference is statistically significant, and may exemplify how the Assessment Tool can influence service delivery. Given the depth of the Assessment Tool, staff may have learned more about a client's needs than they would have otherwise, and therefore were able to provide them with additional referrals.

Table 11. Number of Referrals Given to Clients

# of Referrals	Initiative Non-Participants	All Initiative Participants	Eligible Participants with No Assessment	Participants Completing Assessment
Minimum	0	0	0	1
Maximum	9	11	11	10
Average	2.80	3.29 *	3.19	4.10*
N	171	464	355	68

Source: FJCSC *Efforts to Outcome* platform, December 1, 2018 – May 31, 2019

Note: The following groups were compared for statically significant difference: Initiative Non-Participants and Participants; Eligible Participants Completing and Not Completing an Assessment Tool. Statistically significant differences between the groups at the $p<0.05$ level are noted with an asterisk (*). One Initiative participant who completed an Assessment Tool did not want their referrals reported and therefore is not included in the referral data analysis.

Upon grouping referrals into thematic categories, almost all (95%) Initiative participants were referred to at least one onsite partner, which is consistent with the percent of non-participants who were referred to an onsite partner. **The most prevalent referral category was domestic violence services, with 82% of Initiative participants referred to at least one domestic violence service provider** (Table 12). When considering referrals to individual onsite organizations (Table 13), the most common referral for participants was to the YWCA, a referral that is consistent with the high prevalence of domestic violence as the primary victimization.

Of particular interest are the referrals to polyvictim services (categorized together in Table 12 and presented individually in Table 13). These services – which include an empowerment group, coping skills group, increased onsite counseling hours, and massage therapy – were put in place as part of this Initiative with the goal of providing holistic services to polyvictim clients. **A higher proportion of both Initiative participants and clients completing the Assessment Tool were referred to at least one polyvictim service compared to their counterpart groups** (Initiative non-participants and eligible participants with no Assessment Tool, respectively) (Table 12), with the most prevalent polyvictim service referral being the empowerment group (Table 13). This finding aligns with the FJCSC protocol put into place during the implementation phase of prioritizing those completing an Assessment Tool for polyvictim services.

Table 12. Clients Receiving at Least One Referral in the Referral Category

Referral/Service Category	Initiative Non-Participants (N=171)	All Initiative Participants (N=464)	Eligible Participants with No Assessment (N=355)	Participants Completing Assessment (N=68)
Onsite Partner Referral	93%	95%	95%	100%
Domestic Violence Service Referral (e.g. DV Services, Shelter, YWCA)	69%	82% *[16]	84%	81%
Legal Service Referral (e.g. Legal Aid, Attorney, Court, Family Law Facilitator, Elder Law)	64%	68%	68%	69%
Polyvictim Service Referral (e.g. Coping Skills or Empowerment Groups, Massage Therapy, On-site Counseling)	1%	10% *[17]	3%	52% *[18]
Elder Support Referral (e.g. Council on Aging, Adult Protective Services, Lifeline, Elder Law)	13%	16%	15%	21%
Public Benefit Referral (e.g. CalFresh, MediCal, SonomaWorks)	12%	12%	12%	18%
District Attorney Related Referral (e.g. District Attorney Office/Advocate, Abduction Unit, Good Cause Report)	14%	15%	16%	16%
Adult Mental Health Related Referral	5%	7%	6%	15%*[19]
Homeless Services Referral (e.g. Homeless Outreach Team, Living Room, Other)	8%	10%	11%	13%
Financial Support Related Referral	5%	9%	9%	12%
Child or Youth Service Referral	10%	11%	11%	10%
Child Mental Health Related Referral	8%	7%	7%	7%
Housing/Shelter Related Referral (e.g. Housing/Shelter, Rental Assistance)	8%	5%	5%	7%
Vocational/Life Skills Related Referral	2%	5%	5%	6%
General Community Based Organization Referral	3%	2%	1%	2%
Early Childhood Education Referral	0.6%	0.6%	0.8%	0%
Substance Use Disorder Related Referral	0%	0.4%	0.06%	0%

Source: FJCSC *Efforts to Outcome* platform, December 1, 2018 – May 31, 2019

Note: The following groups were compared for statically significant differences: Initiative non-participants and participants; eligible participants completing and not completing an assessment. Statistically significant differences between the groups at the $p<0.05$ level are noted with an asterisk (*). One Initiative participant who completed an Assessment Tool did not want their referrals reported and therefore is not included in the referral data analysis.

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[16] $\chi^2 = 11.80$, $p=0.001$

[17] $\chi^2 = 13.67$, $p<0.001$

[18] $\chi^2 = 132.82$, $p<0.001$

[19] $\chi^2 = 5.81$, $p=0.02$

Table 13. Clients Receiving a Referral to or Attending the On-Site Organization or Service

On-Site Service/Organization	Initiative Non-Participants (N=171)	All Initiative Participants (N=464)	Eligible Participants with No Assessment (N=355)	Participants Completing Assessment (N=68)
YWCA Referral	69%	82% *[20]	84%	81%
Legal Aid Referral	49%	57%	57%	62%
Verity Referral	23%	24%	20%	40%*[21]
Empowerment Group Referral	0%	4% *[22]	0%	29% *[23]
Council on Aging Referral	13%	16%	15%	21%
District Attorney Advocate Referral	12%	13%	13%	15%
Catholic Charities Referral	11%	8%	6%	15%*[24]
Law Enforcement Referral	7%	12%	12%	13%
Coping Skills Group Referral	1%	2%	0.6%	12% *[25]
Homeless Outreach Team Referral	7%	6%	7%	9%
On-Site Counseling Referral	0.6%	3%	2%	9%*[26]
Massage Therapy Referral	0%	1%	0.3%	7%
Attended Empowerment Group	0%	0.4%	0%	3%
Attended Massage Therapy	0%	1%	0.8%	3%
Redwood Children's Center Referral	0%	0.2%	0.03%	0%

Source: FJCSC *Efforts to Outcome* platform, December 1, 2018 – May 31, 2019

Note: The following groups were compared for statically significant differences: Initiative non-participants and participants; eligible participants completing and not completing an assessment. Statistically significant differences between the groups at the $p<0.05$ level are noted with an asterisk (*). One Initiative participant who completed an Assessment Tool did not want their referrals reported and therefore is not included in the referral data analysis.

[20] $\chi^2 = 11.35$, $p=0.001$

[21] $\chi^2 = 12.01$, $p=0.001$

[22] $\chi^2 = 636$, $p<0.001$

[23] $\chi^2 = 78.72$, $p<0.001$

[24] $\chi^2 = 5.07$, $p=0.02$

[25] $\chi^2 = 26.36$, $p<0.001$

[26] $\chi^2 = 5.87$, $p=0.02$

Relationship Between Assessment Event Types and Referrals/Services Received

Among participants who completed the Assessment Tool, those with a higher number of event types experienced in the last year, or with a higher number of current symptoms, were provided with more referrals. The total number of event types experienced in the last year was significantly correlated with the total number of referrals given[27] and the total number of symptoms reported at the time of assessment was also significantly correlated with the total number of referrals provided.[28] No other significant correlations between number of event types or symptoms experienced and number or type of referral provided were found.

Referrals and Services Provided by Partner Organizations

Partner organizations provide clients with additional referrals and services outside of those provided by navigators. As this data is not entered into the FJCSC ETO database, it is available only on the aggregate level. Two partner organizations, YWCA and Verity, were able to provide this data for Initiative participants who completed a Screener (including clients who screened both in and out) and for participants who completed the full Assessment Tool. For the complete data on referrals and services provided by the YWCA and Verity, see Appendix 6.

The most common referral or service provided by both the YWCA and Verity was a support group referral. The YWCA provided a support group referral to 23% participants who completed only a Screener and 26% of participants who completed an Assessment Tool. Verity provided a support group referral to 16% participants who completed only a Screener and 20% of participants who completed an Assessment Tool. The second most common referral provided by Verity was a counseling referral, essentially tied with the support group referrals and offered to 15% of participants who completed a Screener and 20% of participants who completed the Assessment Tool.

Secondary Trauma Among FJCSC Staff

In order to determine if a change in secondary trauma among frontline staff occurred over the course of the implementation phase, paired sample *t*-tests were utilized with only those staff who completed a ProQOL scale at two time points: before the implementation phase began and when it ended. With the mean sub-scores on a scale ranging from one (low) to five (high), it was observed that frontline staff began with relatively high compassion satisfaction, low burnout, and low secondary traumatic stress. There was a slight increase in both burnout and secondary traumatic stress among staff, though neither of these changes were statistically significant and both remain below the midpoint. There was also a statistically significant decrease in compassion satisfaction, with a mean score decrease of 0.42 (Table 15), though the score remains above the midpoint. While increases in burnout and secondary traumatic

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[27] Pearson correlation = 0.382, p=0.001

[28] Pearson correlation = 0.283, p=0.021

stress and a decrease in compassion satisfaction may indicate that staff experienced an increase in secondary trauma over the course of the implementation phase, the results are still positive. Staff generally experience moderate to high compassion satisfaction, which is characterized by feeling satisfied with one's job, invigorated by the work, successful, happy with work, and capable of making a difference.

Table 15. Secondary Trauma Among Staff Over the Implementation Phase

ProQOL Sub-Scale (Scale: 1-5)	N	Pre-Implementation (mean score)	Post-Implementation (mean score)	p-value
Compassion Satisfaction	6	4.29	3.87	0.04*
Burnout	6	1.78	2.26	0.07
Secondary Traumatic Stress	5	1.58	1.8	0.16

Source: Hundall Stamm, B. (2009). ProQOL, version 5.

Note: Statistically significant differences between the pre- and post- ProQOL sub-scales at the $p<0.05$ level are noted with an asterisk (*).

Key Result Findings

- 91% of participants who completed a Screener at intake screened in as potential polyvictims
- 36% of participants who completed the Tool were returning FJCSC clients, compared to 17% of eligible participants who did not complete the Tool
- 64% of participants who completed the Tool visited the FJCSC 2 or more times during the implementation phase, compared to only 34% of eligible participants who did not complete the Tool
- On average, participants who completed the Tool visited the FJCSC 2.38 times during the implementation phase
- Participants completing the Tool experienced between 3 and 24 different event types over the course of their lifetimes, with an average of 15.93 event types
- Emotional or verbal abuse was the most prevalent event type in the last year and over the lifetime, with 100% reporting this event at some point during their lifetime, and 91% reporting it in the last year
- The other top event types experienced over the lifetime and reported by more than 80% of participants completing the Tool included assault or battery, permanent or long-term loss, justice system involvement (of the client or family member), and substance use (for the client or family member)
- Participants completing the Tool were experiencing between 1 and 16 symptoms at the time of their Assessment, with an average of 9.3 symptoms
- The top 5 symptoms, all reported by at least 75% of participants completing the Tool, experienced both in the last year and at the time of Assessment, were repeated disturbing memories, thoughts, or images; sadness; avoidance; anxiety; and feeling cut off (e.g. feeling distant or isolated)
- Clients who participated in the Initiative received on average 3.29 referrals during the implementation phase, compared to an average of 2.8 referrals received by clients who did not participate
- Participants who completed an Assessment Tool received on average 4.10 referrals during the implementation phase, compared to an average of 3.19 referrals received by eligible participants with no Assessment Tool.
- There was a relationship between the number of event types experienced in the last year and total number of referrals. As the number of event types increased, so did the number of referrals received.
- There was a relationship between the number of trauma-related symptoms at the time of Assessment and total number of referrals. As the number of symptoms increased, so did the number of referrals received.

Lessons Learned

Completing the Assessment Tool

- **Client-staff rapport is key.** Building a relationship with the client was important to starting and completing the Assessment Tool in an efficient, thorough, and holistic manner.
- **A team based approach to completing the Assessment Tool allowed for closer working relationships between staff and took pressure off the individual staff members.** The FJCSC was the only demonstration site to successfully operate a team based approach to the collaborative development and implementation of the Assessment Tool, a strategy put in place after navigators reported an increase in secondary trauma after the pilot phase. Navigators initiated the Assessment Tool during intake and then worked with collocated advocates from partner agencies and the civil legal attorney to continue completing the Assessment Tool amidst regular service delivery. Collaboratively supporting clients resulted in strengthened relationships and improved understanding of clients' needs. Weekly meetings with frontline staff utilizing the Assessment Tool included relationship building activities to further strengthen cohesion and trust among the team.
- **The Screener and Assessment Tool informed service delivery.** Completing the Screener and Assessment Tool allowed staff to learn about clients more deeply and discover additional needs, which led to offering more referrals and services.
- **Intentional staff training and development early on in the process leads to better assessments and working relationships.** It would be beneficial to begin the process of integrating the Assessment Tool into service delivery by first fostering trusting relationships amongst staff through ongoing staff development and team building exercises, and by beginning training on the Assessment Tool and how it affects service delivery early on.
- **Informing community agencies about the Polyvictimization Demonstration Initiative early on would provide for a smoother referral process.** Navigators felt it would have been beneficial for frequent offsite referral agencies to have an understanding of the Polyvictimization Demonstration Initiative in order to facilitate inter-agency understanding of polyvictimization and the information gathered from FJCSC navigators.

Identified Gaps in FJCSC Services

- **There is a need for case management services.** Gaining a deeper understanding of client experiences and needs highlighted the widespread need for case management services. Many clients would benefit from longer term case management where a therapeutic relationship is developed and clients are continuously connected to the full range of available services.

- **There is a need for more bilingual follow-up services.** Many Spanish speaking clients, including many polyvictims, would greatly benefit from some of the new follow-up services offered through the Polyvictimization Demonstration Initiative, such as the onsite counseling and empowerment group. As of writing this, however, these services are not available in Spanish.
- **There is a need for additional navigation staff.** Though there is great identified benefit to the Assessment Tool, it takes time to complete, which can be a burden on the navigation staff. An increased number of navigators would reduce this burden and likely allow for completion of the Assessment Tool with additional clients. Post Initiative, the FJCSC hired a third full-time navigator to help fill this gap.

Lessons Learned Throughout the Initiative

- **There is power in hope.** The most important lesson learned by the FJCSC during the Polyvictimization Demonstration Initiative was the power to foster change for vulnerable polyvictims through hope. An example of this occurred during the pilot phase with a client, "Lorelai."[29] Lorelai came to the FJCSC with a concussion following her hospitalization from a domestic violence incident in March of 2018. Over the course of the intake, the navigator working with Lorelai identified her as a polyvictim, and subsequently received her consent to complete the Assessment Tool. After witnessing a murder by a close relative at the age of four, Lorelai had experienced multiple victimizations in later years that compounded to weigh her down with guilt and shame. Following Lorelai's second visit to the FJCSC, her teenage daughters stated that she seemed "different" in a positive way. In reply, Lorelai said that she now had hope for her future.
- **New polyvictim client needs informed changes in service delivery.** Throughout the Initiative, it became apparent that polyvictims require adaptations to the customary service delivery offerings in order to increase accessibility. To better meet the schedules of clients who work at least one job, the FJCSC began offering additional services, including childcare and after business hours. Polyvictim clients reported a need for more services in Spanish, so the FJCSC hired a full-time bilingual receptionist as the first point of contact, added a second full-time on-site bilingual civil legal attorney, and began offering holistic services in Spanish. The FJCSC aims to continue learning about the unique needs of polyvictims so that services can be adapted or added to best serve them.
- **Building staff capacity and getting leadership buy-in was crucial.** Ensuring that staff were well-trained and informed about the Initiative were important to the project running smoothly over the three year course of the Initiative, as was

[29] Lorelai is a pseudonym to protect the client's privacy.

ensuring the establishment of strong institutional support with an openness to innovation and changes.

- **Using the Assessment Tool with clients may have an impact on staff secondary trauma.** As discovered both qualitatively during the pilot phase and quantitatively during the implementation phase, staff who used the Assessment Tool with clients experienced an increase in their feelings of burnout and a decrease in their compassion satisfaction, both key pieces of secondary trauma. Staff would benefit from increased support and holistic wellness activities when implementing a new type of tool or assessment, especially one that increases the length of the client intake process and delves more deeply into clients' lifetime experiences with trauma.
- **There is a balance to be found between research and providing trauma-informed care.** Throughout the Initiative, FJCSC staff and partners involved in the process of developing the Assessment Tool found it challenging to make decisions that would meet both the needs of the research side of the project and the needs of the clients at the FJCSC. While understanding the value in the rigorous research needed to validate the Assessment Tool, frontline staff also knew that creating strict parameters and methodologies for using the Assessment Tool had the possibility of clashing with their ability to provide trauma-informed care. Clients come to the FJCSC in varying levels of crisis and with a wide variety of needs, and staff must remain flexible in order to meet the client where they are. Creating a Screener provided some relief for staff in knowing that there would be an initial filter of clients for the Assessment Tool, but staff still needed to use their best clinical judgment to determine the clients with whom it would be appropriate to begin the Assessment Tool. The flexibility to administer the Assessment Tool in a way that fits best with each Center allowed for the FJCSC to find a methodology and system that best fit both staff and client needs, while still allowing the researchers to gather important and informative data.

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- Hatchuel Tabernik and Associates

Appendix 1: Strategic Planning Learning Questions

April 12, 2017

Purpose of Screening Tool[30] and Defining Polyvictims

1. Who and when do we screen? Individual victims (including children) or families? At intake or all current clients?
2. What are we screening for?
3. What is the definition of a polyvictim? Are we identifying a very small subset of individuals as polyvictims or identifying all victims as polyvictims?
4. What are the levels of personal experiences used to define polyvictims?
5. How do we account for the difference between traumatic events (violent and/or sexual) and highly stressful events (death of a parent, losing a house, etc.) in our definition of polyvictimization?

Creating the Screening Tool

1. How do we make sure the Assessment Tool is usable and being used?
2. Is front line staff involved in developing tools?
3. What community resources need to be developed to use and distribute the Assessment Tool widely?

Implementing the Screening Tool

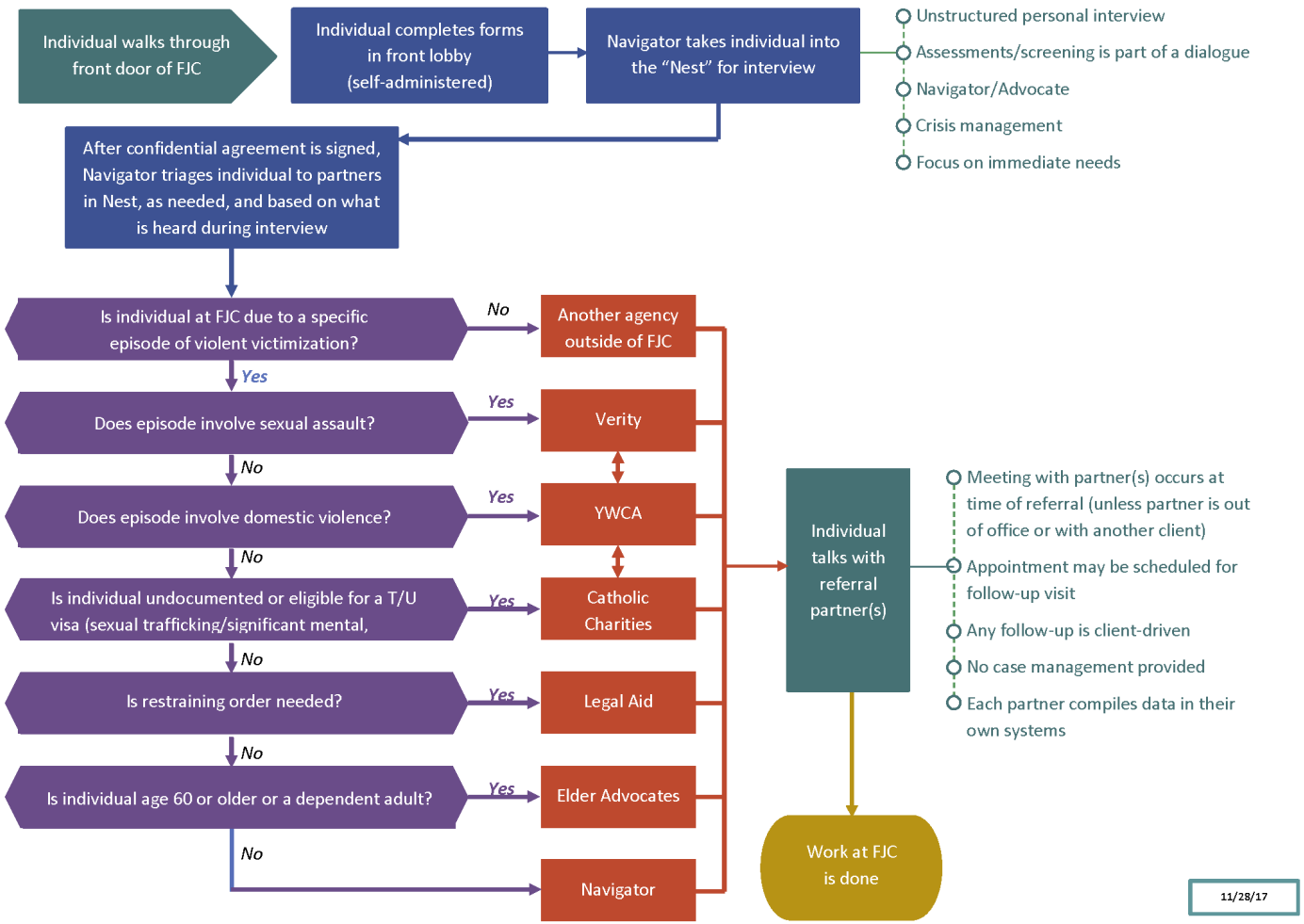
1. Does the Assessment Tool build or hinder dialogue?
2. Is the training to use the new screening tool effective?
3. How do you prioritize treatment following use of the screening tool?
4. Is the screening tool safe and helpful to the client?
5. Is the Assessment Tool culturally competent? Has the interviewer been sufficiently trained to administer the Assessment Tool in a culturally competent way?
6. What is the effectiveness of the Assessment Tool for helping LGBTQ populations? Older adults? Groups with historical trauma?
7. How do we use the results of the Assessment Tool to serve and heal abusers (who may also be polyvictims themselves)?
8. What is the efficacy of the Assessment Tool to identify polyvictims?
9. Does the Assessment Tool help us better serve clients?
10. How do we serve polyvictims and help them get better? Housing, counseling, etc.?

[30] In this appendix, the phrase "screening tool" is used to reference what would become the full Polyvictimization Assessment Tool.

Using Data Derived from the Screening Tool

1. What is the profile of polyvictims in Sonoma County? How do they differ from profile seen elsewhere?
2. What hidden cultures are in Sonoma County and outlying regions that are not getting services? What do we need to know about these groups?
3. What is the differential impact of polyvictimization based on starting point in the life course (children vs. younger adults vs older adults)?
4. What were the touchpoints in life that could have made a difference for them? (3 months ago to15 years ago)?
5. What community resources need to be developed following our increased knowledge of polyvictims in Sonoma County?
6. Are there nuances of working with polyvictims to encourage their service participation?
7. Understanding our local polyvictimization data, what kind of prevention services could be developed?

Appendix 2: Final Client Flow Chart



Appendix 3: FJCSC Screening Tool

FAMILY JUSTICE CENTER
Sonoma County

FJC Client ID: _____

Your answers below can help us ensure that you receive all of the assistance and services that you need while here at the Family Justice Center. None of the information that you provide here will be reported to any law enforcement or child protective agency. You may interpret and answer the questions in the way that fits you best and no further explanation beyond answering "Yes" or "No" is necessary at this time. You may answer any or all of the questions below.

Please fill in the bubble for either "Yes" or "No" as such: ●

Please do not put a check mark (✓) or X (□)

		Yes	No
1.	Have you ever experienced any physical harm or assault?	○	○
2.	Have you ever experienced any type of emotional or verbal abuse?	○	○
3.	Have you ever experienced any natural or manmade disasters?	○	○
4.	Have you ever experienced any type of sexual abuse?	○	○
5.	Have you ever felt threatened?	○	○
6.	Have you ever experienced the long term loss of someone close to you?	○	○
7.	Have you ever experienced any financial difficulties?	○	○

By signing below, you understand that the information provided above is not required and that you will not be denied services for not providing answers. You consent that the information provided above may be used for the purposes of research and education, but that the information used for these purposes will not include your name and will not be able to be traced back to you.

Signature _____ Date _____

Appendix 4: Assessment Tool Event Type Prevalence

Table D-1. Prevalence of Event Types for Participants Completing an Assessment Tool

Event	Childhood (0-17)		Adulthood (18+)		Last Year		Lifetime	
	%	N	%	N	%	N	%	N
Emotional/verbal abuse by parent, caregiver, partner, relative, friend, or other	71%	51	99%	69	91%	69	100 %	69
Assault/battery by parent, caregiver, partner, or relative (completed or attempted)	53%	49	90%	69	63%	68	94%	69
Permanent or long-term loss (of a person due to incarceration, deportation, illness, suicide, or death)	47%	51	84%	63	59%	61	90%	62
Justice system-involvement (client, partner, or close family member)	28%	47	83%	60	62%	58	90%	59
Substance use (client, partner, or close family member)	57%	54	85%	66	72%	65	89%	65
Financial abuse	22%	50	82%	62	71%	62	87%	61
Bullying	69%	52	73%	59	67%	58	86%	59
Neglect by parent, caregiver, partner, relative, friend, or other	56%	55	80%	66	68%	66	86%	66
Sexual abuse/assault by parent, caregiver, partner, relative, friend, or other (completed or attempted)	60%	57	68%	65	38%	64	83%	65
Stalking/inappropriate pursuit	26%	53	74%	65	67%	64	78%	65
Poverty	35%	51	70%	63	54%	63	76%	63
Other forced/unwanted experience(s) related to your body	53%	49	61%	57	32%	56	75%	56
Community violence	40%	50	57%	54	32%	53	72%	53
Other*	46%	46	71%	49	62%	52	71%	49
Strangulation and/or positional asphyxia	10%	50	64%	64	40%	63	69%	62
Severe physical injury/illness and/or mental illness resulting in hospitalization or incapacitation	21%	48	66%	58	47%	59	69%	58
Separation from child(ren) or disrupted caregiving as a child	27%	52	62%	58	44%	59	67%	58
Homeless	10%	51	60%	62	39%	61	65%	60
Held against will	29%	49	56%	57	35%	57	64%	56
Natural and/or man-made disaster	24%	51	61%	61	30%	61	63%	59
Seen someone who was dead, or dying, or watched or heard them being killed (in real life)	26%	51	44%	52	8%	52	61%	51
Chronic or repeated discrimination	39%	51	57%	53	47%	53	60%	53
System-induced trauma	16%	50	56%	54	38%	53	57%	54
Immigration related trauma	14%	28	41%	29	40%	30	45%	29
Animal cruelty	7%	42	38%	45	20%	46	43%	44
Sex or labor trafficking	8%	59	11%	62	8%	62	15%	60

Note: * "Other" events were rarely specified on the assessment tool

Source: Polyvictimization Assessment Tool

Appendix 5: Assessment Tool Symptom Prevalence

Table E-1. Prevalence of Symptoms for Participants Completing an Assessment Tool

Symptom	Childhood (0-17)		Adulthood (18+)		Last Year		Current**	
	%	N	%	N	%	N	%	N
Sadness	50%	42	98%	64	97%	64	97%	64
Repeated disturbing memories, thoughts, or images of a stressful experience	62%	45	98%	57	98%	57	96%	56
Anxiety	49%	41	89%	61	87%	62	87%	61
Avoidance	38%	37	88%	56	88%	56	83%	56
Cut off	49%	43	88%	57	82%	56	75%	56
Sleep disturbances	44%	41	88%	56	81%	57	73%	57
Hypervigilance	41%	39	81%	59	78%	59	73%	59
Low self-esteem	49%	41	83%	57	75%	59	73%	59
Experiencing pain and/or physical symptom(s) which are undiagnosed/resistant to treatment	31%	39	77%	57	76%	59	71%	59
Attention or concentration difficulties	39%	41	70%	56	70%	56	68%	56
Other*	22%	36	64%	47	66%	47	61%	49
Numbing, dissociating	18%	38	63%	54	65%	54	59%	54
Irritable/angry	42%	41	78%	54	70%	50	59%	54
Aggressive or violent behaviors, even if done so unintentionally or unexpectedly	12%	42	42%	50	33%	52	28%	54
Impulsivity	16%	38	43%	49	32%	50	26%	50
Self-harming behavior(s)	26%	38	31%	49	26%	50	22%	51
Suicide attempt, discussion, or thoughts of suicide	26%	46	51%	55	40%	55	21%	56
Health-risk behavior(s)	26%	43	53%	55	35%	55	21%	56

***** "Other" symptoms were rarely specified on the assessment tool

****** Currently experiencing at the time of assessment

Source: Polyvictimization Assessment Tool

Appendix 6: Aggregate Partner Referral/Service Data

Table F-1. Aggregate YWCA Referral and Service Data for Participants Who Completed Only a Screening Tool and Participants Who Completed an Assessment Tool

YWCA Referrals and Services	Screener Completed Only (N=458)	Assessment Completed (N=69)
Support Group Referral	23%	26%
Safe House Screening	12%	14%
Court Accompaniment	11%	16%
Support Group Attendance	7%	3%
YWCA Counseling Referral	9%	3%
Safe House Entry	8%	9%
Good Cause Report	5%	6%
Law Enforcement Interview/Police Report Accompaniment	3%	4%
YWCA Counseling Attendance	1%	0%
RCC Accompaniment	0%	0%
CPS Team Meeting Accompaniment	0%	0%

Source: YWCA client database

Table F-2. Aggregate Verity Referral and Service Data for Participants Who Completed Only a Screening Tool and Participants Who Completed an Assessment Tool

Verity Referrals and Services	Screener Completed Only (N=458)	Assessment Completed (N=69)
Support Group Referrals	16%	20%
Verity Counseling Referrals	15%	20%
Law Enforcement Interviews/Pretext calls	5%	4%
RCC Accompaniment	3%	1%
CPS Team Meeting Accompaniment	2%	0%
Court Accompaniment	1%	0%
Girls Circle Attendance	0.4%	0%
Support Group Attendance	0.2%	0%
Verity Counseling Attendance	0%	0%
Good Cause Reports	0%	0%
Support Group Referrals	16%	0%

Source: Verity client database

Chapter 7

Sojourner Family Peace Center

Milwaukee, Wisconsin

Authors: Sojourner Family Peace Center

CHAPTER 7: Sojourner Family Peace Center

History of the Family Peace Center

The Family Peace Center (FPC), opened in November 2015, is one of the nation's largest and most comprehensive Family Justice Centers. The FPC houses a broad array of 14 co-located partner agencies under one roof, including nonprofit organizations, justice system representatives, law enforcement, mental health practitioners, civil legal providers, school professionals, child advocacy professionals, workforce development professionals, and alternative wellness providers. The FPC is centrally located just north of downtown Milwaukee, Wisconsin, in a 75,000 square foot facility that is highly accessible by public transportation. The FPC was built to reduce the stress on families who found it difficult to navigate the many agencies and systems they needed to visit after experiencing trauma. Prior to the FPC, navigating systems of care required survivors to visit multiple providers at different locations throughout the city. The lack of a centralized location for the various systems of care forced survivors to repeatedly tell and retell their stories. Service providers knew that such an experience was detrimental to the healing process and that many families did not get all of their needs addressed while the providers remained in their silos. The co-location of services provided an opportunity for providers to change how they treat victims and their families. This holistic approach lends dignity and kindness, and creates a community for survivors to find a circle of support following trauma.

Sojourner FPC is governed by Sojourner's Board of Directors as well as three foundational FPC committees: Steering, Operations, and Outcomes and Evaluation, each with representatives from FPC partner agencies. Each of the co-located partner agencies signed a memorandum of understanding (MOU) that committed their agency to providing services to clients and their families at the FPC. There are 14 total partner agencies onsite. Sojourner, a domestic violence nonprofit service agency, is the lead agency of the FPC. The other 13 onsite partners include the Milwaukee County District Attorney's Office Domestic Violence Unit, the Milwaukee Police Department Sensitive Crimes Division, Aurora Healthcare, Milwaukee Public Schools, Wraparound Milwaukee, Core El Centro, Jewish Family Services, Legal Action of Wisconsin, Goodwill Industries of Southeastern Wisconsin, and four distinct programs run by Children's Hospital of Milwaukee: the Milwaukee Child Advocacy Center, Project Ujima, Behavioral Health, and Community Health. See details on services provided and client access in the *Client Mapping* section below.

While all 14 partner agencies are located in the same physical space, the FPC does not yet have an electronic data system that connects each agency's client data systems. Partner agencies do report quarterly sum totals of clients served, absent any identifying information to protect client confidentiality. They are therefore unable to report an unduplicated number of clients served across the entire FPC. The FPC partner agencies collectively served 28,565 ***duplicated*** individuals in 2017, and 30,315 in 2018.

Sojourner, the lead FPC agency, served a total of 9,750 unduplicated individuals in 2016, 11,346 in 2017, and 12,040 in 2018.

While polyvictimization and trauma are issues that plague the nation at large, these issues are particularly pernicious in Milwaukee. Milwaukee faces several factors that create conditions for polyvictimization among residents, including high rates of poverty, hyper-segregation, unemployment, urban blight, and marked racial disparities in incarceration. Legacies of systemic racism and disenfranchisement of communities of color abound in Milwaukee's recent history. For instance, construction of the current freeway infrastructure in the 1960s disproportionately benefited white, suburban dwelling residents while wreaking havoc in communities of color. Houses were torn down, businesses were forced to relocate, and entire neighborhoods split artificially down the middle to accommodate the construction. Two recent high-profile pieces that received national attention highlight problems within Milwaukee: Matthew Desmond's book *Evicted,* detailing the housing rental and eviction issues faced by residents, as well as Keith McQuirter's documentary *Milwaukee 53206,* detailing these issues in one particular zip code of the city. Empirical data support residents' anecdotes and lived experiences. In a recent study of Adverse Childhood Experiences (ACEs), mothers who received home visiting services in Milwaukee experienced more than two times the rate of emotional abuse, nearly three times the rate of domestic violence, and over seven times the rate of household incarceration compared to national rates (Mersky, Janczewski, & Topitzes, 2017).

Polyvictimization reflects the lived experiences of the clients served at the FPC. It is clear through both the experiences of staff and nuanced data collected during the Polyvictimization Demonstration Initiative in 2016, that it is exceedingly rare for a client to seek services for domestic violence and have no history of other trauma in their lives. In fact, the average ACE score of an adult Sojourner client is 5.51 out of 10 (Hope Lives Here Report, 2019). Sojourner's mission is to transform lives impacted by violence. To meaningfully engage that mission, the FPC must allow clients to disclose and heal from ***all*** the ways in which they have experienced hurt. Further, in order to build hope and healing, staff must not only ask clients about negative experiences, but also about their goals.

Site Goals and Focus for the Initiative

Repeated trauma across the lifespan has been associated with negative sequelae in nearly every area of functioning. However, given the proper support, victims also have tremendous capacity for resilience, hope, and healing, despite adversity. The primary stated goals of the Initiative in FPC's proposal to OVC were to develop a model that addresses polyvictimization at FPC and to share information about lessons learned within the field. These primary goals did not change during the three year Initiative and were accomplished through changing policies and practices at the FPC to promote hope and healing amongst polyvictims. Policy changes included developing an intake process for the center and participating in the creation of a validated tool to assess the lived experiences of trauma for victims seeking services.

All 14 co-located partner agencies were involved in this Initiative. The FPC initially proposed that the project team would identify new onsite and offsite partners to deliver the full range of services needed to effectively serve polyvictims. At the start of the Initiative, there were 13 co-located partner agencies. This number grew to 14 with the addition of the civil legal provider, Legal Action, an organization which provides critical onsite civil legal services, ranging from consultation to full legal representation for polyvictims.

All partner agencies were involved throughout the Demonstration Initiative in both formal events and countless informal conversations and collaborations. Formally, each partner had a representative serving on the Polyvictimization Project Team (PT) that met monthly throughout the Initiative. During PT meetings, partners were closely involved in the planning and development of the Polyvictimization Assessment Tool. The partners reviewed the tools provided by the Alliance at each stage of development and lent their own professional experience to inform the team's feedback.

The FPC partnered with a team of researchers from the University of Wisconsin - Milwaukee, including Dr. Joshua Mersky, Dr. Danielle Romain, and Dr. Dimitri Topitzes to conduct a mixed-methods, multi-informant evaluation of the Initiative at the FPC. See more details on the method and results from this investigation in the *Results* section below.

Trauma-Informed Care

In June of 2017, three out of four members of the Sojourner polyvictimization Learning Exchange Team attended a Train the Trainer on trauma informed care in San Diego. The Project Manager and Trauma Support Specialist, hired specifically to lead the Initiative at the Center, used the learnings from the event to facilitate trainings with co-located partners on trauma-informed approaches and staff wellness. In July of 2018, the FPC hosted a training on trauma-informed care for all employees at the Center.

Prior to the opening of the FPC, partners came together during the Strategic Planning to discuss the client experience of the physical space. Their thinking informed the intentional use of calming colors and aromatherapy, safe spaces, confidential areas, comfortable furniture, and designated youth spaces within the Center. Throughout the Initiative, the Center made additional changes to continuously enhance the client experience. The team acquired a fish tank for the shelter; added an accent wall, a couch, and chair to our Milwaukee Police Department (MPD) interview room, and converted a meeting space into a youth drop-in space with a whiteboard wall, couches, soft lighting, and bean bag chairs.

Client Mapping Process

Prior to determining where the Assessment Tool should be implemented during service delivery at the FPC, the project team mapped potential paths through the Center to gain

a clear understanding of how clients physically move through the services offered at the FPC. The following information was gathered through the client mapping process.

Entry Points. The client may have to divulge information one to three times before they engage directly with a receptionist. To gain access to the parking lot, the client must share their name and the purpose of their visit. At both public entrances to the building, the client will again be asked to share their name and the purpose of their visit. If the client arrives at the shelter entrance, they will be rerouted to a public entrance. If the parking lot is full, the client will have to find street parking and use the Walnut Street entrance. To gain access to the facility after five pm, the client will need to ring both the outdoor and indoor intercoms.

Reception Desk. Once the client has gained access to the building, they check-in at the reception desk. If unsure about the purpose of their visit, both returning and first-time clients often share information so that reception may direct them to the appropriate agency.

As a result of mapping, seven FPC agencies were identified as potential first touchpoints for clients: Sojourner, Aurora Healthcare, Children's Hospital of Wisconsin (CHW) Milwaukee Child Advocacy Center, CHW Behavioral Health, District Attorney's Office, Jewish Family Services, and Milwaukee Police Department Sensitive Crimes Unit. A brief description of all 14 co-located FPC agencies and notes on how clients access each service are described at the end of the chapter in *Appendix 1*. The client mapping also identified several goals for improving the client experience as well as pathways for achieving each goal. The goals were around the following: location and visibility; accessing the building and security; diversity and inclusion; customer service; and referrals. A complete map of the positive ways the Family Peace Center was addressing, along with items to revisit and pathways for improvement can be found in Appendix 2.

The FPC's mapping process confirmed that the FPC needed a formalized first touchpoint and served as a catalyst for conversations with partners to determine how to improve the coordination of services while protecting clients. As a result of the Initiative, the FPC began developing an electronic Centralized Data System (CDS) in August of 2017. Throughout the development of the CDS, the following needs were identified:

- An intake process that allows for the uniform collection of demographic information and assessment data (including the Polyvictimization Tool) from each client walking through the doors, and, with client consent, the sharing of information between co-located partners to reduce the need for clients to repeat details about themselves and their reason(s) for seeking services at the Center.
- A process to track and follow up on referrals for service and engagement in services.
- A systematic way to collect data about clients served and measure the impact of the FPC.

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Assessment Tool Development and Implementation

Reviewing the 30 Recommended Tools from the Literature Review

The FPC Polyvictimization Project Team (PT) is comprised of one or two representatives from each co-located partner and was established to ensure the perspective of FPC partners are considered during innovation sparked by the Demonstration Initiative. Representatives serve as champions of the Initiative in their home agencies and collect feedback to inform the PT decision-making process.

After discussing all the experiences which clients disclosed upon seeking services at the FPC, the PT determined the Assessment Tool should include the most common events that clients present as having experienced. They created the following list of common traumatic events FPC clients have experienced, directly or vicariously, throughout their lifetime:

- Domestic violence (family, intimate partner violence)
- Sexual assault
- Child abuse/neglect
- Community violence
- Financial instability/poverty
- Discrimination (racism, sexism, homophobia, immigration status, etc.)
- Housing instability
- Food insecurity
- Bullying (cyber, revenge porn)
- Trafficking (sex, human, labor)
- Natural disaster
- House fire
- Chronic or serious illness (self or family)
- Family loss/displacement (death, divorce, foster care, incarceration, absenteeism, military)
- AODA issues (taking/giving medicine when not sick)
- Mental illness (diagnosed, undiagnosed, untreated, self, family, IP)
- Non domestic violence crime
- Loss of a child (foster care, miscarriage, abortion, death, loss of custody/visitation)

As the PT discussed the criteria for an effective Assessment Tool, partners expressed a preference for:

- A brief assessment (no more than 20 questions) that asks about lifetime experiences of/exposure to traumatic events. Partners determined, for the purposes of the Assessment Tool and the impact of trauma on memory, that follow-up questions on recency should only be associated with traumatic events that have immediate safety, medical, and/or forensic implications. A “triage plan” should be developed for disclosure of relevant experiences.
- General, clear, and relatable wording of events questions/statements was essential to create a conversational flow.
- A comprehensive scale to capture the type of exposure to traumatic event(s).
- A brief assessment of referral-relevant, general symptomatology questions. Partners felt that it is more important for clients to identify what issues feel

immediate and disruptive in their lives at the moment than conduct a complete inventory of symptoms.

Partners agreed that no single recommended assessment would be sufficient to screen for potential traumatic experiences and gather necessary information to make appropriate referrals. Therefore, a developed Assessment Tool that combines the structure of event statements from the Polyvictimization and Trauma Screening Checklist (events only) and Life Events Checklist 5 (LEC-5), a brief, validated mental health functioning screener, and a question about immediate concerns would be most suitable.

Many of the symptomatology tools were designed for use in a mental health setting. Considering that advocates would primarily be responsible for administering the Assessment Tool and are not trained mental health professionals, partners expressed concerns about the potential impact of asking detailed symptomatology questions, both on staff and on clients. Partners agreed, for the purposes of the Assessment Tool, that an in-depth symptom screening was not necessary to make an appropriate referral. Free counseling, a service available to all adult FPC clients, was included in every intake. Partners felt confident that once the Assessment Tool had been adapted/developed, a referral process had been established, and advocates had received training and access to ongoing support on implementation, they would feel confident in administering the Assessment Tool.

PT representatives were asked to write down their top three choices on a slip of paper. The three commonly agreed upon assessments were:

1. Polyvictimization and Trauma Symptoms Checklist (events questions only) – Wording of questions encompasses a wide variety of experiences. Partners felt the inclusion of system-induced trauma was important and that the definition should expand to include feeling discriminated against in any way. The Flowchart on Trauma-Informed actions is a great resource to help advocates determine appropriate referral needs. The chart also helps advocates identify issues that may be of immediate concern without being too specific regarding recency.
2. LEC-5 – The Assessment Tool is brief. Wording of items on the Assessment Tool encompass a wide variety of experiences and the exposure-based scale allows for a more conversational approach. The statement about “other unwanted or uncomfortable sexual experience” can increase disclosure of trafficking. The statement on “combat or exposure to war-zone” is inclusive of the experience of military families and refugee populations.
3. ACEs – Despite its gaps in experiences, partners are familiar with the ACEs scale. Given that most advocates have administered this assessment, adopting it requires minimal training. In addition, familiarity with its scoring and implication of risk factors can increase the accuracy of service referrals.

Reviewing Draft Assessment Tools

Each iteration of the Polyvictimization Assessment Tool was shared with PT representatives and advocates during agency check-in meetings. The PT requested feedback from these teams and the VOICES advisory group.

The feedback was informed by advocates, partner agency staff, FPC's VOICES group, local evaluation partners, and qualitative data collected from client focus groups. The advocate team, who was primarily responsible for administering the Assessment Tool, conducted mock intakes with the Assessment Tool prior to providing their thoughts. The PT team also attended a VOICES meeting, reviewed the Initiative goals, and asked about VOICES members' intake and referral experiences prior to requesting feedback. Collective responses were reviewed and organized by emergent themes.

Feedback on Questions

While the questions included in the Assessment Tool captured a wide variety of potentially traumatic events, the total number of questions was intimidating to advocates who would administer the Assessment Tool. They expressed particular concerns about the Assessment Tool feeling like a barrier to available services, and the impact this would have on a trust-building, conversational approach. The specificity of the perpetrator associated with some sets of questions felt "bulky and redundant." Advocates suggested combining overarching categories (i.e. assault/battery), thereby creating space to talk through the specifics (Have you ever been physically hurt? By whom? Can you tell me a little bit more about that experience? etc.). Advocates also found the Assessment Tool to be a deterrent to the natural flow of conversation. Partner agency staff expressed concerns about the lack of triage questions at the outset, (i.e. Are you experiencing any pain right now? Do feel like you want to hurt yourself or anyone else? Have you recently been strangled/choked?) and an inquiry about services already being received.

VOICES members were happy to see the inclusion of sexual assault and strangulation questions, as many of them were not asked about these experiences during their initial intake. Several members expressed concerns about the similarity of the Assessment Tool's terminology to police/system terms and the language being difficult for clients to understand if read verbatim. There was also confusion about the inclusion of questions on natural disasters which led to the conclusion that the purpose behind seemingly irrelevant questions would need to be explained.

Feedback on the Feel of the Assessment Tool

Implementation of the Assessment Tool would shift how frontline staff interact with clients coming through the FPC doors. Advocates often focus on safety planning, meeting immediate needs, and assessing interest in ongoing services during first contact. There were several concerns about the mental bandwidth of clients in crisis, who are focused on dealing with things that feel more immediate and significant.

Several VOICES members commented on the similarities between the questions included in the Assessment Tool and the questions they had been asked in unsafe, clinical environments. One member said, “This is too beautiful a space to feel this clinical.” They stated that if administered while clearly emphasizing the importance of using gathered information to meet their needs and not to, “get me in trouble or get my kids taken away,” they would answer the questions once they felt comfortable with the person conducting the intake.

Feedback on the Length

Advocates expressed a concern about the amount of time necessary to administer the Assessment Tool, identify immediate needs and safety concerns, make appropriate referrals, and complete required data collection for other funding sources, as they often have limited time with clients to complete intakes.

VOICES members shared how immediate their needs felt when they sought services at the FPC. They explained how answering a battery of questions before they were connected to services would have reduced their rapport with the person conducting their intake. They also suggested that the questions would have irritated them by making their immediate needs feel secondary.

Feedback on When the Assessment Tool is Implemented

Advocates, staff, and VOICES members all felt the Assessment Tool was not appropriate for a first touchpoint. Clients (VOICES and focus group participants) expressed concern with sharing their story with a stranger and suggested a full trauma history be taken *after* a rapport was built to establish trust and increase the accuracy of disclosure. One VOICES member captured this sentiment when she commented:

> “You’re not sure of what’s going on at first, or you’re afraid to be open and honest at that time.”
> **- Family Peace Center Voices Member**

Focus group participants expressed concerns about being treated differently by service providers who received their information.

Advocates appreciated the depth of the Assessment Tool and acknowledged that knowing more about the lives of clients could improve empathy and strengthen a trauma-informed approach to service provision. However, they expressed more comfort with gathering the information over time, as opposed to completing the Assessment Tool in a single session.

Importance of Staff Training

Advocates requested additional training to implement the Assessment Tool with fidelity in a way that would not be re-traumatizing for clients. They asked for additional clarification around the purpose and use of the Assessment Tool.

VOICES members stated that the Assessment Tool was something they would expect from a clinician and was not concurrent with the experiences that they had with FPC advocates. However, they also understood the purpose of gathering the data and suggested that if advocates were going to administer the Assessment Tool, they should be properly trained on how to explain the Assessment Tool and maintain a conversational approach.

Piloting the Assessment Tool

After reviewing the client map, the FPC found that seven co-located partners could be potential first touchpoints for clients. The PT initially planned to designate a staff person in each of those agencies to administer the Assessment Tool with clients during their first visit to the FPC. After discussing implementation strategy with partners, however, they determined the best course of action would be for Sojourner advocates to take the lead in administering the Assessment Tool. There were two reasons for this shift: 1) Both behavioral health partners have clauses in their service agreements restricting the usage of information shared in sessions for research purposes; and 2) Licensure and/or agency reporting requirements bind advocates and intake staff to report information that may potentially expose clients to oppressive systems and/or cause unnecessary harm. The confidential status of Sojourner advocates protects clients, builds trusting relationships, and creates a safe space for disclosure of traumatic experiences. Four Sojourner advocates were chosen to pilot the Assessment Tool: the lead navigator, two Sojourner District Attorney advocates, and one Sojourner advocate from the FPC Advocacy program.

The PT concluded that if the FPC was able to pilot the Assessment Tool with the information they held at the time, the staff determined that the team to administer the Assessment Tool would consist of the lead navigator and three Sojourner advocates. Sojourner advocates carry an ongoing caseload that includes follow-up, creating natural opportunities to collect additional information in a conversational manner and connect clients to appropriate services. Advocates would ideally schedule time with new and existing clients to go over the Assessment Tool after explicitly explaining its purpose, allowing clients to make an informed decision to participate.

Capacity was the main challenge in administering the Assessment Tool. Advocates were still responsible for their daily workflow which, for the Sojourner District Attorney advocates, was difficult given the volume of clients reporting to the District Attorney's office for charging conferences. Another challenge was staff support. As the pilot period drew to a close, Sojourner's Trauma Support Specialist, who was tasked with providing support and training to the advocates administering the Assessment Tool, took on a more active role, administering up to three Assessment Tools a day.

Implementation of the Assessment Tool

Full implementation began December 1, 2018 and ended May 31, 2019. After considering client volume, the FPC was projected to complete 54 Assessment Tools during the six-month implementation period. This number was calculated by determining how many clients would be able to complete the Assessment Tool from the following groups:

- Established clients working with advocates;
- Clients enrolled in support group;
- New clients who expressed an interest in providing this information;
- Clients participating in the evaluation process; and
- Clients living in the Sojourner Truth House shelter.

Screening Toward the Assessment Tool

Given the prevalence of clients who screened in as polyvictims using shorter Screeners developed by other FJCs (e.g., upwards of 90%), the FPC did not see the utility of creating a shorter Screener as the vast majority of clients would screen in. Instead of a formal Screener, they used the options detailed below to offer the Assessment Tool to clients.

Offering the Assessment Tool

In line with a trauma-informed approach, advocates administering the Assessment Tool informed the client of its purpose and acclimated them to the structure of the Assessment Tool when possible. When offering an opportunity to complete the Assessment Tool, staff ensured clients understood that their participation was voluntary and, if at any point they did not want to respond to a question or complete the Assessment Tool, they would be free to decline answering or end the conversation without impact on service delivery. While it was the goal to complete the Assessment Tool in as few sessions and as thoroughly as possible, the completion timeline ultimately depended on the comfort and availability of the client.

The Assessment Tool was offered in the following circumstances:

Support Group Clients: The Trauma Support Specialist (TSS) funded through the Initiative offered the Assessment Tool to support group participants in early December with the option to schedule time with herself or the client's Sojourner advocate. An additional opportunity was offered when clients reached week 15 of service provision. The group facilitator notified the TSS, who checked Osnium (Sojourner's client database) to see if the client had already started/completed/refused the Assessment Tool. The TSS then connected with the Sojourner advocate for clients who have not completed the Assessment Tool and ask them to check-in. Clients also received a class credit for going through the Assessment Tool, completed or not.

During Evaluation Interviews: The FPC Outcomes and Evaluation team included the Assessment Tool into client evaluation interviews in which clients provided data on a variety of assessment tools for evaluation purposes. The team offered the Assessment Tool in alignment with the current practice of introducing and explaining the purpose of each evaluation survey implemented.

Completing the Assessment Tools

A completed Assessment Tool required a response to every question and reason by the staff administering the Assessment Tool. If the administrator did not feel that a certain question was appropriate, they would check “not appropriate to ask.” If, for some reason, an advocate was unable to ask a question (i.e. client did not return for services after the Assessment Tool had been started or the implementation period ends), they would check “user did not ask” before submitting the Assessment Tool. While the Assessment Tool does not ask specifically about the perpetrator of a traumatic event, staff would note it if a client chose to share.

Lessons Learned, Keepers, Do-overs

Local Evaluation

The local evaluation was conducted by a team of researchers from the University of Wisconsin - Milwaukee including Dr. Joshua Mersky, Dr. Danielle Romain, and Dr. Dimitri Topitzes. This local research team conducted a mixed-methods, multi-informant evaluation of the Initiative at the FPC. The team’s final integrated evaluation report follows.

Qualitative Analysis Overview

Qualitative data were collected from staff and clients at the Sojourner Family Peace Center (FPC) from September to December 2017 and again from January to April 2019. Across the two waves of data collection, 16 staff and 26 clients participated in the evaluation. Below is a brief summary of key findings.

Qualitative Wave 1: Sample and Design

Staff from 12 of the 13 partner agencies at the Family Peace Center and clients actively engaged in services were selected for this study: a total of 12 staff (i.e. one per partner agency excluding one co-located partner that does not provide direct service) and 16 clients participated. Supervisors at each partner agency submitted the names of three staff, and from this list the evaluation team randomly selected participants to recruit. Some agencies had only one staff member located at the FPC, in which case they were the sole person recruited. The client sampling procedure was two-fold. First, clients were selected for a focus group from an existing support group. Second, staff members at the FPC were asked to obtain a list of names of current clients. The evaluation team subsequently recruited these individuals to participate in a focus group or interview.

The evaluation team completed interviews and focus groups at the Family Peace Center between September and December 2017. Staff interviews were approximately 45 minutes long and were conducted in conference rooms to ensure privacy. Client focus groups were also conducted in conference rooms and lasted approximately 90 minutes, while client interviews were conducted in intake rooms and lasted approximately 45 minutes. Interviews and focus groups were transcribed and coded for keywords within each sampled group. Coded sections were reviewed and refined, with themes developed iteratively from re-reading the data. Additionally, a content analysis was conducted on several questions, including those related to the intake process, information sharing and confidentiality, client knowledge about the FPC prior to receiving services, and potential additional inter-agency partnerships.

Qualitative Wave 1: Results

An integrated analysis of staff and client data exposed complementary themes and a few competing perspectives. Staff reported that gaining greater knowledge about their partner agencies would help them share information and connect clients to resources. Staff recognized that improving communication and collaboration among agencies would enhance service continuity for clients. Many clients also mentioned their desire to receive information about available resources and services. However, client feedback suggested that it is important to consider the timing and amount of information shared, as clients who seek services from the FPC are often in a state of crisis and may be unable to process a large amount of information at intake. Therefore, staff and clients agreed that it is important to provide clients with informational resources that they can take home.

Staff and clients also agreed that priority should be given to addressing needs identified by the client. Yet, some staff reported feeling conflicted between working to meet the client's immediate needs and helping them to address deeper issues that may promote long-term healing. A few staff mentioned that they felt that clients were often provided too much direct assistance, which could impede their growth. Their comments suggested that while it is important to provide assistance and support, it is also important to foster client self-determination and empowerment. By contrast, some clients expressed that they wanted more help navigating referrals and that immediate needs are more important for them during initial meetings. With regard to self-determination, clients who feel that they have choice in seeking help and a voice in identifying their needs and goals may be more likely to follow through on referrals and service plans. In addition, clients underscored the importance of staff responsiveness and timeliness. Some clients noted that their ability to follow through on their service plans was often undermined by personal adversities, and they emphasized that staff should demonstrate patience and compassion toward them when they struggle to follow through.

Participants universally acknowledged the enduring influence of trauma on their lives. Many clients disclosed experiencing a profound degree of family violence in childhood and adulthood, along with an array of daily stressors such as economic insecurity. Thus, many staff recognized the value of assessing trauma as a means of understanding and

working with clients. Yet, some staff cautioned that addressing trauma with clients may not be beneficial if clients are not ready to disclose or receive services. Nevertheless, most staff indicated that they should be well-trained in trauma-informed practices, and some staff specifically recommended that the Center enhance its services for trauma-exposed youth as well as perpetrators of partner violence, many of whom also have trauma histories.

Qualitative Wave 2: Sample and Design

Staff from Sojourner who administered the Assessment Tool and clients who had completed the Assessment Tool were selected for this study; a total of four staff (three advocates and one administrative staff) and 10 clients participated. Staff had been involved in both Version 2 and 3 of the Assessment Tool; some clients had completed Version 2 of the Assessment Tool while others completed Version 3 recently. All staff who administered the Assessment Tool with clients agreed to participate. The client sampling procedure involved two sources. First, clients who were selected for an earlier focus group with the Alliance were contacted for their participation in an additional focus group. These individuals had completed Version 2 of the Assessment Tool in April to May 2018. Second, staff members who had administered the Assessment Tool prospectively submitted a list of names of clients who may be interested in providing feedback about the experience. The evaluation team subsequently recruited these individuals to participate in an interview.

All interviews and focus groups were conducted at the FPC between January and April of 2019. The staff focus group and client focus group were each approximately 75 minutes long, while client interviews typically lasted between 45 to 60 minutes. All focus groups and interviews were conducted in private conference or intake rooms to ensure confidentiality and privacy. Interviews and focus groups were transcribed and coded for keywords within each sampled group. Coded sections were reviewed and refined, with themes developed iteratively from re-reading the data. Cross comparisons were made between the client and staff keywords and themes, noting similarities and differences in what each group thought about the Assessment Tool and process of administration.

Qualitative Wave 2: Results

An integrated analysis demonstrated consistency among clients and staff on several points. Both groups saw value in having conversations with clients about trauma, although they generally recommended that these conversations occur after the client is no longer in crisis. Second, staff and clients identified several common purposes of talking about trauma – namely psychoeducation and helping others. Normalizing trauma and responses to traumatic events was important to both groups, yet clients often mentioned that they had previously been unaware or in denial of prior abuse. Having pointed conversations about traumatic events can increase awareness, particularly when examples are provided. Both groups emphasized the importance of having a trusting relationship with well-trained and empathetic advocates when talking about trauma.

Clients and staff also offered some suggestions for improving the Assessment Tool and general conversations about trauma. Both groups were concerned with providing context (i.e., the "what" and "why") talking about trauma and discussing confidentiality if information were to be shared with agency partners. Additionally, client choice was highlighted as an important theme. Both groups felt staff exhibited flexibility and skill in enabling clients to help direct the assessment process, though they felt the Assessment Tool should be revised to enhance client choice and empowerment. Specifically, a few clients and all staff recommended the need to prioritize positive experiences over negative traumatic events, suggesting a greater focus on strengths and resilience. Staff felt that additional training on these points – context, language, scoring, direct practice skills, and knowledge on particular topics (e.g., immigration, general trauma) could help them feel more comfortable having conversations about trauma with clients in the future.

Quantitative Analysis Overview

Quantitative analyses were performed on two sets of data collected from different client samples at the FPC. First, a Polyvictimization Assessment Tool that was developed by the Alliance was completed with 57 clients by Center staff, including trauma support specialists, victim advocates, and an evaluation director. A descriptive analysis of the data was used to generate prevalence estimates of various forms of trauma exposure and trauma-related symptoms. Second, analyses were performed on data collected from 69 clients at multiple time points by the Center's evaluation director, with the aim of promoting continuous quality improvement of agency services. Based on these assessments, an analysis was performed to assess the prevalence and associations among measures of childhood adversity, adult adversity, hope, and distress.

Dataset #1: Polyvictimization Assessment Tool

Data collected using the Assessment Tool were analyzed to assess the prevalence of adult traumatic events and symptoms. Childhood trauma prevalence was not analyzed due to high rates of missing data. It should also be emphasized that clients with missing adult data were assigned a zero value, indicating that they did not experience a given form of victimization. It is likely that some of these clients experienced traumatic events and symptoms that they did not disclose or that were not assessed. Therefore, the percentages reported below should be interpreted as conservative, lower-bound estimates.

Nearly all clients (96.5%) who completed the Assessment Tool experienced assault/battery in adulthood by a parent, caregiver, partner, or relative. Other prevalent forms of adversity and trauma reported were emotional/verbal abuse (86.0%), stalking/inappropriate pursuit (82.5%), poverty (75.4%), and financial abuse (66.7%). Less common forms reported were immigration-related (14.0%), sex or labor trafficking (7.0%), other victimization (7.0%), and natural and/or man-made disaster (3.5%).

Unsurprisingly, given the high rates of trauma exposure, high rates of trauma-related mental health symptoms were also endorsed. Symptoms of depression (75.4%) and

anxiety (75.4%) were the most prevalent. In addition to mood disturbances (e.g., depression; sadness), other posttraumatic stress symptoms were highly prevalent. For example, 64.9% of the sample reported repeated disturbing memories (i.e., intrusive symptoms). Another 59.6% of the sample reported avoidance symptoms, and 70.2% reported hypervigilance (i.e., arousal symptoms).

Dataset #2: Family Peace Center Interviews

A second set of data collected via client interviews at the FPC was used to analyze the prevalence of childhood adversity (n = 69) and adult adversity (n = 53). All subjects were female, and their mean age was 34.9 years (range 19-58). The racial/ethnic composition of the sample was 52.8% African American, 27.8% Caucasian, 9.7% Hispanic/Latina, and 9.7% other race/ethnicity.

Adverse Childhood Experiences (ACEs) were assessed using the Childhood Experiences Survey (Mersky et al., 2017). For this report, five forms of child maltreatment and five forms of household dysfunction were analyzed. Results indicated that the most prevalent forms of child maltreatment were physical abuse (58.0%) and sexual abuse (56.5%). emotional abuse (56.1%), emotional neglect (37.7%), and physical neglect (20.3%) were reported less frequently. Among household dysfunction types, the reported prevalence was as follows: divorce/separation (66.7%); mental health problems (63.8%); substance abuse problems (59.4%); domestic violence (55.1%); and incarceration/jail (31.9%). In aggregate, 92.8% of clients reported at least one ACE, and over two-thirds (68.1%) reported four or more ACEs.

Adult adversity was assessed using the Adult Experiences Survey (Mersky et al., 2018). For this report, ten adult adversities were analyzed. Results showed that most respondents had been physically abused (96.2%) or emotionally abused (96.2%) by a partner or spouse. More than half of clients (56.6%) reported that they had been sexually assaulted in adulthood by a partner, spouse, or other individual. Most clients reported that a current or former partner/spouse had a substance use problem (77.4%), a mental health problem (67.9%), or had been incarcerated (75.5%). Most clients had experienced other environmental adversities as well, including discrimination (83.0%), homelessness (75.5%), crime victimization (58.5%), and chronic financial problems (52.8%). In aggregate, 100% of clients reported at least one of the 10 adult adversities, and 86.8% reported four or more adversities.

At multiple time points, client hope was measured using the Adult Hope Scale (Snyder et al., 1991) and client distress was measured using the Kessler Psychological Distress Scale (Kessler et al., 2006). Initial (i.e., baseline) hope and distress scores were compared against the earliest post-baseline hope and distress scores collected. For the full sample, total distress scores decreased slightly from baseline (mean = 11.1) to post-baseline (mean = 10.9) while hope scores increased slightly from baseline (mean = 6.1) to post-baseline (mean = 6.3).

Table 1 presents correlations between clients' total scores for childhood adversity, adult adversity, hope, and distress. Total ACE scores (range 0-10) and adult adversity scores

(range 0-10) were strongly correlated (r = .61), confirming that childhood adversity is associated with later life adversity. Likewise, there were significant correlations between pre- and post-test scores for hope (r = .60) and distress (r = .45).

Baseline and post-baseline hope scores were not associated with childhood or adult adversity scores. Baseline distress scores were marginally correlated with childhood adversity (r = .24) and significantly correlated with adult adversity (r = .30). However, post-baseline distress scores were not correlated with childhood adversity (r = .10) or adult adversity (r = .01).

Given these unexpected findings, an exploratory path analysis was conducted to assess the connections between adult adversity, baseline distress, and post-baseline distress. Figure 1 shows that, after accounting for baseline distress, greater adult adversity was linked to *lower* post-baseline distress (B = -.14). However, the association was not statistically significant (p = .30), and the results should be interpreted cautiously given the small sample and low statistical power. Nonetheless, these provisional findings point to the need for further evaluation of whether and why distress levels of clients with profound trauma histories (i.e., polyvictims) decrease while they are served at FPC.

Table 1. Correlations between Cumulative Adversity, Hope, and Distress (N = 69)

	1	2	3	4	5	6
1. ACE Score	--					
2. AGE Score	0.61**	--				
3. Hope, Baseline	-0.06	-0.14	--			
4. Hope, Post	0.11	-0.02	0.60**	--		
5. Distress, Baseline	0.24+	0.30*	-0.27*	-0.38**	--	
6. Distress, Post	0.10	0.01	-0.15	-0.23+	0.45**	--

Note. + p <.10, * p <.05, ** p <.01.

Appendix 1: Sojourner Family Peace Center Partners and Corresponding Entry Points

Sojourner: Advocacy, crisis intervention, safety planning, crisis shelter, 24-hour crisis hotline, children's programming, education, ongoing support, goal-setting and healing, empowerment support groups, and help filing restraining orders to adult victims of domestic violence.

- Walk-ins – When a client arrives without an appointment or has not disclosed previous contact with an FPC partner agency, they are connected to a Sojourner advocate for needs assessment and referral(s).
- Hotline – If ongoing support is needed for a client who calls the Sojourner Hotline, a referral is sent to the FPC Advocacy Supervisor, who assigns the client an advocate. Depending on the client's needs/preferences, referrals may be made during the initial follow up call or as the result of an in-person appointment.

Aurora: Sexual Assault Nurse Examiners (SANE) and physical exams, forensic evidence collection, emotional and mental support after violence or assault, and wellness support. A Health Navigator position was added during the Demonstration Initiative to better connect clients to services to meet ongoing health needs.

- Walk-ins– The client may arrive at FPC because of sexual assault and may request or be immediately referred to see a SANE nurse for a forensic exam.
- Appointment – The client may report to the FPC for an initial visit if they have an appointment scheduled by the Aurora Healing Center to see an Aurora Healing Counselor.

CHW-Behavioral Health & Child Psychiatry Clinic: Diagnosis and treatment for a wide range of psychiatric and behavioral conditions, and processing trauma for children and adolescents.

- Appointment – Families may present to the FPC for an initial visit if they have an appointment scheduled by the CHW behavioral health intake office to see a CHW practitioner.

- FPC referral – An existing FPC client who expresses interest in mental health services for their children may be directly referred to CHW Behavioral Health. The client is given the offsite CHW intake telephone number, along with an informational sheet about available services. After the client makes the initial call, CHW staff will book their first appointment at FPC.

CHW Community Health & Education: Provides school nursing and services navigation throughout the Milwaukee community surrounding the FPC. CHW Community Health & Education does not serve clients at the FPC at this time.

CHW Milwaukee Child Advocacy Center (MCAC): A safe place for children and adolescents who may have been abused or have witnessed a violent crime. The center

brings together a team of professionals to evaluate and investigate cases of child abuse and help children and families.

- Appointment – Families referred through law enforcement, child welfare, or a medical provider present to the FPC for an initial visit if they have an appointment at MCAC.

CHW Project Ujima: Addresses the needs of victims of violent crime by providing treatment to help the victim recover physically and emotionally. Project Ujima also directs victims to community organizations that might help in their long-term recovery.

- The client fills out a referral form with FPC staff, providing demographic information and explaining needs. FPC scans and emails the form to the Project Ujima contact, who will reach out to the family.

CORE/El Centro: Integrative healing therapies designed to nourish body, mind, and spirit in a culturally sensitive environment. Services include massages, acupuncture, NASA auricular acupuncture, reiki, mindfulness, meditation, cranial sacral therapy, and movement classes.

- The client fills out a one-page referral sheet – either independently or with staff – that includes demographic information, information about services, and client goals around healing methods. The client then selects the services in which they are interested in and how they would like to proceed with contact, i.e. if they would like CORE to reach out or if the client would prefer to initiate the call. The client also receives a service information sheet so they can select the healing methods they would like to discuss with CORE.

District Attorney's Office – Domestic Violence Unit: Reviews domestic violence referrals by law enforcement to evaluate if criminal charges are appropriate. A client may interface with the DA's office at the FPC for the purposes of initial charging conference, case updates, and support during court proceedings.

- Walk-in – A client may report to the FPC for the initial visit of a charging conference and will be seen on a first come, first served basis. The client is connected to a Victim Witness Advocate who will provide case updates and attend court appointments. Afterwards, the client is given the option to see a Sojourner Advocate immediately following the charging conference.

Goodwill: Employment, job readiness and training, and financial empowerment.

- A client is connected to Goodwill through Sojourner's Life Skills Program. When a Life Skills Advocate identifies an appropriate employment or financial empowerment need, they refer the client to Goodwill's Employment Specialist. This referral is sent by email and includes the client's name, safe contact information, and the reason(s) for referral. Sojourner's Life Skills Program works collaboratively with Goodwill to support the client by removing barriers such as

transportation, uniform costs, identification, and other potential roadblocks that could prevent the client from achieving employment goals.

Jewish Family Services (JFS): Trauma-based individual psychotherapy, education, safety planning, and goal setting for adults.

- Offsite referral – A client can be referred to JFS counselors at the FPC from the JFS main campus if her/his primary presentation is domestic violence.
- FPC referral – An existing FPC client who expresses interest in mental health services may be directly referred to JFS. The client is given the offsite JFS intake telephone number, along with an informational sheet about JFS services. After the client makes the initial call, a welcome packet is sent for them to fill out and return at their first appointment.

Legal Action: Legal advice or support with harassment, child abuse, domestic violence injunction, family or housing law matter, and immigration law. Legal Action became a co-located partner during the Demonstration Initiative.

- The client works with an FPC Advocate to fill out a referral form that includes their basic demographic information and respondent information, if applicable. The client chooses from a checklist of legal services available and signs a release for the FPC and Legal Action to share and update information. Staff then fax the consent form to Legal Action, who reaches out to the client. Legal Action is available to meet the client at FPC if the client chooses.

Milwaukee Police Department-Sensitive Crimes Division (MPD-SCD): Safety and crime reporting, updates on cases, and initial crisis help for crimes including domestic violence, sexual assaults, child abuse, abduction of children, human trafficking, and missing persons.

- Walk-in – When a client requests to see SCD with an urgent safety concern, an available officer will meet with the client. If there is no officer available, a district squad will be called to respond. If the situation is not urgent, the client will be asked to schedule an appointment.
- Appointment – A client can be given an appointment if they walk in with a non-urgent situation and there is no staff available to serve them immediately. Appointments are also given to individuals who encounter law enforcement at districts, hospitals, during delayed disclosure, or as a result of a child maltreatment report.

Milwaukee Public Schools (MPS): The MPS School Liaison provides system navigation and advocacy for families, community partners, and school staff, including addressing parent safety concerns, support or help communicating needs from school, and learning about the services and options available.

- When a client asks for support at their child's school, the onsite MPS School Liaison can meet with the client if they are available. The client has the option to

make the first point of contact or have the School Liaison reach out via phone call or email.

Wraparound Milwaukee: A system of care providing a continuum of mental health services and support for Medicaid eligible children, adolescents, and young adults. Central to all programs within Wraparound is care coordination, as they offer a range of trauma-informed services and support.

- A client who expresses interest in mental health services for their children or young adult is presented with an informational sheet on different program eligibility and referral line. FPC staff can call the referral line with the client or the client may visit onsite Wraparound staff at the FPC.

Appendix 2: Current Client Experiences and Pathways for Improvement

Location and Visibility

Positives: The FPC is conveniently located within the Milwaukee community. The current open walk-in hours are very important and helpful to clients in need of services.

To revisit: There is a general lack of awareness in the broader community about the entirety of services available at the FPC.

Pathways for Improvement: More community engagement through in-house events, outreach at speaking engagements, festivals, and other community facing opportunities; review marketing materials and website; integrate tours of the Center for new clients to familiarize themselves with available services; create an Ambassador/Greeter position to guide visitors.

Action Steps: Work with Education and Marketing teams on events and information sharing. Cross-training between these teams occurred in the fall of 2018 during the Demonstration Initiative. Create the FPC Referral Guide to build awareness of available services and knowledge of how to connect clients among FPC staff. The Youth Trauma Support Specialist began providing FPC tours for clients as part of the shelter intake process to better familiarize and connect shelter clients to all available FPC services.

Accessing the Building and Security

Positives: Buzzing in to the gated parking lot and building entrances along with visible onsite security staff creates a protective and safe environment for both staff and clients.

To revisit: Stringent security measures to building access can be frustrating to clients during subsequent visits. The parking lot gate and building doors can stay open briefly after a client is buzzed in, allowing for the possibility of someone tailgating a client without checking in.

Pathways for Improvement: The Center must balance safety and confidentiality with customer service and visitor flow. FPC security and safety teams will continue to conduct an ongoing evaluation of security systems and protocols.

Action steps: Review security protocols and reception desk staff engagement with visitors. Explore navigator role capacity and position needs for the Center.

Diversity and Inclusion

Positives: Through ongoing interactions, clients feel safe and respected and they directly witness the diversity of staff at the FPC. The Center provides trauma-informed care with already warm and engaging frontline staff. The FPC physical space feels and looks welcoming to all.

To revisit: During the first few touchpoints, clients did not see a reflection of how they identify themselves in the FPC staff.

Pathways for Improvement: Diversity reflected in staff and culturally competent staff.

Action Steps: The Sojourner Board convened a Diversity sub-committee that focused on reviewing board makeup and hiring practices and creating a diversity dashboard. The FPC also convened a staff diversity and inclusion Point Team to address oppression, diversity, and cultural awareness. This Point Team is working to make FPC staff safe and accommodating for all. This Point Team is reviewing the FPC website and marketing materials to ensure the use of more inclusive language (e.g., avoiding gendered language). There are a number of collaborative efforts across teams (e.g., polyvictimization, diversity and inclusion, sexual assault and trafficking) to provide anti-oppression and culturally specific trainings and workshops to FPC staff and partners.

Customer Service

Positives: New and returning clients feel front desk and staff contacts are welcoming, kind, and helpful.

To revisit: Front desk staff do not always have enough information or support during busy times.

Pathways for Improvement: Ongoing training for front desk and other frontline staff around trauma-informed care, vicarious trauma, and customer service. Support for breaks and busy times at the front desk.

Action steps: Reviewing navigator role for support in handling FPC first touchpoints. Center wide trainings around trauma and client care. Updating and creating information sharing policies and the FPC Centralized Data System.

Referrals

Positives: Most clients felt that referrals happen quickly and feel like a warm hand-off. Clients would like ways to show appreciation to FPC staff.

To revisit: Advocate role clarity –what clients can expect in terms of contact turnaround and follow-up. If not called back, is it because advocates have too much on their plate? Inquiries from Sojourner website are not always responded to. Clients learn about available services later in their journey than they would have liked.

Pathways for Improvement: Continue to innovate ways to share information quickly, efficiently, and warmly. Advocate/staff role clarity and letting clients know what they can expect. Increased advocate and staff knowledge of partner services and how to make referrals to co-located and visiting partners.

Action Steps: In progress – Creation and implementation of the FPC Centralized Data System. Created and disseminated the FPC Referral Guide. Sojourner administrative team review website messaging capabilities.

Chapter 8

Family Safety Center
Tulsa, Oklahoma

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CHAPTER 8: Family Safety Center

History of the Family Safety Center

An original site of the 2005 President's Family Justice Center Initiative, the Family Safety Center (FSC) opened its doors in 2006 after two years of community meetings. The Family Safety Center was a co-located facility where a victim of domestic violence, sexual assault, or stalking could access one place for safety planning, danger assessments, emergency protective orders, and other crisis intervention services. FSC's organizing partners, staff and programs in the Harvard offices included:

- the City of Tulsa, the original grantee of the award;
- the Tulsa Police Department, who provided seven detectives from the Family Violence Unit;
- forensic/SANE nurses, who provided forensic documentation and sexual assault exams;
- the Tulsa County Sheriff's Office, who provided protective orders; and,
- the District Attorney's Office, who facilitated prosecution and provision of victim-witness advocates.

Additional partners included the 14th District Court, who enabled the provision of a video courtroom for an emergency protective order docket; Domestic Violence Intervention Services (DVNIS)/Call Rape, who provided advocates, civil legal services, self-sufficiency referrals, and childcare; the Tulsa Metropolitan Ministry, who offered spiritual support; Retired Senior Volunteer Program (RSVP) for volunteer recruitment; and the YWCA, who helped resolve immigration and translation issues.

All professionals worked for independent agencies who located these resources and personnel in a single building to serve a special needs population.

In 2006, DVIS/Call Rape provided initial administrative services such as payroll, partner management for daily operations, and basic executive administrative activities. However, by 2011, it was clear that organizational growth through the expansion of partnerships and victim services would require a change in administrative response and more focused overall coordination. In February 2012, the CEOs of each partner agency agreed to form a standalone 501(c)3 nonprofit agency to operate the partnership of agencies, fundraise for its future growth, and develop a strategy for sustainability. The FSC received its IRS designation in April 2012.

While the founding partners engaged in the strategic planning process for a community wide response to domestic and family violence, a new board of community leaders began to address governance, organizational structure, and day-to-day responsibilities. Executive and administrative staff originally engaged by DVIS were retained and progress and growth continued.

In 2012, the FSC, as a new nonprofit, received its first contract to help support the operation of agency partnerships from the City of Tulsa, through the Tulsa City Council.

The FSC was also awarded a new grant from the Department of Justice (DOJ) to form a high-risk, high-lethality, rapid intervention team to identify characteristics of the most lethal cases and address and prevent homicide. Private sector and philanthropic organizations provided additional sources of revenues. The FSC still continues to receive multiple sources of funding, providing a sustainable mix of revenues from local government contracts, federal grants, and private and philanthropic gifts that all provide management to the partner agencies who work collectively under the guiding principles and operating rules at the FSC.

It was not long before the FSC was seeing an increased number of clients, creating a capacity issue which presented a need for expanded office space to house new staff and partner agencies. The City of Tulsa and the Tulsa Police Department offered free space to the FSC in what was formerly a property warehouse, forensic lab, and booking area/holding cells in the Municipal Courts Building in downtown Tulsa adjacent to the Tulsa County Courthouse. In October of 2013, with the help of the Community Development Block Grant from the Department of Housing Urban Development, in addition to significant private contributions, in-kind gifts and services, and support from the Cherokee Nation, the FSC moved to a 15,000 square-foot refurbished space in downtown Tulsa.

Today, the FSC has 14 staff members – 10 of whom manage initial client intake and navigation in addition to handling day-to-day activities of the staff and partners housed at the FSC. A Polyvictimization Project Coordinator also exists within the Center to facilitate project management. These staff develop and implement operating procedures and coordinate external communications, building management, finance, and strategic planning for the FSC board and partners to ensure successful delivery of multiple services to each client.

By the end of 2018 the FSC served more than 3523 first time clients, 1844 returning clients, and 1749 children. The FSC continues to experience a consistent increase in victims seeking services since the inception of the Center. Due to an increase in victims visiting the Center, the FSC is once again in need of a larger space to accommodate an increase of staff, existing partners, and to welcome new partners.

Contextual and Environmental Information of Community

Community Demographics

According to the most recent census, Tulsa County is comprised of an estimated 649,399 people. It is 51.3% female and 48.8% male. The population by race is:

- 66.6% White,
- 12.4% Hispanic or Latino,
- 10.6% African American,
- 6.5% identify another race,
- 6.5% identify as two or more races,
- 6.3% Native, and
- 3.4% Asian/Native Hawaiian/Other Pacific Islander.

The median age of the total population is 35.5 years. 66.3% of Tulsans 16 years of age and older are in the labor force. 92.5% are employed and 7.3% are unemployed. The labor force is comprised of 37.6% blue collar workers and 62.4% of white collar workers. The median household income is $52,770 and the per capita income is $30,681. The education levels are 1.0% with no schooling completed, 26.3% with a high school diploma, 24.1% with some college but no degree, 8.5% have an associate's degree, 20.4% have a bachelor's degree, 9.6% have a graduate degree. 48.5% of Tulsans are married, 14.0% are divorced, 5.8% are widowed, and 30.1% have never been married.

Historical Relationships and Community Trauma

Tulsa's past is riddled with historical trauma. It is prevalent in the Native population as well as the African American population. While many of these events with the Native population occurred almost 200 years ago, they continue to have long term effects of historical trauma. Tulsa was part of Indian Territory and as a result of the Indian Removal Act of 1830, the Five Civilized Tribes - Choctaw, Cherokee, Muscogee (Creek), Chickasaw, and Seminole Nations moved into the region. Tulsa's name comes from the Lochapoka Muscogee (Creek) term "Tulasi" or old town.

While the Native population is predominantly served by the various tribal victim services agencies, the FSC tries to actively involve native communities. The Muscogee (Creek) Nation, Osage Nation and the Cherokee Nation were involved in the Polyvictimization Demonstration Initiative and FSC staff are regularly invited to attend community events sponsored by the Native communities.

The African American population in Tulsa flourished prior to 1921. Known as "Black Wall Street" the Greenwood district in Tulsa had the largest and wealthiest African American business community in the country at the time. In 1921 the Tulsa Race Massacre, one of the largest and worst acts of racial violence in the nation, occurred. Over 800 individuals were severely injured, several hundred people were reported dead, and over 10,000 citizens were left homeless. Today, the FSC actively involves organizations and attends community events that provide services and outreach predominantly to the African American population. Despite its occurrence almost 100 years ago, the Tulsa Race Massacre created long term effects that add to the prevalence of continued historical trauma for Tulsa's African American population.

Additionally, Oklahoma ranks first nationally in numbers of adults with high Adverse Childhood Experiences (ACEs) scores. A 2017 National Survey of Children's Health conducted by the United States Census Bureau found that 30.4% of Oklahoma children incurred two or more adverse experiences, ranking it number one among other states. The state also experiences high incidents of intimate partner and family violence. The Oklahoma Fatality Review Board reported that between 1998 and 2017, 1,697 victims died in Oklahoma because of domestic violence. In 2017 alone, 91 people lost their lives. These deaths reflect victims, children, and perpetrators involved in domestic violence events.

The analyzed data from the pilot of the Assessment Tool revealed the significant physical, emotional, and cognitive functioning impacts of different events on those participating. As children, FSC clients experienced an average of six events, though the

number was as high as 16 in individual data. Over a lifetime, clients reported an average of 12 events with as many as 24 events and in the past year, an average of 12 events with a high of 18 events. Accompanying symptomology, such as sleep disturbances, anxiety, repeated disturbing memories, sadness, anger, and dissociative behaviors were reported at significantly high levels (68.0% and up to 91.0%). While the high levels of trauma and symptomology were not necessarily surprising, one unexpected trend emerged: Tulsa survivors reported significantly higher and increasingly more severe levels of trauma than the other five Centers when more than two events were experienced.

The figure below demonstrates this phenomenon for the pilot:

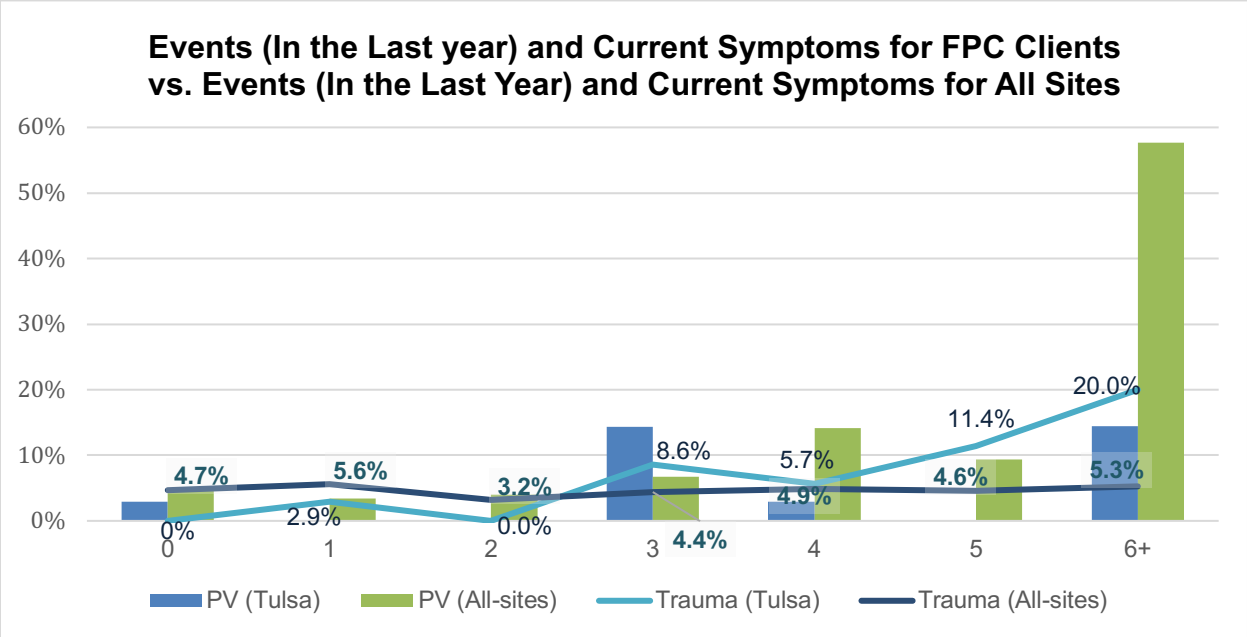


Figure 1: Pilot Testing Data - Events (In the Last Year) and Current Symptoms for FPC Clients compared with Events (In the Last Year) and Current Symptoms for All Sites (Mandatory items only)

The analyzed data from final implementation of the Assessment Tool also reflected this phenomenon. Of the cases in Tulsa, 62.92% experienced two or more traumatic events in the past year.

Original Family Safety Center Goals

Enhance Capacity to Provide Services Through Agency Partnerships and Community Collaborations. Tulsa achieved the goal of enhancing access to services by hiring Janine Collier, Project Coordinator, to dedicate her time and energy to connecting and formulating relationships with existing and additional partners. In addition, Nida'a Abu Jbara was hired to work as the Graduate Assistant with University of Oklahoma Research partner, Dr. Jody Worley, to assist in collecting, analyzing, and reporting information from captured data. Dr. Worley and Nida'a Abu Jbara assisted in crafting processes to obtain data for interviews with partners and staff; focus groups with survivors; and presentations provided to the stakeholders, Tulsa community organizations, and to fellow demonstration sites.

Provide Effective Response to Polyvictimization Through Comprehensive Holistic Treatment Options. To this end the FSC was able to link and leverage existing resources including, OU College of Medicine, Forensic and SANE Nursing Program, DVIS, Parent Child Center of Tulsa, and Mental Health Association.

Increase Collaboration and Engagement from Partner Agencies. The Project Coordinator met individually with each person identified as a stakeholder prior to the first stakeholder meeting. The FSC held five large group meetings and three stakeholder meetings at the onset of the Initiative. During the first two meetings, the FSC disseminated information about polyvictimization and the Demonstration Initiative, and onboarded and engaged the stakeholders into the process. The third meeting was held to disseminate information about next steps concerning the intake process, the Screener, and the timeline for Assessment Tool implementation. A fourth meeting was held in the second year to update stakeholders on the status of the Initiative and the Polyvictimization Assessment Tool. A final meeting was held in the last year to share the experience and findings of the Initiative.

The FSC collaborated with the Alliance, Initiative partner sites, and partner agencies for help, input, and direction. FSC staff and partners recruited other social service providers in the community and reached out to survivors. Center partners and the FSC staff expressed concerns about not progressing quickly enough in the Initiative but eventually embraced their role in drafting an unprecedented process.

The Alliance TA team connected sites to process frustrations during those periods of struggle and pause, providing a structured and guided approach while encouraging each Center to embrace their differences. Their ability to organize meetings across Centers, provide guidance every step of the way, step back and let the sites process through the information, and organize the large amount of information, was encouraging and motivating and ultimately led us to successfully co-develop the Polyvictimization Assessment Tool.

Expand Trauma-Informed Care Approaches. The FSC sent a client navigator to the Alliance's Train the Trainer on Trauma-Informed Care. The Navigator reported that she was given an excellent curriculum from expert Raul Almazar to share with staff and partners. She shared that the time in the training was short but provided an avenue to connect with the trainers/providers from the other Initiative sites and to share experiences and plans for implementing the knowledge back at their respective agencies. The key take away was enhancing the focus on customer service and incorporating it into the training for staff and partners. All Center participants joined monthly calls with the Alliance for follow-up and support.

Based on the training received, the Navigator conducted three trainings for partners. Two were in a webinar format and the third was in-person. She also provided four additional in-person trainings to staff and partners addressing burnout and vicarious trauma. The Navigator created a basic format that could be adapted to reflect additional trauma-informed content, including addressing vicarious trauma for professional service providers. The Navigator, in conjunction with the Project Coordinator, created a burnout scale to measure signs of burnout in service providers.

Create a Trauma-Informed Organization. Incorporating trauma-informed practices for clients, staff, and partners created greater transparency and connection was another key goal. Addressing vicarious trauma enabled staff and partners to construct and thrive in a welcoming atmosphere. If clients have a safe, inviting and caring environment in which they can interact with a provider with whom they have genuinely connected, they will likely return because they trust that the FSC is an inclusive community that can assist them in navigating systems. In 2017, FSC saw a total of 3,723 new clients and 1,044 returning clients. In 2018, FSC saw 3,523 new clients and 1,844 returning clients. After incorporating trauma training at FSC, the number of returning clients from 2017 to 2018 has increased by 800. In 2019, from January to the end of June, FSC has seen 1,786 new clients and 1,238 returning clients.

Staff Support

The FSC found that practicing thoughtful, day-to-day methods of care allowed staff to process their thoughts and emotions better. These methods included regular check-ins, encouraging staff to take a lunch away from their desks or the client area, allowing staff to step into the quiet room when they need a break, and encouraging them to speak with the Project Coordinator. Additionally, involving staff in decisions that affect them, providing training and sharing time, and simply expressing appreciation represent crucial actions to maintain and improve staff morale. Staff members are more likely to be hopeful when they know what they are supposed to do, and are given support and guidance when they do not. FSC has incorporated quarterly sessions for the staff and partners to address vicarious trauma. These include chair yoga, painting, improvisational comedy, mindfulness, and meditation.

Personnel Policies and Changes

The hiring team also added a new process to the second interview. In hiring staff, the team is especially sensitive to the prospective hire being a past trauma survivor, accounting for the fact that working in the FSC's fast-paced, high-crisis environment can be a trigger. In the first interview, the candidate met with the Executive Director or the Director of Programs. The story of the FSC is shared with them and they are given a basic overview of the daily operations and organization of the facility. In the second interview, to help the prospective hire obtain a better understanding of the nuances of working in a Family Justice Center, the hiring team incorporated an exercise that provides an experience similar to the process clients complete when they access services. Candidates begin in the conference room with one or two staff members who interact with them personally and conversationally. They then travel to a different location within the Center to interview with more staff and partners. The process of moving to different locations in the Center and being interviewed continues until they have met with all staff members and at least one person from each of the onsite partner agencies.

The FSC developed a month-long onboarding process for new hires, as well as a more structured onboarding process for interns and volunteers. The trauma-informed training regimen prepared staff, interns and volunteers to help clients, staff, and partners achieve self-efficacy in their positions. Staff were expected to complete the classroom

training; the experiential training; the in-depth training for the intake specialist position and the client navigator position; the basic, extended, and full Office for Victim of Crimes (OVC) Training and Technical Assistance (TTAC) Victim Assistance Training (VAT) online video courses; and the Alliance's Creating Pathways to Justice, Hope, and Healing Through a Polyvictimization Framework presentation. The interns and volunteers also complete some variation of this training that is tailored to their positions and interests.

The FSC began a strengths-based employee evaluation process called Balanced Scorecard. The process involved reinforcing good behavior in an organization by isolating four separate areas that need to be analyzed. These four areas involve learning and growth, business processes, clients, and finance. The learning and growth area allow employees to set their own goals and staff are asked to include a trauma-informed practice they would engage in outside of work. They self-evaluate after six months and again at the end of the year.

Aesthetics and Physical Space

The physical space of a trauma-informed organization needs to be warm, inviting, and welcoming. To better observe this practice and create a more inviting and comfortable environment, FSC remodeled the interview room for sexual assault victims, the security specialist area (the first point of contact for client), the intake area, the quiet room, and the staff break rooms. Due to the high volume of infants, children, and teen survivors, the Center created a teenage friendly area and an additional space for infants and children.

Interview Room for Sexual Assault Victims

Teen Overflow Area

Inclusion of Survivor Feedback

The FSC receives and actively incorporates ongoing survivor feedback from client exit surveys and VOICES members. Six focus groups were conducted to provide additional client input as a Polyvictimization Demonstration Initiative deliverable. FSC hosted three focus groups in 2017; two for English speaking participants and one for Spanish speaking participants. The purpose of the focus groups was to gather information concerning survivor defined success in the context of their experiences with Tulsa service delivery agencies by considering: their perception of the intake process, how they defined trauma, how the intake process could be more trauma-informed, and the optimal time to seek additional information about prior victimizations. The overall goal was to improve the services provided at the Family Safety Center by screening for polyvictimization events and providing warm handoffs to treatment providers to assess and treat trauma-induced symptomology.

Survivor-Defined Success

The overarching theme that emerged during all three survivor focus groups was that survivors experienced or wanted to experience a connection with genuine, caring providers who consistently followed-up and assisted them in a comfortable, inviting environment that provides a sense of hope. When the facilitator asked, “What could help you be successful?” one participant responded with, “People and resources that follow-up and do what they say they are going to.” Another responded, “Not just look at you blankly and say they are going to help. People who really care.”

Survivors defined success as being connected with case managers that were able to prepare and assist them in coping with their situations and navigating systems to receive the resources they needed. The survivors felt that their success was contingent on obtaining resources. They prefer that the resources be compiled, connected, and delivered in one place, in a thoughtful way. Some of the resources survivors would like to see available to them were greater assistance and support in transitional times such

as: leaving the shelter, leaving the abuser, ending counseling, and coping with the systems.

Another aspect of survivor-defined success was education and awareness, particularly regarding prevention. The survivors communicated a need for psychoeducation and awareness of abusive dynamics being provided to people in early life and continue throughout life. In the event that abuse occurs, it was suggested that extensive psychoeducation and awareness be provided to each survivor. The Assessment Tool assists in this educational process by creating an awareness of events that occurred throughout an individual's life and provides specific information about victimizations for the assessor to share psychoeducation in which to address the victimizations.

A survivor in the Spanish-speaking group shared that the Hispanic community lacks knowledge of services available to IPV survivors. A suggested solution included providing handouts about the Family Safety Center at schools and community functions held for the Hispanic population. Deisy Ramirez, Executive Administrator at the Family Safety Center, now attends community events to provide that knowledge to the Hispanic community.

Additionally, participants shared safety as another aspect of survivor-defined success. As a result of their concerns, safety planning is now offered by multiple partners at the FSC. Another safety issue discussed was the parking at the Family Safety Center. Some of the survivors said that it was inconvenient and parking in the garage felt unsafe. The FSC improved parking facilities by providing parking closer to the building for the clients and staff. To ensure a greater level of safety, the FSC trained staff in basic safety procedures and offers clients an escort to their vehicles is there is a safety concern.

The participants suggested that a support group would improve survivor connections and strengthen the survivor community, which in turn would provide a pathway for survivors to connect in those transitional times, as well as in their day-to-day lives. The FSC started a VOICES chapter in Tulsa to provide the backbone of survivor volunteers to serve as mentors.

Survivors expressed the importance of having a choice to participate or opt out of any additional screenings added to the intake process, and that additional assessments should enhance their ability to be healthy and perform self-care. In addition, they agreed that the screening should result in services that are connected to resources and some sort of follow-up should occur. As a result, changes in delivery were made to reflect these suggestions, and a more intentional case management processes developed for future implementation.

Finally, a Spanish-speaking participant reflected that one resource that was available to her was therapy. She shared that she did not utilize therapy but felt that it could have helped her, suggesting, "Everyone could use more therapy." When administering and reviewing the Assessment Tool with the survivors, navigators discovered that the Assessment Tool created an awareness of the relationship between the past and current victimizations and that this often led survivors to engage in therapy.

Client Mapping Process

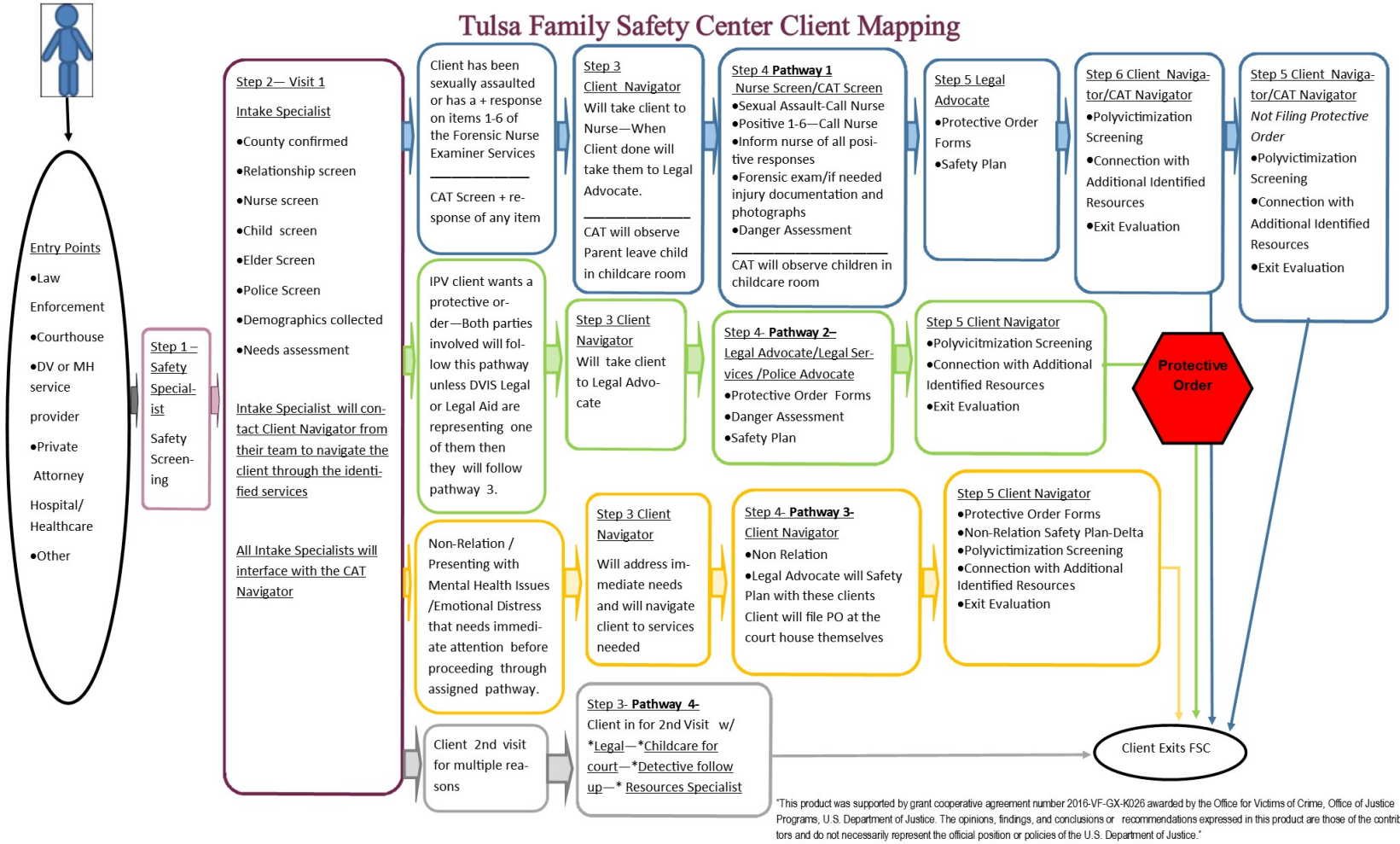


Figure 2: Tulsa Family Safety Center Client Mapping

One of the major activities conducted during the Demonstration Initiative was the client mapping process. The project coordinator observed the different areas of the Center over a three-week time span. She found watching, listening, and learning the inner workings of the client flow process at the FSC to be an invaluable exercise in supporting the implementation of the Assessment Tool. The project coordinator created and shared the client map via email with the FSC onsite partners, and met with the Navigators and intake staff to discuss and critically review the map. The map was emailed to the partners who were asked to review and share their thoughts and comments at the FSC Operational Committee (OPS) Meeting. Staff and partners reviewed and discussed agency suggestions and have since revisited and altered the client map multiple times. After each adjustment, staff brought the client map to the OPS meeting to discuss the changes with partners. The client mapping exercise was the best way to visualize the precise place the Assessment Tool should be administered. When determining the best placement of the Assessment Tool during the first year, FSC created a client flow process that was more engaging and seamless. It also provided FSC with a concrete method to present client flow and develop a feedback loop to track and adjust changes to client flow based on survivor and partners suggestions.

Assessment Tool Development and Implementation

Process for Reviewing the Literature Review

The FSC scheduled individual meetings with representatives from each participating partner agency. Agency representatives often included clinical directors of mental health services or other individuals in administrative roles familiar with the direct client services provided by their agency. To collect a full range of perspectives and insights, staff also met with nurses, physicians, social workers, attorneys and other legal support staff who work with survivors of domestic violence in collaboration with the partner agencies. Meetings were held with 16 different agencies and the review process was implemented by Tulsa Family Safety Center (FSC) and its consultants from the University of Oklahoma.

The literature review, conducted by the Alliance, listed 30 potential assessment tools. The list was emailed to each partner with a request that they review all tools prior to the meeting. The email also included three guiding questions designed to facilitate the discussion. The questions included: 1. Are there questions that you think should be included in a screening/Assessment Tool for this population? 2. Are there any questions that you and your partners use or tools that you have developed that you would recommend for other service providers? 3. Do you have suggestions about the length of time to complete screening/ assessment tools, the format of questions, wording of specific questions that are relevant for this population?

Dr. Worley began each meeting by stating the goals and purpose of the Demonstration Initiative and shared a brief overview of the protocol that would be followed to develop the Assessment Tool. In most of the meetings, the subsequent discussion continued by asking the partner if they identified or used any of the tools in the list provided. Generally, the partners elaborated more on the process rather than the tools. At the end

of each meeting, the FSC provided a copy of the 30 assessment tools from the literature review to the partners for their review and feedback in a follow-up meeting. Audio recordings and meeting minutes were consolidated into one document to organize and summarize the findings from the meeting. This was a valuable tool for identifying the areas of agreement among agency partners, and was very helpful in generating the report to answer the following six questions about the screening tool: 1. Which tools of the list that you are familiar with or used? 2. Which are the top three tools that you prefer, and why? 3. Which tool(s) would be most suited for the Family Safety Center in Tulsa? Why? 4. Are there any questions that were missing and you think should be included in a tool? If so, which ones? 5. Are there any questions or tools that you have developed and used that you would recommend for other service providers? 6. Do you have suggestions about the length of time to complete screening tools, the format of questions, wording of specific questions, and any other suggestions?

Results from Meetings

Out of the recommended tools, the top three favorites among partners/staff was ACEs (Adverse Childhood Experiences), AES (Adult Experiences Survey), LSC-R (Life Stressor Checklist - Revised). There was agreement among partner agencies that ACE and LSC-R captured the information needed from a screening tool to inform decisions for further referral and assessment. There were six agencies that were either using or used ACEs and four agencies were either using or used LSC-R. Each of the following tools were preferred by at least one agency: ACEs, AES , THQ (Trauma History Questionnaire), PCL-5 (PTSD Checklist for DSM-5), TSC-40 (Trauma Symptom Checklist), DTS (Davidson Trauma Scale), and Polyvictimization and Trauma Symptom Checklist. They reported that ACEs and AES would be most suited for the Family Safety Center.

Stakeholders did not mention any particular questions they thought must be included in the Assessment Tool. They shared general gaps in the tools such as suicide screening, anxiety and depression questions, home safety checks, substance use questions, emergency contact information, and questions around animal abuse. They expressed the importance of identifying survivor needs beyond events, symptoms, and feelings, and including practical services (e.g., changing the locks on the doors or helping to pack and move especially if physically injured or infirm). Additional missing topics including stalking, questions about the domestic violence experience of males, questions about veterans, lack of focus on LGBTQIA+ clients, and lack of focus on emergency management for natural disasters (earthquakes and tornados).

Some general agreements on the tools and the processes were that personal engagement (interview format) yields better information than self-report; collecting screening information within the first three visits is ideal; trauma symptoms screenings are sometimes used repeatedly through treatment; and education and training across collaborative agencies on polyvictimization and screening for risk behaviors is necessary. Partners believed the important pillars are training and education for future assessors because the comfort of the assessor when using the Assessment Tool is essential to capturing accurate information from the client. Additionally, they expressed the assessor should possess good communication skills and disseminate the

information in a trauma informed manner. They thought considering the clients experience of the violent incident that brought them into the Center and exploring their historical violent experiences was important to capture. Lastly, they cautioned that data sharing would have a different implication for male/female victims, veterans, and LGBTQIA+ populations.

Piloting the Assessment Tool

A stream of questions or a survey does not necessarily support a conversational style, create rapport, or capture the depth of the client's story. Open-ended questions are more likely to facilitate a conversation and build rapport in a short amount of time because the client does most of the talking while the assessor listens. Using close-ended questions controls and directs a conversation and can feel more like an interrogation because it limits the client's response. However, if a person is in crisis, close-ended questions are the better choice to ascertain the situation or capture information because direct and guide the conversation. Of course, if the client is in crisis, it is likely that they should not participate in the Assessment Tool at that time.

To honor the conversational approach that the FSC partners requested, the project team opted to organize the questions from the Assessment Tool into groups encompassing events and symptoms. Open-ended questions were created to represent each group of the Assessment Tool. To this end, the groupings restructured the 39 event questions into 10 groupings and the 22 symptom questions into six groupings for the purpose of context and delivery.

Dr. Worley analyzed site-specific data for the pilot. The graph below shows that clients experienced at least three events and seven or more trauma symptoms.

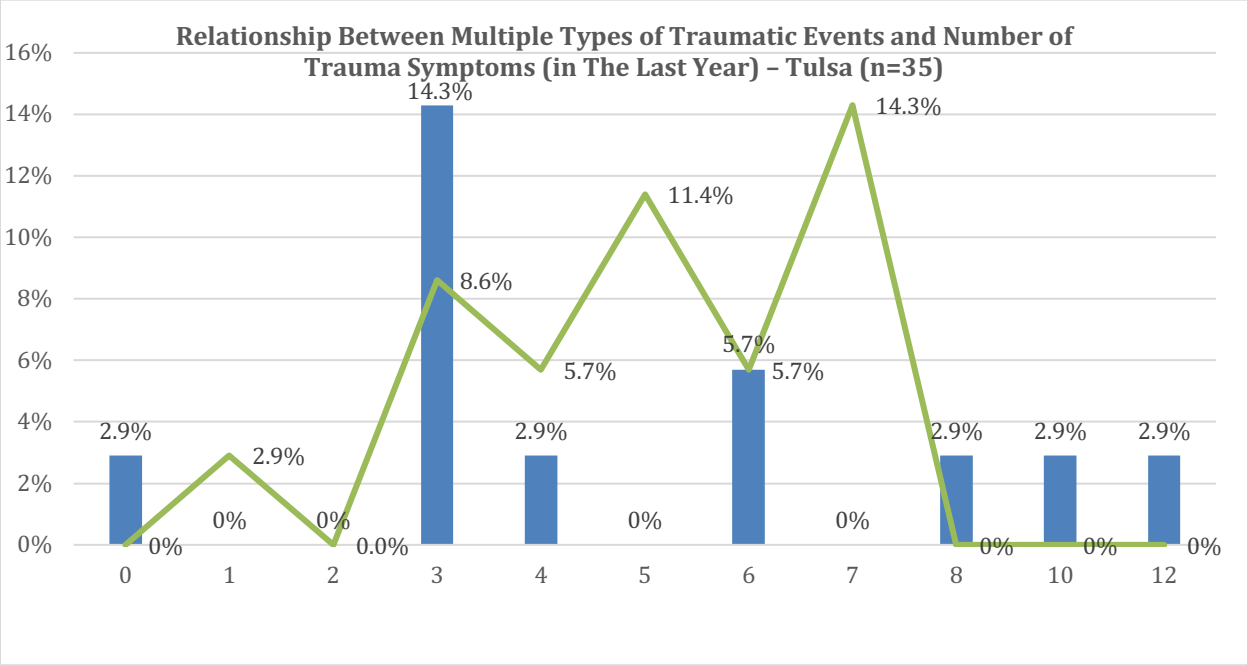


Figure 3: Relationship Between Multiple Types of Traumatic Events and Number of Trauma Symptoms in the Last Year

The most poignant discovery was illustrated in Dr. Worley's single case analysis.

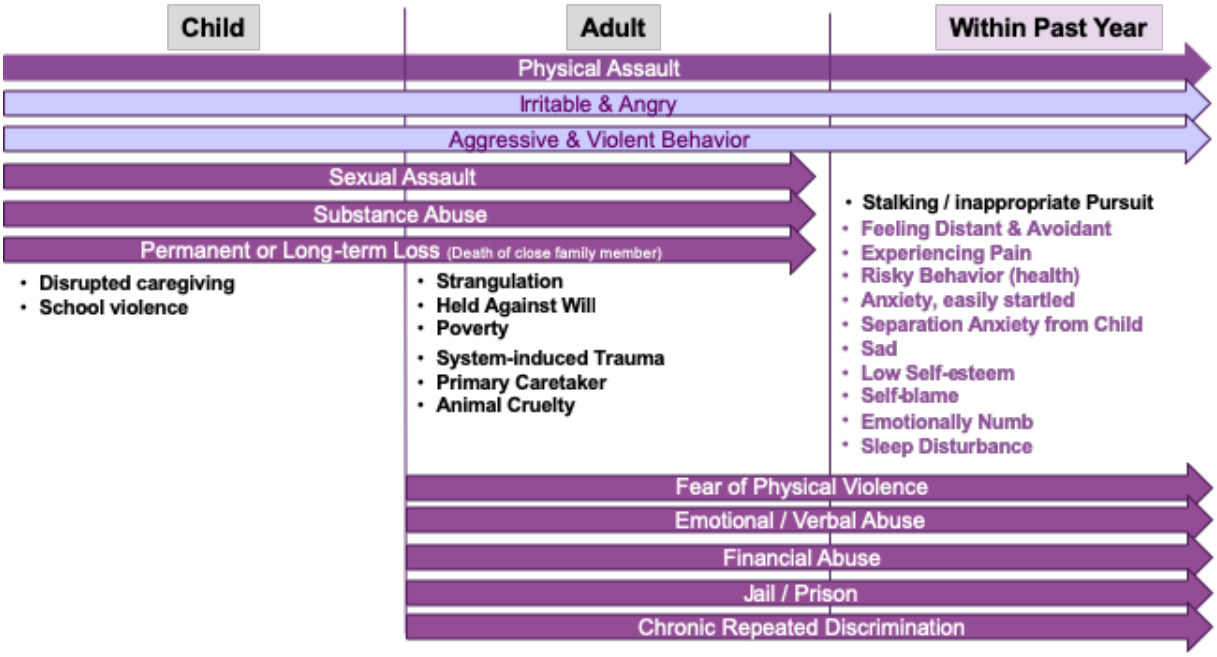


Figure 4: Tulsa Single Case Analysis

"This single case analysis reflects the expressed voice of a single survivor and the lived experience of polyvictimization across his/her lifespan. From the Assessment Tool, we learned that this survivor has experienced some events and symptoms from the time he/she was a child until as recently as within the past year (e.g., physical assault; being irritable and angry; aggressive and violent behavior).

We also learned that some events were prevalent when this person was a child and during adulthood, but are not current experiences within the past year (sexual assault; substance abuse; permanent or long-term loss). Other events were not present as a child but started as an adult and continued within the past year (fear of physical violence; emotional verbal abuse; financial abuse; jail/prison; chronic repeated discrimination). Finally, what this single case analysis shows is that some events were specific to certain periods within the life history of this survivor (disrupted caregiving and school violence as a child; strangulation as an adult; and stalking/inappropriate pursuit and anxiety [started] just within the past year).

By organizing the responses for this survivor in this systematic and focused way, we are able to better "see and hear" the unique lived experience of this survivor that contributes to insight and understanding for making a much more informed referral. While it is likely that some of this story would emerge in later conversations with a counselor/therapist/other helping professional, having access to this information from the initial screening tool allows us to make referrals to even more specific services. This single case analysis reflects some of this person's history on the pathway of polyvictimization. We can use this information to help them along a pathway to hope."

- Dr. Jody Worley

Creation of the Screener

The FSC created the Screener due to time constraints when administering the Assessment Tool. The victimizations were grouped in a natural order of generalized victimizations that rendered 10 questions for events and six for symptoms. Dr. Worley was engaged through the entire process of developing the Screener. The grouping and questions below represent the final version of our Screener.

Event Questions by Group

Group 1 Physical harm #1 #2
Group 2 Emotional Abuse #7 #10 #11 #20 #25
Group 3 Traumatic Loss #14 #15 #16 #17 #23
Group 4 Crime Victim #6 #18 #21 #22
Group 5 Sexual Abuse #3 #4 #5 #6
Group 6 Financial Abuse #8 #12 #13
Group 7 Child Specific #9 #17 #19
Group 8 Natural or Manmade Disaster #24 #27 #28
Group 9 Other #26

Tulsa Family Safety Center
Polyvictimization Screener

1. Have you experienced any physical harm?
2. Have you experienced any type of emotional abuse?
3. Have you experienced any type of traumatic loss?
4. Have you felt threatened?
5. Have you experienced any type of sexual abuse?
6. Have you been the victim or perpetrator of a crime?
7. Have you experienced any financial difficulties?
8. Did you experience any type of abuse or neglect as a child?
9. Have you experienced a natural or man-made disaster?
10. Have you experienced any other adverse situations?

** If the client responded “Yes” to any of the questions above, then the User of the Tool proceeded to ask the survivor about the [victimization] experienced during their lifetime. If client responded “No” then the User moved to the next question on the Screener.

Symptom Items by Group

Group 1 Physical #1 #10
Group 2 Emotional #7 #8 #11 #15 #17
Group 3 Cognitive #9 #16 #17
Group 4 Behavioral #2 #3 #4 #13 #14
Group 5 Re-Experiencing Trauma #5 #6 #12
Group 6 Other #18

Tulsa Family Safety Center

Polyvictimization Screener - Symptoms

1. Have you experienced any physical pain?
2. Have you experienced any emotional pain?
3. Have you experienced any changes in your thought processes?
4. Have your experienced any changes in your behavior?
5. Have you experienced re-occurring thoughts, feelings or behaviors related to the trauma you have experienced?
6. Are there any other emotions, behaviors, or thoughts that you are experiencing that we did not discuss and would you like to share?

** If the client responded "Yes" to any of the questions above, then the User of the Tool proceeded to ask the survivor to describe, share more about the [symptom] experienced during their lifetime and how [the symptom] is affecting the client, if at all. If client responded "No" then the User moved to the next question on the Screener.

The Screener was used at exit interviews as a part of the navigation process before the client exited the Center. The objective was to determine whether or not the Screener would provide the same data as the final Assessment Tool. Additionally, the FSC wanted to determine if either tool (Screener and/or Assessment Tool) would aid in identifying polyvictims and connecting and/or providing them with specific services to meet their needs. The Screener was a shorter version of the Assessment Tool and was easier to incorporate in the exit process because it enabled the navigators to capture significant information and share psychoeducation with the client in an expedited manner. Clients and staff seemed more accepting of the Screener.

Implementation of the Final Assessment Tool – Version 3

During final implementation, the navigators conducted the Assessment Tool with clients who agreed to be assessed. The navigators met with the clients after they completed their intake with the intake specialists and initiated conversation with the client about participating in the Assessment Tool. The client then visited other partners for the services they needed. Prior to leaving the Center, clients conferred with the navigators to ensure they had received the services for which they initially came to the Center. At that time, the navigator would complete the Assessment Tool if the clients were amenable to participate.

Training

The navigators were already trained on the Assessment Tool. However, FSC created an electronic version of the Assessment Tool on ETO and trained the navigators to use the electronic version. There was dialogue about the Assessment Tool in formal meetings as well as impromptu meetings. Communication between the project coordinator and the navigators was ongoing and consistent throughout the day.

The polyvictimization coordinator and navigators regularly discussed the Assessment Tool, the impact it had on clients, improvement of administering the Assessment Tool, and how to recruit clients to participate. They also discussed how to enhance psychoeducation and resource referrals for clients based on their responses on the Assessment Tool. During meeting staff discussed the purpose of the Assessment Tool and strategies for administering the Assessment Tool (e.g. time needed, motivational interviewing, psychoeducation materials, possible referrals etc.). Meetings continued throughout the final implementation, during which the team actively processed questions, challenges and successes.

How the Assessment Tool Guided Service Delivery

The Assessment Tool guided service delivery on many levels. It helped educate the staff and partners about polyvictimization and how to recognize and work with clients who presented with it. The Assessment Tool brought a richer, trauma-informed lens to Center practices with clients, staff, and partners. It helped the team gain insight into the services that the Center lacked. The Assessment Tool provided numerous lessons that ran deep into the organizational structure for clients, staff, and partners.

> "The Assessment Tool provided the navigators with more in-depth information about the client and their experiences with trauma. This helped navigators provide more personalized referrals for clients based on the types of trauma they have experienced. It also gave navigators a good opportunity to provide more personalized psychoeducation based on the client's experiences."
>
> **- Rhiannon Dennis**
>
> "The Polyvictimization Assessment Tool allowed us as navigators to establish better rapport with our clients, and because of this, we were able to identify and discuss with our clients other available community supports and resources, which may not have been requested during our initial contact. The Assessment Tool has also opened the discussion for how we, as navigators, can enhance interactions with our clients. For example, printed materials to help clients better understand the psychoeducation provided, as well as the results of the Assessment Tool."
>
> **- Karen Warrior**

Some of the changes that staff saw as a result of utilizing the Assessment Tool included: more individualized referrals to additional services, increased client awareness of the connection between their current event and the prior incidents in their lives, and a deeper connection between the navigator and the client.

"Based on the client's response and/or questions regarding the items in the Assessment Tool, we were able to identify additional needs of each client. For example, a client may not have realized the significance of several major losses during their lifespan, and the Assessment Tool offered a pathway for discussion/psychoeducation on loss and the grieving process, as well as connection with grief counseling services within the community."

- Rhiannon Dennis

Shift in Approach from Pilot to Final Implementation

While there was not a substantial shift in approach from the pilot to final implementation, the Center incorporated several small adjustments. There was a shift in how the navigators explained the Assessment Tool. Navigators told the clients that the Assessment Tool could possibly help them understand the traumatic events and symptoms they have experienced. The navigators also set appointments for other services and asked the clients to take part in the Assessment Tool when they returned to the Center.

A Different Approach

FSC staff shared that they would have created a built-in aspect to the Assessment Tool that would provide a way to share the client's strengths or protective factors. It is important to provide positive resilient characteristics as well as share the historical occurrence of victimizations and the related symptoms. The Hope Scale was recommended as a tool to show resilience. The FSC opted to ask two of the questions off of the Hope Scale during the exit evaluation. The clients showed a higher level of hope upon leaving the FSC.

Below are Dr. Worley's findings from the 89 Assessment Tools that were completed at the FSC during final implementation.

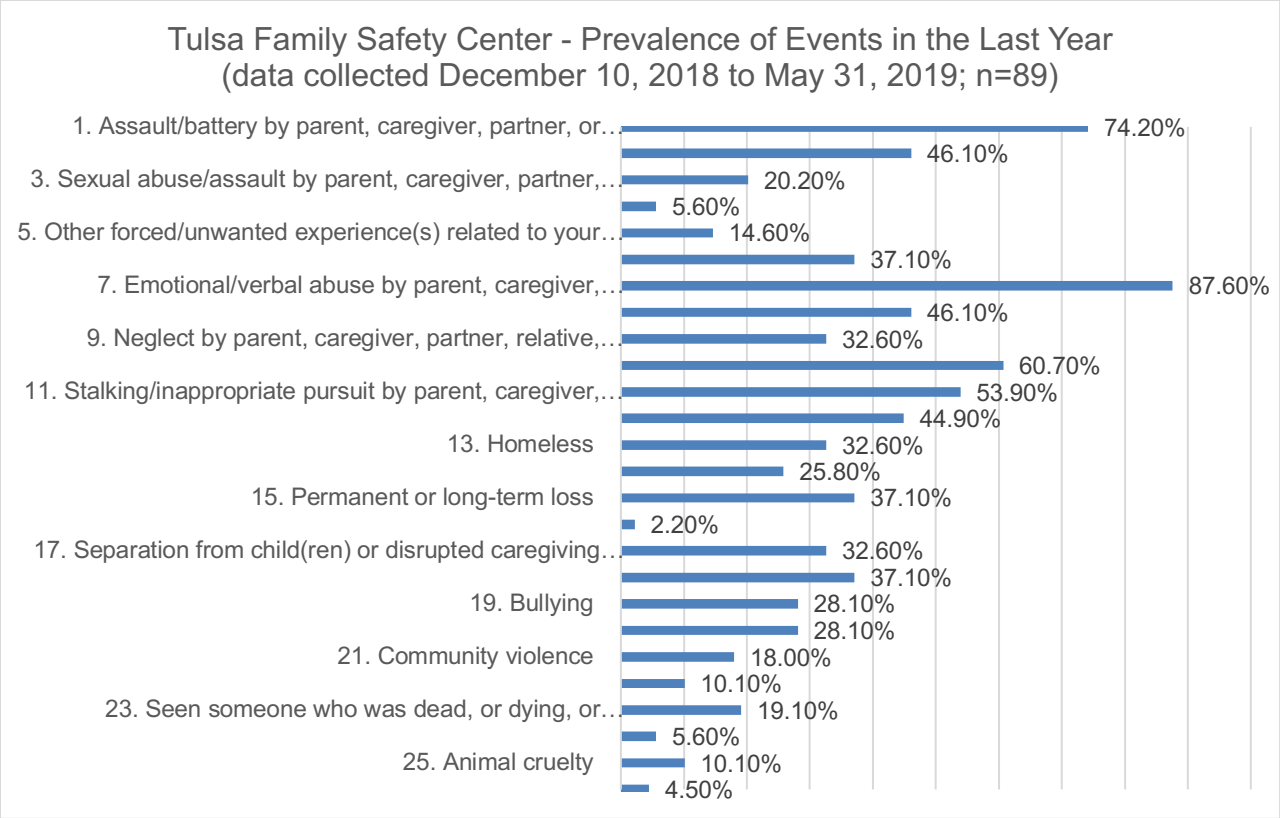


Figure 5: Pilot Testing Data – Tulsa Prevalence of Events (In the Last Year)

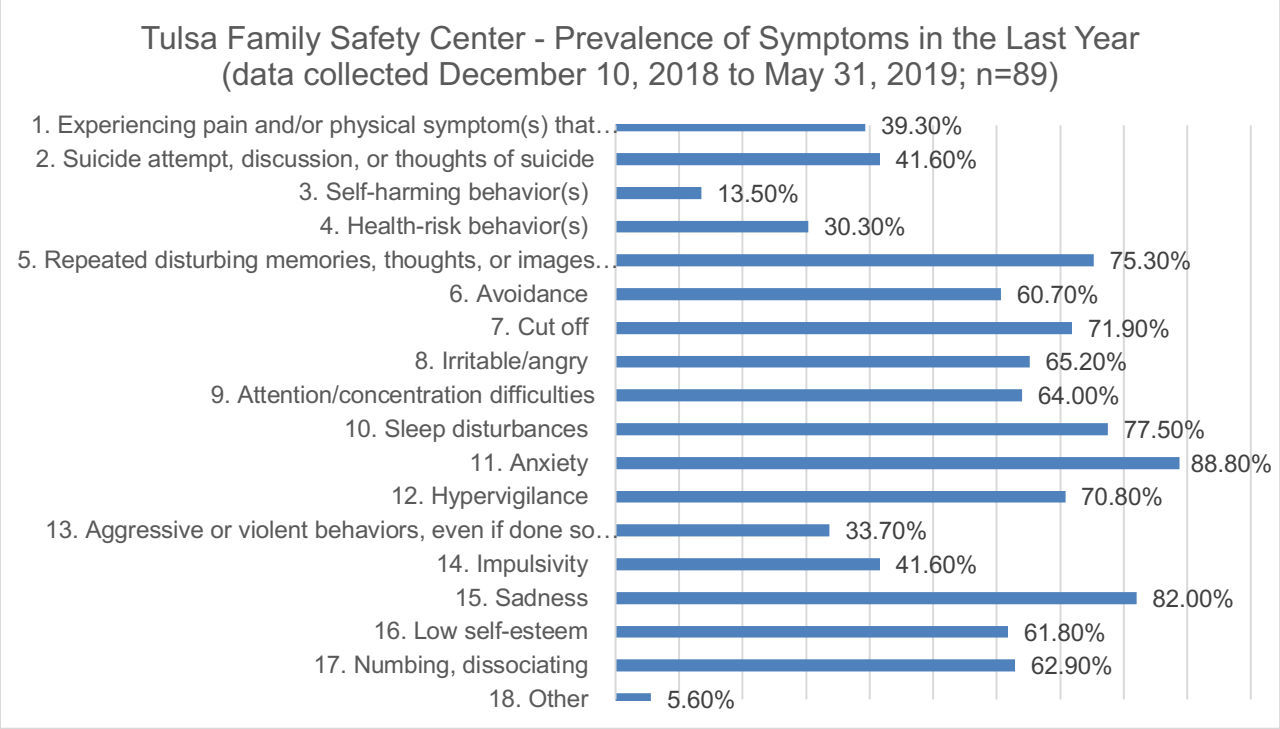


Figure 6: Pilot Testing Data – Tulsa Prevalence of Current Symptoms

Survivor Views on the Polyvictimization Assessment Tool

FSC conducted two focus groups in 2018 and one focus group in 2019 to gather information concerning clients' experiences with the Polyvictimization Assessment Tool during the pilot and final implementation phases. The goal was to better understand: their perception of the Assessment Tool, how long it took, how clients felt about answering the questions, and their beliefs around the value of the Assessment Tool. The overall goal was to consider the survivor's perspective when making alterations to the Assessment Tool.

Clients were overwhelmingly pleased with their experiences at the Center: they arrived nervous and left hopeful. Survivors stated that they utilized services and were generally content with the services they received. They felt respected and heard.

Survivors expressed their concern with the length of the Assessment Tool. They shared that the time spent in the FSC to obtain services was long enough and believed the Assessment Tool extended the time spent in the FSC. Clients suggested the intake staff provide the Screener and the navigators make an appointment on the client's protective order court date to administer the full Assessment Tool. Others shared they were not prepared to answer all of the questions but were thankful for the connection with the navigator and the awareness they gained about themselves and their lives by participating in the process.

Survivors all agreed that the client should ultimately decide how to complete the Assessment Tool, whether as a checklist or a conversation. But almost all agreed that to complete the Tool they needed to be informed of the context and purpose of the Assessment Tool.

The group collectively responded and agreed that it is important for the process to be tailored to the client. They believed adding more onsite services and individualized safety planning personalized to the type of trauma would be helpful. Clients shared that the FSC should add mental health and substance abuse providers onsite. They shared that co-locating such providers onsite could help clients transition smoothly to longer-term care with therapists at the mental health provider's home office.

Another stated that debriefing the client before they leave the Center is important. The group believed the FSC client flow process does a good job getting people what they need. One survivor shared that there should be follow-up with the survivor and the perpetrator to ensure they are accessing therapeutic services. The group responded that if the Assessment Tool is completed in a supportive way, it can help clients gain insight into their lives. They stated that service providers need to have empathy, truly listen to clients, and work to meet survivor needs in an empathetic manner.

Lessons Learned, Keepers, Do Overs at Conclusion of Initiative

The FSC experienced successes throughout the Demonstration Initiative. They built a stronger trauma-informed framework for clients, staff, and partners. The Assessment Tool revealed areas in which the FSC needs to onboard onsite partners to better serve clients. It verified that most clients seeking services are polyvictims. It opened doors for

the Center to provide more tailored services to individuals. The greatest success was that the FSC began the shift from operating purely as a crisis-centered, protective order focused FJC to a community to which survivors return to ask for additional assistance when they need it. The Demonstration Initiative provided a pathway of growth for the Family Safety Center.

One of the surprising aspects about the Initiative was the timeline of the process. In the beginning, progress felt unsettlingly slow. Looking back, activities which seemed to be untimely were actually useful for observations, connection making, creativity, and formulation of plans, which then led to action. The team frequently felt lost and confused during the first year of developing the Assessment Tool and pilot testing because they kept looking for the "way" before realizing that sites were in fact creating the "way". In recognizing this process, staff learned that re-evaluation is essential for growth and provides a pathway for change. New centers looking to implement the polyvictimization framework need to be prepared to embrace change. Learning, training, and applying trauma-informed practices with clients, staff, and partners created greater transparency and connection.

"The most surprising thing about utilizing the Assessment Tool was how all but one of the participants felt relieved after completing the Assessment Tool because they felt that their experiences were validated. The one client that did not find the Assessment Tool helpful did not complete it because she found the questions triggering, so we stopped at that point and transitioned into a crisis counseling session."

- Rhiannon Dennis

"I was not surprised. I did learn that what is viewed as trauma/victimization greatly depends on a person's experience and coping skills. I think that it helps to be very aware of your own personal biases, values, and experiences to avoid transference to your clients."

- Karen Warrior

The FSC consistently refers to the client mapping process to create better approaches that develop more effective service delivery. It enabled FSC to review the client flow process on a regular basis and make alterations to enhance services. It was the necessary visual guide for the process. When it was a challenge to keep the client flow process intact from beginning to end staff and partner agencies referred to the client mapping process for assistance. The FSC recommends that centers engage in a client mapping exercise to create a visual of their client flow process to learn, grow and ultimately become more effective. It was through the client mapping process, it became glaringly obvious that FSC lacked physical space to facilitate an all-encompassing trauma-informed environment. To alleviate this, leadership secured a new facility and location for an expanded facility.

The FSC found that the most successful strategy was to develop a connection with the client. This connection increased the number of returning clients because they came back to check-in, ask for additional help, and even assist other clients.

> "The most successful strategy utilized was establishing a rapport with the client's early in the process. We also found it beneficial to incorporate the Assessment Tool as a part of an ongoing service for returning clients; e.g. maybe a client was willing to participate but didn't have time during the initial visit, but rapport allowed us to schedule an appointment at the client's convenience to administer the assessment."
>
> **- Rhiannon Dennis**

Frontline staff found that the most difficult part of the process was finding clients willing to complete the Assessment Tool. Most people declined due to time constraints. Scheduling appointments were unsuccessful as clients would no-show or cancel the appointment. Different approaches were tried when discussing the Assessment Tool with clients. They seemed more willing to complete the Assessment Tool when explained in terms of how it could bring insight to their experiences rather than the impact the research may have. Once that was discovered, clinicians would start with how it could help clients and discussed the research at the end of that conversation. Another challenge involved determining which situations were appropriate for use of the Assessment Tool. Because the majority of clients visit the FSC to file an Emergency Protection Order, staff had to read non-verbal cues and use listening skills to assess the client's emotional ability to participate in the Assessment Tool.

> "I learned how many mental health and victim service providers believe it is damaging to ask clients about their trauma. This topic was discussed regularly on calls and I always found that most clients find it helpful and validating to discuss their traumatic experiences. After completing the Assessment Tool with 46 people during final implementation, no clients reported that it was a negative experience for them. The one client that was triggered stated that she felt it was too soon for her to complete the Assessment Tool, but that she could see how it would be helpful at a later time."
>
> **- Rhiannon Dennis**

The survivors who participated in the Assessment Tool were relieved that someone finally asked them about the traumas they experienced.

"A client with a high number of traumas came in for services. Prior to completing the Assessment Tool she had only identified a few of the events as traumas because she thought only physical and sexual abuse were considered trauma. She said it opened her eyes and helped her understand why she has some of the symptoms she has experienced. She also appreciated the psychoeducation that was provided. She was relieved when gaslighting was explained as an abuse tactic. She had been gaslighted by her abuser for years and as a result she thought she was 'crazy.' She reported that it helped her realize that she is not crazy and that her symptoms were a result of the trauma she had experienced over the years. The experience was validating for her. She accepted referrals for counseling and a sleep study for people with insomnia and chronic nightmares."

- Rhiannon Dennis

Through this Initiative, the FSC discovered that many of the Center staff also experienced trauma. Numerous professionals in this field survived many trauma-filled events both professionally and personally. The Polyvictimization Demonstration Initiative provided a pathway to healing for the professionals at the Family Safety Center as described in the previous section trauma-informed organization. The FSC actively welcomes transparency, embraces mistakes, and expects and accepts conflicts as a part of the daily operations.

"Preparation. Make sure your staff/Center understand and are prepared to invest the time necessary to walk the client through whatever the Assessment Tool may bring up for them. Having a practice or resource for the Assessment Tool assessor to debrief after sessions, if needed, was also helpful...Trust your skills and training when working with people. While data collection is a wonderful tool to guide practice and to provide better service, it cannot/should not be your primary focus."

- Karen Warrior

The Assessment Tool allowed staff to gain a deeper understanding of the trauma with which clients had to cope. It provided a conversational way to obtain information from the client to better assist them with services. The Assessment Tool affected the way frontline staff work with clients, particularly because it assists in obtaining helpful information they would not have previously obtained. The Assessment Tool presents excellent opportunities to share psychoeducation, and provide suggestions for services directly related to experiences clients have shared. It is a much more individualized, personalized way of working with clients. Ms. Dennis believes that for clients who completed the Assessment Tool, she was able to provide more in-depth psychoeducation and more tailored referrals because of the knowledge gained in the process. She felt the Assessment Tool was thorough but thinks that the question about living in a military or combat war zone would be helpful to keep on the Assessment Tool, despite the fact that most clients have not experienced that type of trauma. Veterans visit the office on a regular basis and that question would apply to them if they

were deployed in a combat zone. Ms. Warrior said that the Assessment Tool provided a pathway to increase rapport; she would not say it changed the way she interacted with her clients.

Acknowledgement of People and Agencies

Thank you to Office for Victims of Crime for giving the Family Safety Center this opportunity to learn and grow as a Family Justice Center that is better serving our community. Thank you to Alliance for HOPE International for guiding the Centers in this journey. The FSC appreciates all that the Alliance has done to facilitate the success of this Initiative. Thank you to Milwaukee, New Orleans, Queens, Sonoma, and Stanislaus for sharing this journey. Thank you, Dr. Worley and Ms. Nida'a Abu Jbara, for making the research process a supportive and seamless endeavor.

Most importantly, the FSC would like to thank the survivors and express their gratitude for their trust to participate with us in the focus groups as well as those who opted to be assessed with the Assessment Tool and our VOICES members. Their input has been invaluable.

The FSC also wants to thank all of the onsite and offsite partners and the community partners that actively participated in this endeavor: Parent Child Center of Tulsa, Legal Aid Services of Oklahoma, Tulsa Metropolitan Ministries, Tulsa Police Department-Family Violence Unit and SANE Forensic Nurses, Oklahoma Equality Center, Tulsa County Sheriff Department, Community Service Council, HARUV USA, 14th District Court, Tulsa County Court Clerk, Office of the Attorney General, Ascension - Saint John's Hospital, LIFE Senior Services, Tulsa County District Attorney, Mental Health Services of Oklahoma, OU Tulsa Police, Domestic Violence Intervention Services, Counseling and Recovery Services of Oklahoma, Family and Children Services, Muskogee Creek Nation, Cherokee Nation, Department of Health and Human Services, Day Springs Villa, and OU Internal Medicine.

Chapter 9

Stanislaus Family Justice Center

Stanislaus, California

Authors: Arleen Hernandez, Lisa Mantarro Moore, and Jim Myers

CHAPTER 9: Stanislaus Family Justice Center

History of the Center

On April 15, 2009, the Stanislaus County Board of Supervisors passed an ordinance establishing the Stanislaus Family Justice Center (SFJC). Community stakeholders, including the Modesto City Council and additional policy leaders, joined committees that focused on initial development, governance, and facilities. The SFJC opened on October 22, 2010, with the mission to offer victims and survivors a path to safety and hope through compassion and coordinated services. The Center's grand opening was strategically scheduled to immediately follow the Family and Domestic Violence Coordinating Council's annual conference. The District Attorney's Office was at the forefront of developing the Family Justice Center in Stanislaus County. The Sheriff's Office was also a strong proponent of the framework and provided staff for committees as development commenced. In September of 2017, the SFJC moved to its current location at 1418 J Street, where it provides a wide variety of services to the community. The SFJC had the distinct honor of being recognized as Nonprofit of the Year by the California State Senator Cathleen Galgiani in June of 2018. The work of SJFC is strongly supported by the local community and has garnered statewide recognition.

As a nonprofit organization, the SFJC is overseen by a volunteer Board of Directors comprised of 13 community members who bring a wide variety of professional expertise ranging from banking to health administration. The Board of Directors has been actively involved with the SFJC since the Center's opening. Board members not only volunteer their time and talents to the SFJC but also fundraise to support the Center's nonprofit status. The SFJC initially collaborated with six partners that shared office space in the facility and included the Child Abuse Interviews Referral and Evaluations (CAIRE Center), Sheriff's Office, Behavioral Health and Recovery Services (BHRS), District Attorney's Office, Children's Crisis Center (CCC), and Haven Women's Center (HAVEN). The SFJC currently collaborates with eight onsite partners that include the CAIRE Center, the Sheriff's Office, BHRS, the DA's Office, HAVEN, Without Permission (WP), Center for Human Services (CHS), and Sierra Vista Children & Family Services (Sierra Vista). SFJC has the privilege of housing its own Civil Legal Unit comprised of attorneys, paralegals, and legal advocates who provide legal assistance to clients for restraining orders, child custody, dissolution/divorce, and immigration matters. This Demonstration Initiative provided SFJC with even more opportunities and resources for clients. It helped the Center establish and fund the Trauma Support Service Unit (TSSU), which is comprised of interns from Brandman University and supervised by a Licensed Clinical Social Worker. This unit provides mental health services and support to adult clients and their families. A brief description of SFJC's partners and their services can be found at the end of this chapter.

Data gathered from 2017 to March of 2019 indicates that, on average, SFJC serves 230 new clients and 1,250 returning clients per year.

Community Context

Although Stanislaus County's population is 44% Latinx, SFJC clients are almost 60% Latina. Of the 20.5% foreign-born residents in the County, 38.7% are naturalized U.S. citizens and 61.3% are not U.S. citizens. Immigration raids, misinformation of immigration policies, and rising reports of violence against immigrants incite more fear in the community served by SFJC.

The county hosts a largely agricultural community and many clients represent that demographic. Client population consists largely of field workers as well as undocumented individuals. SFJC developed positive relationships with onsite partners as well as offsite partners and spearheaded a prevention focused movement within the community. The number of individuals identified as polyvictims has affirmed the necessity for additional client services.

The current political climate surrounding the topic of immigration discourages immigrants, regardless of status, from reporting crimes. This includes mixed status families, where a victim of a crime may be a United States citizen or permanent resident who refuses to report for fear of jeopardizing undocumented family members or jeopardizing their own pathway to citizenship. The fear of reporting crimes and risking deportation can be a tool used to abuse people who entered the country without authorization. This tactic has been seen in cases of workplace abuse, theft of wages, and domestic violence, intersecting with the realities of living as an immigrant who is a woman, LGBTQIA+, elderly, disabled, a dependent child, or any other typically marginalized person.

At the SFJC, prospective clients have often expressed concern about entering the building after seeing law enforcement vehicles in the parking lot. These individuals have indicated to other clients, staff, and community members that they are fearful of retribution by the government if they seek services, file police reports, or file for legal assistance. Those who do come for services have resorted to not fully identifying their situation for fear of reprisal or deportation. They fear not only for themselves but for their extended family, including their offender. The SFJC has tried to alleviate their concerns, and the increase in fluent bilingual staff has allowed the Center to break down certain barriers and provide reassurance and support to clients served.

Original Site Goals and Focus of the Polyvictimization Initiative

The SFJC applied to the Polyvictimization Demonstration Initiative, understanding that the ability to build and develop a polyvictimization framework would be crucial to the survivors in their community. The Center engaged in a strategic planning process to identify service gaps and develop an implementation plan for the use of the Polyvictimization Assessment Tool and the delivery of holistic victim services. Stakeholders were instrumental in this process and included SFJC staff, mental health providers, community leaders, and client advocates. The robust variety of perspectives ensured that SFJC had several voices and experiences from which to draw. The SFJC

also ensured that policies and practices would promote and protect victim confidentiality, privacy, and safety. This Initiative also required the SFJC to improve infrastructure for systematic collection and analysis of victimization data and evaluation of programs.

In order to provide more comprehensive services, new partnerships needed to be established to provide vision, holistic healing, and self-care programs for survivors as SFJC proceeded forward in the Initiative. The SFJC anticipates hiring a Client Wellness Coordinator in the next two years to create and implement activities requested by polyvictims (Reiki, dance, meditation, yoga, journaling, mindfulness activities) and recruit instructors to provide these activities either in-kind or at low cost.

In preparation for a more comprehensive the community for this process, Dr. Chan Hellman conducted a free stakeholder workshop in July 2019 on the science of hope. This training drew over 85 attendees, including law enforcement, probation officers, victim advocates, mental health advocates, educators, social services, child welfare services, adult protective services, and additional key community stakeholders.

SFJC also began working with Atomogy, a software development company based in Modesto, on the development of an automated case management system to collect data within the agency, provide more efficient services to the client, and evaluate and report program outcomes.

Gary Bess and Associates served as the research partner and were contracted to assist with process evaluation regarding strategic planning, tool selection, pilot testing, and final implementation.

SFJC Lobby

SFJC Private Waiting Room

SFJC Children's Room

SFJC Waiting Area

SFJC Intake Rooms

Implementing Trauma-Informed Care Approaches

In June 2017, SFJC Office Manager Arleen Hernandez attended the two day "Train the Trainer" on trauma-informed approaches hosted by the Alliance. At the training, Arleen learned new methods to improve client care and helped educate SFJC staff on methods for interacting and connecting with clients on a more organic and personal level. The training also emphasized the importance of holistic care and other approaches to providing services. It is often too easy for service providers to become lost in the documentation and procedural paperwork, but the trauma-informed lens reiterates the necessity of engaging clients and providing wraparound care. Arleen's ability to connect with peers from the Initiative was crucial. Not only did it strengthen her resolve in the mission of the Demonstration Initiative, but it also provided her with the necessary resources to further develop SFJC programs. Arleen adopted an active role in working with frontline staff to better educate them on ways to receive and engage with clients. She demonstrated the need to personalize services and remind frontline staff that each client has a history that needs to be respected and addressed. As a result, SFJC revisited the flow and structure of the facility.

The training spurred positive changes in the SFJC layout as staff and leadership became aware that the front lobby, waiting area/café, Kids Zone, and interview rooms. A close review of these areas affirmed the areas were functional, yet not warm or inviting. Management examined these spaces through a new, more trauma-informed lens and realized they needed to be client-centered as opposed to simply functional and tidy.

SFJC added stress balls and small gadgets for clients waiting to be seen in the lobby, provided small games for children in the lobby, included a weighted blanket for the children in the Kids Zone, hung encouraging messages in the interview rooms, and displayed art projects done by other clients in the café. They also replaced interview

room chairs with couches, added soft lighting, and placed sound machines in the first-floor interview rooms to ensure privacy and confidentiality.

SFJC also developed new service models to incorporate more engaging and positive activities which include yoga, crafts, and healing services. The SFJC coordinated with two partner agencies, the Center for Human Services and Sierra Vista, to offer more group sessions both onsite and offsite. The staff has noticed general success when victims of trauma have the opportunity to heal with their community using nontraditional self-care methods. Due to the difficulty clients may experience with finding time and flexibility to come to the Center for their direct self-care, SFJC developed plans with facilities around the community to offer services that include childcare and located them with awareness of transportation constraints. The SFJC is in the process of coordinating with the nine Family Resource Centers in the county who are managed by the Center for Human Services to offer wellness services and find ways for clients to heal with both cultural sensitivity and awareness of their life situations.

At the outset of the Initiative, Centers agreed that survivor inclusion and incorporation of their feedback would be crucial to creating a trauma-informed polyvictimization framework that meets their needs. The SFJC conducted a small focus group with clients and received feedback about both the length and content of the Assessment Tool. Several of the clients indicated they were unprepared to answer questions about their lives and previous abuse and trauma from their childhoods. Those interviewed in Spanish seemed to be comfortable with the Assessment Tool and appreciated their ability to share experiences that they had not previously been asked. It was interesting that the English-speaking members of the focus group referenced that the use of the Assessment Tool could be triggering. It seemed as though the cultural differences of the clients dictated their appreciation of the Assessment Tool.

Client Mapping Process

A key outcome of the client mapping process was to develop an intake process that was respectful and welcoming to clients. Previous focus groups revealed that clients' initial contact with SFJC could be uncomfortable and confusing. The following quotes from clients participating in the focus group highlight this finding:

> "…It was super unclear while I was here and even up to the point when I was doing the intake. I didn't know why I was here.
>
> **- Survivor**

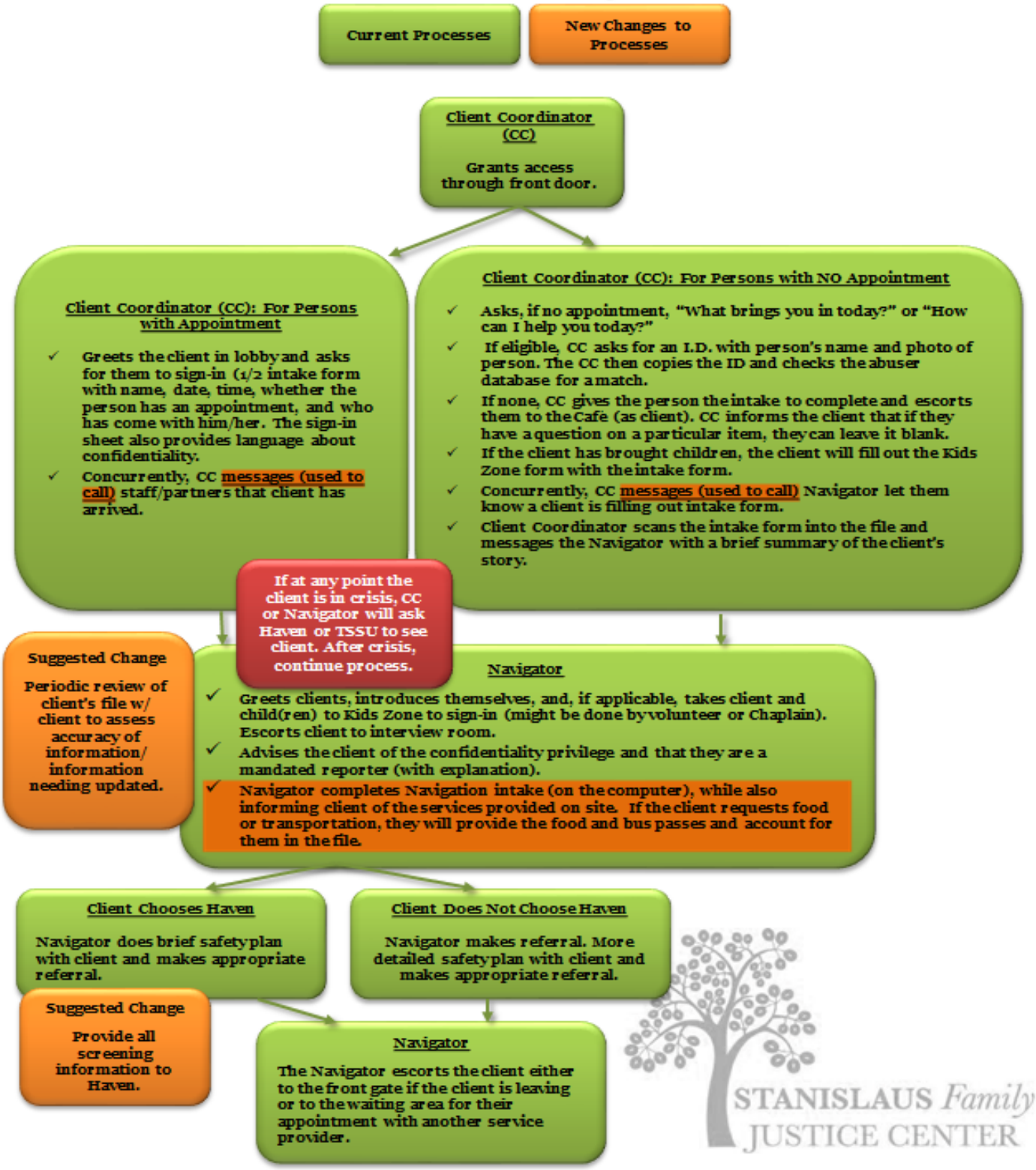
> "I don't think they really could have made it any different or better other than make me aware why I was doing it in the first place. If I'd known there were a lot of services in this building that would have been a blessing. Then I probably would have been a little more at ease, and felt a little less interrogated."
>
> **- Survivor**

With the feedback and understanding that the initial contact with clients is crucial, the SFJC and its onsite partners developed the client process map to revisit and revamp the intake process. A committee comprised of staff, partners, research partners, and stakeholders convened every other month to review the mapping of client activity. The committee evaluated case scenarios used roleplay to review, dissect, and make comments on what the current process entailed. From those meetings, the Center modified and developed new models and strategies for client intake. Throughout the Initiative, the committee and partners would revisit the client mapping process.

It was through the client mapping process, the SFJC developed a more secure check in process in the lobby, that protected the safety and confidentiality of staff and clients. The SFJC also enhanced client and staff safety after pilot testing of the Assessment Tool. Visitors and clients were provided badges upon entry and staff was more cognizant of where clients were sitting so that their safety was not compromised.

Stanislaus Family Justice Center

Client Process Map



Assessment Tool Development and Implementation

The SFJC created a Strategic Planning Committee, comprised of professionals and survivors to provide guidance throughout the Demonstration Initiative. One of their first tasks was to review the 30 validated instruments provided by the Alliance through the literature review.

The Committee examined the tools using the guided process outlined below:

Guiding Questions:

Out of the recommended tools, which are your top 3 favorites and why?

Please be sure to think about specific reasons: such as length of time to complete, format of questions, wording from specific questions, etc.

What criteria did you use to select your top three (3) favorite tools?

Which tool(s) would be best suited for screening victims/survivors and why?

Please be sure to account for time to complete, qualifications of person completing the tool, logistics, etc.

What did the recommended tools miss?

Are there "local" trauma questions that you think should be included for the SFJC? If so, what kinds of questions?

Any other comments?

Seven tools were ultimately chosen by the Committee for a deeper analysis and ultimately the four tools below were recommended to the Alliance as tools that could create the basis of the Polyvictimization Assessment Tool. Below is a list of the tools and recommendations made by the Strategic Planning Committee:

1. Combine the Adverse Childhood Experiences (ACEs) and the Adult Experiences Survey (AES)

*Rationale For Choosing **ACEs**:*

The committee liked that the instrument was short – only 10 items – and specifically addressed polyvictimization.

"I liked the format, it is short. Questions are easy to understand, and if we are looking at polyvictimization, this is what it gets to."

- Steering Committee Member

*Rationale For Choosing **AES**:*

The committee found the AES to be a good accompaniment to the ACEs because it addresses trauma experiences in adulthood. They found the questions clear (e.g., minimizes interpreting what domestic violence means to a particular individual) and they thought the assessment's focus on many events and issues was a strength.

> "Questions don't title it like domestic violence or sexual assault. It asks about the particular behavior that is happening to you, so you wouldn't have to necessarily identify yourself as a victim of a particular behavior."
>
> **- Steering Committee Member**
>
> "Addresses a lot of different events/issues I haven't seen before [on surveys]."
>
> **- Steering Committee Member**

2. Life Stressor Checklist-Revised (LSC-R)

*Rationale For Choosing **LSC - R**:*

The Committee members agreed that the LSC-R thoroughly assesses each trauma. The committee also liked that the assessment was self-administered, potentially producing more reliable answers. It was also determined to be non-invasive, as it did not delve into too much detail about the traumatic event(s). The main issue identified with using the LSC-R, however, was that it could potentially take a long time to complete if the individual experienced several traumatic events.

3. PTSD Checklist For DSM-V (PCL-5)

*Rationale For Choosing **PCL-5**:*

The committee liked the response set categories (*Not at all*; *A little bit*; *Moderately*; *Quite a bit*; and *Extremely*) and the detailed, salient questions. However, they found some questions to be quite long.

> "Strong jumping off point if you had some concerns about someone having PTSD because it follows the DSM."
>
> **- Steering Committee Member**

4. Trauma Symptom Checklist (TSC-40)

*Rationale For Choosing **TSC-40**:*

The committee liked the scaling format of no labels for mid-scale categories (0 = Never, 1, 2, 3 = Often) and found the succinct survey items and scoring rubric to be a key strength of the instrument.

Piloting the Assessment Tool

In the piloting phase, 28 Assessment Tools were completed by new and returning clients. Of the 28 Assessment Tools completed, three-quarters (75.0%) were completed

in two or three sessions. The average number of sessions needed to complete the Assessment Tool was similar between new clients (mean = 2.00) and returning clients (mean = 1.82).

After initial pilot testing, the SFJC had to review its implementation. Originally, the Learning Exchange Team (LET) believed that the SFJC navigators and HAVEN staff would complete the event portions of the Assessment Tool and that the TSSU would complete the symptoms portion. However, during pilot testing HAVEN informed the SFJC that it would not be able to return the completed Assessment Tool to SFJC staff, citing confidentiality concerns. This required the SFJC to work solely with TSSU. During the piloting phase, periodic brief "check-ins" with staff completing the Assessment Tool were conducted to assess initial perceptions of use (e.g., the utility of the tool, the length of time required to complete). Key takeaways about the Assessment Tool are presented below.

Final Implementation Results

The key findings regarding the rates of prevalence regarding events, symptomology, the type of events, and symptomology experienced by clients are presented below. The results are based on a sample of N=35.

Childhood Events and Symptoms

- ✓ The average number of childhood events for clients was 3.8, with 42.9% of clients having experienced at least five childhood events. The top childhood events experienced by clients were 1) *bullying* (37.1% of clients); and 2) *assault/battery by parent, caregiver, or relative* (31.4%), *sexual abuse/assault by parent, caregiver, relative, friend, or other* (31.4%), and *emotional/verbal abuse by parent, caregiver, relative, friend, or other* (31.4%).
- ✓ The average number of childhood symptoms for clients was 3.2, with one-quarter (25.9%) of clients having experienced at least five childhood symptoms. The top childhood symptoms experienced by clients were 1) *repeated disturbing memories, thoughts, or images of a stressful experience* (experienced by 40.0% of clients); and 2) *being irritable or angry* (28.6%), *sadness* (28.6%), and *numbing or dissociating* (28.6%).

Adult Events and Symptoms

- ✓ The average number of adult events for clients was 8.7, with 97.1% of clients having experienced at least five adult events. The top adult events experienced by clients were 1) *emotional/verbal abuse by a parent, caregiver, relative, friend, or other* (88.6% of clients); 2) *poverty* (62.9%); and 3) *strangulation and/or positional asphyxia* (54.3%).
- ✓ The average number of adult symptoms for clients was 6.5, with two-thirds (65.7%) of clients having experienced at least five adult symptoms. The top adult symptoms experienced by clients were 1) *repeated disturbing memories, thoughts, or images of a stressful experience* (80.0% of clients); 2) *sadness* (68.6%), and 3) *low self-esteem* (62.9%) and *sleep disturbances* (62.9%).

Recent Events and Symptoms

- ✓ The average number of events in the last year for clients was 6.5, with two-thirds (65.7%) of clients having experienced at least five events in the last year. The top events experienced in the last year by clients were 1) *emotional/verbal abuse by a parent, caregiver, relative, friend, or other* (74.3% of clients); 2) *poverty* (60.0%); and 3) *assault/battery by parent, caregiver, relative, friend, or other* (40.0%).
- ✓ The average number of current symptoms for clients was 5.7, with 57.1% of clients experiencing at least five current symptoms. The top current symptoms experienced by clients were 1) *repeated disturbing memories, thoughts, or images of a stressful experience* (68.6% of clients); 2) *sadness* (65.7%), and 3) *low self-esteem* (57.1%).

Lessons Learned

Strengths of the Assessment Tool/Process

Staff reported that using the Assessment Tool facilitates getting a detailed client background (e.g., history and any recurring trauma events), and allowed for staff to obtain a more detailed view of the experiences that their clients faced. The vulnerability of clients allowed staff to approach clients with a softer, more sensitive appreciation for their past experiences.

It was clear that textbook handling of trauma victims does not apply to each person. The clients' past experiences certainly led them to react differently to current situations. This allowed the SFJC staff to see patterns and identify trends in the victim's lifetime and connect with their family and children at a deeper level. Staff found that sharing information amongst the SFJC intake team gave clients an even better experience of services that previously identified.

In addition, the Assessment Tool gave staff an opportunity to enhanced case management. The more comprehensive information a client provided gave staff the opportunity to find appropriate resources. Many of these resources did not come from the client's initial request for service, but became apparent during the use of the Assessment Tool.

Staff also reported that clients responded positively to sharing their traumatic experiences. Clients felt as though they were being heard and that their experiences were taken seriously and not dismissed. The Assessment Tool gave staff a chance to better connect with clients and gave clients a chance to see that they could trust staff.

Other strengths when using the Assessment Tool were that the process allowed clients to "connect their own dots" as it related to their trauma experiences. Staff noticed that many clients had been in survival mode for so long, that they did not acknowledge the volume of the trauma they experienced. The Assessment Tool gave clients a chance to self-reflect and acknowledge trauma which they had previously dismissed. The polyvictimization framework validated survivor's beliefs that their past traumas could affect their current situation and possibly offer explanation as to circumstances and events they faced. Many survivors indicated that they thought their experiences were

"normal" so they did not dwell upon the severity of their trauma and how it impacted them.

Weaknesses of the Assessment Tool/Process

Initially, staff reported feeling that the Assessment Tool was lengthy and time-consuming. Although acknowledging its strengths, they felt concerned about the time commitment for the client and the staff administering the Assessment Tool. However, once staff were trained on the Assessment Tool and began to see tangible results, they became more accepting of its value and time commitment.

Staff initially viewed the Assessment Tool as an exercise for only capturing data on the first visit. It became apparent through the Demonstration Initiative and working with the other Centers that the SFJC needed to modify staff job descriptions to become case managers rather than just navigators. The change of roles from navigators to case managers changed the direction of service delivery and gave staff the chance to transform the relationship with clients while administering the Assessment Tool over an extended period of time.

Initially, staff struggled with understanding the utility of the Assessment Tool and how it would benefit the Center and the clients. Staff did not understand how the information collected would be utilized at the Center or national level. However, once staff embraced understood its use, they came appreciated its utility both at the Center and elsewhere. The SFJC leadership learned how important it was to engage and include staff throughout the process so that they had a sense of ownership within the Initiative. Staff later shared that the Assessment Tool allowed them to feel like they were making a difference by providing clients a deeper understanding of connections and intersections of their lived experiences.

> "Our desire to gather the information should NOT be the first thing out the gate. We need to build that rapport; sometimes maybe we leave the [Assessment] Tool to be utilized by TSSU or counselors and therapists."
>
> **- SFJC Staff Member**

After pilot testing, there were a number of resources that needed to be available to clients to better address mental health and physical symptoms. Staff were concerned that they may not have the resources to deal with "Pandora's Box" (e.g., crisis) that could result from using the Assessment Tool. This gave the SFJC the chance to review services and enhance levels of care.

Staff were also concerned that the Assessment Tool may "re-traumatize" clients, thus causing them to shut-down and/or end the therapeutic process. As a result, it was determined that mental health clinicians needed to be onsite to help clients manage triggers and emotional response. Staff also suggested adding medical personnel onsite to assist clients displaying any current symptoms. While this was not completed during the Demonstration Initiative, SFJC's staff will address this going forward. Currently, SFJC has collaborated with the local health clinic to provide immediate support and assistance.

Stanislaus Family Justice Center Partner Agencies:

Child Abuse Interviews, Referrals and Evaluations (CAIRE Center) coordinates forensic interviews with law enforcement for children who have been abused or have witnessed domestic violence. CAIRE is a program of the Community Services Agency (CSA).

The Sheriff's Office works with clients to take initial and/or supplemental reports. The department also participates in CAIRE Center interviews and connects with victims and families to provide safety and offender accountability.

Behavioral Health and Recovery Services (BHRS) has onsite clinicians who provide trauma psychoeducation and crisis intervention to families going through the CAIRE Center, regardless of insurance coverage. They also provide assessments for MediCal covered children and teens who may qualify for outpatient services, outpatient counseling, case management, and crisis intervention services.

District Attorney Criminal investigators co-located at the SFJC assist in further investigation and interviews with victims and potential witnesses; help ensure peaceful enforcement of court orders so that the children will enjoy a relationship with both parents; help enforce existing orders; locate and return children who have been taken or detained in violation of another person's custody right; and assist in investigating elder abuse and missing persons/runaway minors. Victim advocates co-located at the SFJC help clients and their families navigate the criminal justice system, providing them with information regarding victims' rights and the criminal justice system. They also help clients fill out the application for the California Victim's Compensation Program for restitution, provide safety planning, and gather victim impact statements to be presented at trial. Advocates also escort victims and their families to court and coordinate meetings or court orientations with deputy district attorneys.

Haven Women's Center (HAVEN) is the local domestic violence and sexual assault shelter for the county. They serve all survivors of domestic violence, sexual abuse, and human trafficking regardless of gender identity, immigration status, or sexual orientation. They provide crisis intervention, safety planning, peer counseling, restraining order assistance, court accompaniment, emergency shelter, support groups, youth services, and emergency response.

Without Permission (WP) is a faith-based nonprofit organization that focuses on victims/survivors of human trafficking. WP provides assessments and referrals while working directly with a certified navigator. The navigator is a familiar and safe presence who serves and supports a survivor long-term through six cornerstones of restoration as needed.

Center for Human Services (CHS) is a local nonprofit with a forty-five (45) year history of providing quality prevention, intervention, counseling, and shelter services throughout Stanislaus County. Programs at CHS are organized under four (4) major categories: Youth Services (prevention/intervention), Counseling (mental health and substance

use), Shelter (Hutton House and Pathways) and Regional (Family Resource Centers). They provide individual and group substance use counseling and PTSD counseling.

Sierra Vista Child & Family Services (Sierra Vista) is a nonprofit community-based organization serving children, youth, adults, and families since 1972. The agency provides an extensive continuum of services including community-based Family Resource Centers, mental health counseling and consultation, case management, parent education, child abuse prevention and intervention, domestic violence counseling, private and public school services, perinatal substance use services, and foster care services. Sierra Vista specifically provides mental health clinicians to our Spanish-speaking clients.

Acknowledgments

The opportunity to participate in this Demonstration Initiative has been incredible. The Stanislaus Family Justice Center has enhanced its mission significantly. It was with the support of a number of individuals and agencies that the Center created, reviewed, implemented and executed the Assessment Tool. SFJC is so fortunate to have had the leadership of the former Executive Director Carol Shipley whose enthusiasm could not be matched and the current Interim Executive Director Lisa Mantarro Moore. SFJC staff including Arleen Hernandez and Romero Davis were integral to the success as they brought so much effort and experience with them: their compassion for the clients is evident. Research partners Gary Bess and Associates, and especially Jim Meyers, were a tremendous help with navigating the way. A special thanks is due to the navigators who met with the clients and administered the Assessment Tool – Jessica Fuentes, Angela Maldonado, Kristella Zambrano, and Sandra Martinez. The civil legal unit was a wonderful partner in this process, the SFJC is grateful for their support. The partners truly enhanced our service delivery including Sierra Vista, Havens Women's Center, and Center for Human Services. Clinicians Dr. Heather Pearson and Michelle Riley were crucial as their input and work assisted the Center and the clients in the Assessment Tool. The SFJC owes a debt of gratitude to Stanislaus County for their support of the efforts and to the generous supporters including the Gallo and Foster Families. The support and guidance from the Board of Directors have allowed the Center to continue to serve the clients and the community with success.

The SFJC extends its heartfelt appreciation to the Alliance and its team for their support and hand holding throughout this process. The Alliance gave consistent and direct support to the team throughout internal changes to keep the Center on course. A special thanks to the Department of Justice, Office for Victims of Crime, Office of Justice Programs staff that supported this Initiative, Susan Williams and Stacy Phillips. The support of Dr. Chan Hellman and Jason Featherngill for their dedication and ability to see the big picture about how to make a difference in the lives of others has been phenomenal. A special, heartfelt gratitude goes out every day to Casey Gwinn and Gael Strack for whom, without their vision, the Center would not be here today. Casey and Gael have led the Center and taught the team to dream big. They offer hope to not only victims, but to each team member in the Family Justice Center movement. They continue to push the team to look forward to a better place for those the Center serves.

Chapter 10

Queens Family Justice Center

New York, New York

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With contributions from staff at the Mayor's Office to End Domestic and Gender-Based Violence (ENDGBV), Urban Institute, Mayor's Office to End Domestic and Gender-Based Violence, Queens Family Justice Center, Mayor's Fund to Advance New York City

CHAPTER 10: Queens Family Justice Center

Introduction

From January 2018 to March 2019, the Urban Institute (Urban) conducted an evaluation of the Polyvictimization Initiative (Initiative) at the Queens Family Justice Center (QFJC) by request of the Mayor's Fund to Advance New York City (Mayor's Fund). The QFCJ's participation in the Initiative was supported by a local Polyvictimization Initiative Consulting Committee made up of staff from the Mayor's Office to End Domestic and Gender-Based Violence (ENDGBV), QFJC Administrative Staff, Safe Horizon, NYC Alliance of Sexual Assault, Mount Sinai Sexual Assault and Violence Intervention program, Voces Latinas, and Sanctuary for Families. During this time, the Urban team worked closely with the Mayor's ENDGBV to coordinate evaluation activities, and obtained feedback on interim and final evaluation results from the Consulting Committee. Primary features of the Initiative at the QFJC included staff training in trauma-informed service delivery, client service mapping, development and implementation of the site specific Screener (Screener), developed in conjunction with but outside of the Initiative, and use of the Polyvictimization Assessment Tool (Assessment Tool) to inform and improve service delivery for clients who have experienced polyvictimization.

History of the Center

The QFJC was established in 2008 and is operated by ENDGBV. The QFJC includes 20 onsite and 25 offsite partner organizations, with 103 individual professionals onsite. The Center is housed in a 16,000 square foot stand-alone facility. Since 2008, the QFJC has provided comprehensive civil legal, counseling and supportive services for survivors of intimate partner violence, elder abuse and sex trafficking. However, in 2018 the center expanded its focus to address all forms of gender-based violence including but not limited to: sexual assault, human trafficking, family violence, stalking and female genital mutilation. The QFJC is a safe, caring environment that provides one-stop services and support to survivors of domestic and gender-based violence. Key city agencies, community, social and civil legal services providers, and the District Attorney's Office are located onsite at the QFJC to make it easier for survivors to get help. Services are free and confidential, and all individuals are welcome regardless of language, income or immigration status.

The QFJC provides a client-centered approach to service provision whereby the client is provided with information and options related to their needs, after which they determine which services they will use. A list of services offered at the QFJC can be found in

. When a client initially visits the QFJC they meet with a client screener who, in consultation with the client, links the client to a case manager at the QFJC for safety planning and to create a service plan at the QFJC that makes appropriate referrals to onsite social service providers and/or city agencies. The QFJC maintains an FJC administrative data system that includes basic demographic, appointment, referral and

service information for each client. This information is only collected in the aggregate and with the client's permission. The QFJC provides services to thousands of clients annually; for example, rom July 1, 2018 through December 31, 2018, the QFJC served 2,639 unique clients through 5,387 client visits.

Table 1:Services Offered by the Queens Family Justice Center

- Familv law assistance
- Financial assistance
- Immigration legal assistance
- Police services
- Links to job training
- Economic empowerment services
- Help applying for and troubleshooting public assistance case issues
- Elder abuse services
- Mental health counseling
- The District Attorney's Office
- Housing and shelter
- Case management
- Computer time classes
- Safety planning/risk assessment
- Housing legal services
- Children's counseling
- Education program referrals
- Support groups
- Wellness services
- Children's services
- Psychiatry/medication management

Community Context

Queens is the second most populous borough of the five boroughs in New York City, and accounts for over 27% of the city's total population, with an estimated population of 2,358,582 (NYC Department of City Planning 2018). Queens is a very diverse borough; the race/ethnicity of Queens residents is 40% White, 28% Hispanic or Latino, 27% Asian, and 20% African American (NYC Department of City Planning, 2018). In addition, 47% of Queens population is foreign born and 56% of families speak a language other than English at home (NYC Department of City Planning 2018). In 2017, almost 14% of all families in Queens with children under 18 (and 28% of families with a single female head of household) had incomes below the poverty level (NYC Department of City Planning 2018).

While the overall rates of violent crime in NYC have decreased dramatically since 1990, domestic violence crimes in the city have persisted and even grown in recent years (NYC Mayor's Office to Combat Domestic Violence 2017). In Queens, in 2018 there were 24,577 intimate partner domestic incidents, 1,105 intimate partner felony assaults, 115 intimate partner rapes, and six intimate partner homicides reported to police (NYC Mayor's Office to End Domestic and Gender-Based Violence 2018).

Initial Polyvictimization Initiative Goals at the QFJC

As part of the Polyvictimization Initiative, there were two original site goals: (1) develop models for addressing polyvictimization within FJCs or similar co-located victim services; and (2) share information about lessons learned with the field. To achieve the first goal, ENDGBV planned to participate in the development and implementation of a polyvictimization assessment tool at the QFJC and identify new partners to deliver the full range of services needed for polyvictims. To achieve the second goal, ENDGBV planned to work collaboratively with local service providers; coordinate with OVC and the designated TA provider (Alliance for Hope International, Alliance) throughout implementation of the project; and partner with a research entity (Urban Institute) to conduct a site-specific project process evaluation. A primary element in accomplishing these goals was creation of the Polyvictimization Initiative Consulting Committee as noted above. The purpose of the Consulting Committee was to come together to learn about the needs of polyvictim clients at the QFJC and determine best practices around the design and implementation of the Assessment Tool.

Urban Institute Evaluation Methodology

As the ENDGBV-selected research partner for QFJC, the Urban team employed a mixed methods approach to conduct a process evaluation of the Screeners and Assessment Tool's development and implementation in QFJC from January 2018 through March 2019. The research team used qualitative and quantitative research methods to document and assess: (a) development of the Screener/Assessment Tool at QFJC; (b) implementation of the Screener/Assessment Tool; and (c) validity of the Screener/Assessment Tool. Evaluation data sources included: a review of QFJC program materials, interviews with 22 QFJC administrative staff and partner agency staff, a stakeholder survey, focus groups with QFJC polyvictimization clients, observations of program operations, analysis of Screener/Assessment Tool data, and analysis of QFJC client administrative data[31].

Developing the Pilot Assessment Tool and Service Model

As part of the Initiative to better serve polyvictims, QFJC staff participated in client mapping activities to identify gaps in services which they subsequently worked to address by implementing additional, trauma-informed practices in service delivery and physical spaces. Simultaneously, they engaged with the Alliance; the initiative's national

[31] Additional details on Urban's evaluation methodology can be found in the forthcoming final evaluation report: Bastomski, S., Ricks, A., Henderson, E., and J. Yahner. In press. *Evaluation of the Polyvictimization Initiative at the Queens Family Justice Center*. Washington, DC: Urban Institute.

evaluator, the Hope Research Center at the University of Oklahoma; and fellow sites to develop the pilot version of the Assessment Tool that would identify those clients.

Through the client mapping process, QFJC staff identified goals to improve intake and service delivery to polyvictims

The client mapping process was a key component of the Polyvictimization Initiative. It involved creating a process map of the typical QFJC client's journey from intake to provision of long-term services. Client mapping helped QFJC staff identify polyvictimization service strengths, gaps in services, collaboration pathways, and key partners and services that needed to be included. It also helped staff develop strategies to improve service delivery for polyvictim clients.

At the QFJC, the client mapping process provided an understanding of how clients learned about the Center, identified steps in clients' movement through the QFJC, and illustrated how staff communicated and collected information about clients. **As a result of client mapping, the QFJC was able to identify three process and service gap issues.** First, there was a lack of client specific information sharing. For example, clients had to repeat incident and abuse history multiple times during service provision. Also, the client tracking system did not link to the individual case management systems operated by QFJC partner agencies.[32] Second, the QFJC identified how client volume impacted their service delivery; clients were not always able to meet with Case Managers on the same day and staff were often unable to provide a "warm handoff" of the client to the next service provider. There was also no formal process for following-up with clients after meetings, as each partner agency was independent and applying their own protocols regarding client follow-up. Lastly, the QFJC was able to identify a policy issue around the role of Case Managers. Case Managers were usually the first point of contact for a client after screening and remained the central point of contact. However, expectations of their role needed to be clarified, such as how to handle common concerns, properly complete referral forms, and engage in follow-up.

QFJC staff were also able to identify challenges including a lack of multidisciplinary team meetings to review cases, the ways staff turnover impeded collaboration and effective service delivery, and the lack of awareness among community members about the services provided at QFJC. **From the client mapping process, the QFJC identified both short- and long-term goals to improve intake and service delivery.** The four short-term goals were: (1) improve screening to be more client-centered by placing less emphasis on data collection and more on addressing client needs; (2) create a best practices document and provide more training for Case Managers on QFJC policies and procedures; (3) create a mentoring program for part-time Case Managers; and (4) finalize new MOUs and an operations manual. The two long-term goals were: (1) redesign QFJC's client tracking system so that questions were only

[32] Notably, the lack of a link between data systems is intentional, designed to protect client confidentiality in case of a subpoena.

asked when necessary to determine service needs and (2) create more community-based program partnerships so that clients can receive services closer to their homes.[33]

QFJC implemented changes to create a more trauma-informed environment

The QFJC implemented four significant changes during the pilot phase to enhance customer service and create a more trauma-informed environment. First, the Center's space was made more comfortable and welcoming. There were physical changes to the security, reception, and waiting areas: decorations with warm colors, artwork, lavender diffusers, plants, LGBTQ-affirming signs, and welcome signs in various languages. In addition, QFJC added a snack bar with a water cooler, snacks, and tea/coffee. Second, supervisors began monthly observations of staff to assess, among other things, each staff member's customer service skills. Third, to increase the trauma-awareness of staff, a Safe Horizon supervisor attended the Alliance's-sponsored "Train the Trainer" event on trauma-informed care and subsequently provided trainings for security staff, civil legal staff, reception staff, and onsite police officers to increase their trauma sensitivity. Additional trainings were offered for all staff, including LGBTQ sensitivity training, Skills for Trauma Psychotherapy, Trauma Informed Care and Cultural Considerations, and Grounding and De-Escalation Techniques. Furthermore, the QFJC started to hold quarterly events focused on staff wellness and self-care, including an event on mindfulness and grounding techniques using art.

Key QFJC stakeholders reviewed tools and literature on polyvictimization

In addition to development of the polyvictimization service model, QFJC staff participated in the pilot Assessment Tool development process. Led by the Alliance, and in collaboration with other sites, a core group of QFJC staff and the Consulting Committee took part in reviewing polyvictimization-relevant tools, suggesting features of the pilot Assessment Tool, and providing iterative feedback on draft questions.

The Alliance began the tool development process by reviewing relevant literature and tools and selecting 30 "promising tools," which were shared with the sites. QFJC stakeholders provided written feedback on the promising tools, including on their formatting and implementation practices. Subsequently, the Alliance drafted the 61-question Pilot Assessment Tool with OVC, the Hope Research Center, and feedback from all six sites.

QFJC stakeholders requested changes to the Pilot Assessment Tool and its implementation

Feedback from the QFJC stakeholders flagged several issues related to the Pilot Assessment Tool's structure and implementation plans. First, the Consulting Committee shared that a two-tiered implementation approach was crucial to the Pilot

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[33] QFJC and its partner agencies did make progress towards these goals during the project period. Changes included: (1) the creation of a mentoring program for all Case Managers during new staff orientation; (2) work on updated MOUs and operations manuals; (3) efforts to update the data tracking system; and (4) initiatives to allow QFJC and community-based organization staff to tour each other's facilities.

Assessment Tool's success at QFJC, stating in a feedback form that "there was almost universal agreement among partners and staff that the polyvictimization screen should be implemented in two-steps – (1) a short events-based screen conducted by the case manager to identify the presence of polyvictimization and (2) an extensive symptomology-based screen conducted by the polyvictimization clinician" (QFJC 2017, August 15). Ultimately, this feedback was incorporated into the final Assessment Tool (see: Final Tool Revisions and Implementation) but not during the pilot phase. After reviewing Alliance's drafts of the pilot Assessment Tool, QFJC stakeholders provided additional feedback on question topics, phrasing and the tool's implementation requirements. After receiving feedback from the QFJC, as well as from the other Initiative sites, Alliance finalized the pilot Assessment Tool.

The Alliance finalized the Pilot Assessment Tool and provided QFJC with implementation guidance

The pilot Assessment Tool implemented at QFJC and at all other sites included 61 questions about victimization events, other adverse life experiences, and trauma symptoms. QFJC Case Managers implemented the pilot Assessment Tool in accordance with the guidelines set collaboratively by the Alliance, OVC, the Hope Research Center, and the six sites in terms of the timeline for tool implementation and the number and composition of clients with whom the tool was administered. The Alliance led the establishment of several key agreements about the use of the pilot Assessment Tool across all sites, which were shared at Initiative-wide meetings. Some of the key agreements included not using the tool as a checklist, using the tool conversationally, and using the tool to direct the delivery of services.

Implementing the Pilot Assessment Tool

The pilot Assessment Tool implementation at QFJC included three stages: QFJC eligibility screening, introduction of the tool by a Client Screener, and assessment of the client with the pilot Assessment Tool by Case Managers. The pilot Assessment Tool was implemented at QFJC between March 1 and May 31, 2018, and QFJC used it with 45 clients, 32 of whom were new, nine were returning, and four were of unknown status.

Pilot implementation began with routine practice by Reception, Client Screeners, and Case Managers, supported by their supervisors

During pilot Assessment Tool implementation, initial information was collected for all visitors to the QFJC by the Client Services Specialists (frontline staff reception and client screeners). *During the* pilot Assessment Tool *implementation phase, this did not deviate from QFJC's routine practice.* Clients arrived and passed the security entrance, including metal detectors. They then checked in at the front desk; clients with appointments were diverted to the waiting room and District Attorney (DA) clients were diverted to the specific DA's waiting area. For new QFJC clients, frontline staff/reception collected the client's name, date of birth, ZIP code, and precinct. They explained the services offered at QFJC, gave an overview of the process, and estimated the wait time. Typically, stakeholders estimated, this entire process took between three and five minutes.

Next, two Client Screeners employed by Safe Horizon introduced the pilot Assessment Tool to clients, obtained initial consent to participate in the research, and conducted the routine screening and intake process. The Client Screener greeted the client in the waiting area and brought them to the screening office, where they gave an overview of the QFJC and the Polyvictimization Initiative. At this point, clients were offered the chance to participate in testing a new tool, and Client Screeners explained the tool and emphasized that participation was voluntary (although this informed consent process was designed to help clients understand the Initiative, researchers received some indication during program observations that clients did not always understand the initiative at this stage.) By design, the opportunity to participate was only offered to English speaking clients and to clients who were not in emotional distress, as assessed by the Client Screener. Staff estimated that approximately 30% to 60% of clients fell outside these categories and were not offered the pilot Assessment Tool.

Some clients also declined to participate after the Initiative was explained; though the numbers were not tracked, staff reported that the most common reasons clients declined included being tired and being busy. Clients who agreed to participate signed consent forms for the Polyvictimization Initiative and for typical QFJC services. Then, as part of the routine practice, the Client Screener held a short conversation to assess the client's needs and completed an intake form. If, through this conversation, the Client Screener established that the client did not meet the QFJC's eligibility requirements (i.e., that the client was not found to be a survivor of IPV, elder abuse, or sex trafficking[34]), the Screener connected them to an appropriate agency. If the client met eligibility requirements, the Client Screener reached out to the Case Managers to inform them that the client was ready and whether the client agreed to complete the pilot Assessment Tool.

Participating clients were administered the pilot Assessment Tool by one of the two Safe Horizon Case Managers. *Notably, the Case Managers completed all routine case management activities prior to beginning the pilot Assessment Tool.* In accordance with that, the case management sessions began with the Case Manager meeting the client in the waiting room and bringing him/her to a private office. They then spent approximately one hour completing usual activities, including: risk assessment, safety planning, connecting them with services to address their immediate needs (e.g. housing/shelter and lock changes), referral to specialized services (e.g.., mental health counseling, legal services, and public benefits administration), and scheduling follow-up meetings. Throughout this process, the Case Managers took handwritten notes about any experiences or symptoms relevant to the pilot Assessment Tool that came up in the course of conversation, which could be input into the electronic tool after the session concluded. Once all those activities were completed, the Case Managers then brought up the pilot Assessment Tool again and confirmed whether the client was still interested in participating. According to the implementation guide, the Case Managers were to complete all questions conversationally however, in practice, the Case Managers

[34] On September 8, 2018, the QFJC expanded eligibility requirements to include victims of any form of gender-based violence.

typically had to specifically ask clients about some events or symptoms that did not come up in conversation.

Case Managers formally asked Pilot Assessment Tool questions after the typical case management session

If the client remained interested in completing the pilot Assessment Tool, the Case Manager began the formal administration of the tool. During this process, the Case Managers opened the paper tool; read the remaining questions, and recorded answers directly in the tool. Although some information could be gleaned conversationally during the case management session, in order to fully complete the tool, Case Managers frequently had to bring various issues up again and ask questions directly from the tool to collect information about topics that had not already come up during conversation. This was an ongoing challenge identified by the QFJC during the Alliance calls, and in conversation with the other sites. Typically, Case Managers completed the tool in one session (80%), though 9% of tools required two sessions and 2% (one tool) required three. Overall, based on staff reports and researcher observations, the time to complete the pilot Assessment Tool was between 15 and 90 minutes, in addition to the case management session.

Stakeholder Perspectives on Pilot Implementation

Staff and clients received many benefits from using the Assessment Tool

Implementation of the pilot Assessment Tool at the QFJC resulted in many benefits to staff and clients; staff reported increased understanding of clients, and clients felt their experiences were validated.

First, the use of the pilot Assessment Tool enabled Case Managers to learn information about clients they would not otherwise have known, which allowed staff to better understand them. One stakeholder described the benefits that accrued to the service provider, saying “it’s an important step to understand all the experiences that are happening in people’s lives… Maybe having more information about people’s experiences can help us better reflect on what services we need to provide.”

Clients received benefits from the tool as well. Many clients appreciated the opportunity to share about their past experiences, because it made them feel listened to or cared about. Staff reported that clients seemed to respond well and feel a sense of relief at being asked about their lives. During Urban-led interviews, clients echoed this sentiment, sharing that they felt comfortable answering the pilot Assessment Tool questions. Additionally, some staff believed that the pilot Assessment Tool implementation provided a venue to educate clients about their victimization experiences. Helping clients understand their condition and treatment—called “psychoeducation”—is used in many evidence-based models to help coping and empowerment (Gentry, Baranowsky, & Rhoton 2017; Lukens and McFarlane 2004).

Stakeholders felt the Pilot Assessment Tool was difficult to implement with their existing service models

Despite the strengths associated with the pilot Assessment Tool implementation, the tool had both structural and implementation challenges at QFJC. **First, during implementation of the pilot Assessment Tool, the length of the tool remained a constant challenge at the QFJC**. Based on stakeholder interviews, some stakeholders believed that both providers and their clients could be inconvenienced by the additional time needed for the pilot Assessment Tool. In interviews, several stakeholders noted that the volume of clients at QFJC was high and some clients already had wait times of several hours. Some stakeholders also doubted whether many clients could take the extra time out of their days to complete the pilot Assessment Tool. Speaking of the challenges facing the Center as a whole, one stakeholder suggested "when you have 50 clients a day, that [length is] just not feasible."

Relatedly, some stakeholders at QFJC were concerned that certain aspects of the Assessment Tool were not client-centered, an important value of theirs (and of the Polyvictimization Initiative's). Most clients entered the QFJC seeking services for immediate safety needs (e.g., an order of protection for domestic violence or shelter housing). Safe Horizon, the service provider tasked with using the pilot Assessment Tool, trains and requires their staff to engage in client-centered practice—meaning that the client's identified needs and desires come first. As such, after pilot Assessment Tool implementation, stakeholders worried that the tool would interfere with the delivery of immediate services the client desired. As QFJC stakeholders shared with the Alliance, typically, "the information covered in the required questions [of the pilot Assessment Tool] usually is not captured within the first few meetings with the client, and it is up to the client if and when to share this information" (QFJC 2017, November 27). Accordingly, although staff made it clear that clients could choose not to answer a question, a position that was reinforced through the Initiative, some stakeholders felt that asking clients to share details that had not come up in conversation was not in line with the QFJC's client-centered approach.

QFJC stakeholders also held concerns about the implementation of the tool, including that its use was not improving the services provided to clients during the pilot stage. First, stakeholders noted that because most clients arrived at the QFJC already knowing what they wanted, the use of the pilot Assessment Tool did not shape the services the client chose to engage with. Second, because the City's contracting process with subgrantees to ensure full compliance with the DOJ's policies, QFJC had not yet hired any of the grant funded new specialized staff for the Initiative during the early months of the pilot phase, stakeholders were concerned that clients were being asked sensitive questions, but the QFJC had no new services to offer them in response, either because of a lack of specialized polyvictimization services or because of a lack of capacity. Stakeholders generally agreed that if clients were to be asked sensitive questions, there should be a correspondingly specific service to provide them. The limitations, according to stakeholder interviews, were only exacerbated by the limited nature of the high-demand services, such as immediate access to mental health counseling. However, these limitations were addressed during the final implementation phase.

Question phrasing in the Pilot Assessment Tool may have the affected accuracy of some client responses due to lack of understanding

Additionally, the events-based questions in the pilot Assessment Tool were not phrased in the research-recommended behaviorally specific framework, which may have prevented some clients from understanding questions. It is important to highlight that—as per the Initiative-wide agreements about the tool—the pilot Assessment Tool was intended to be used in a conversational manner, so it was not designed to be read verbatim. However, due to the length of the tool, the many time periods that needed to be captured, the lack of connection between many of the questions to allow for smooth transitions during conversation, and the comfort levels of the staff, the Case Managers at the QFJC made the decision to read some questions verbatim. The questions, however, were not all phrased in a behaviorally specific way. Behaviorally specific questions are considered best practice in screening and assessment tools because they focus on specific actions rather than labels. Research shows they elicit more disclosures of past victimization experiences, potentially because they reduce stigma and make it easier for clients to understand what is being asked (Bowen & Murshid 2016; Khan et al. 2018; Koss 1985; Lindhorst, Meyers, & Casey 2008; Murray 2019).

In the case of the pilot Assessment Tool, not all of the events-based questions were behaviorally specific, and both frontline staff and researchers observed indications that clients may not have understood the questions sufficiently to provide valid responses. For example, during stakeholder interviews, some case Managers shared that some clients needed additional explanation of the words used in the tool. In addition, during program observations, Urban researchers similarly noted that some clients had trouble understanding some questions. For example, one client was asked if they had experienced “community violence,” a term used by researchers and practitioners to describe exposure to interpersonal violence committed in public areas (Suglia, Ryan & Wright 2008). The client responded that they had not, but later the described frequently hearing gun violence in the neighborhood, directly contradicting the client’s negative response to the community violence event question. This finding suggests that the client may have misunderstood the what the term “community violence” meant, and was not able to answer the question accurately as a result.

Stakeholders worried that Pilot Assessment Tool could trigger clients

The fears about the possibility that the pilot Assessment Tool could trigger or activate clients’ trauma was exacerbated by staff’s concerns about its implementation by non-clinical staff who lacked the training to respond appropriately. During stakeholder interviews, both frontline and supervisory staff repeatedly shared that they worried about Case Managers’ abilities to implement the pilot Assessment Tool because it was simply not their area of expertise, stating, for example, “that’s not what they’re trained to do.” One stakeholder noted the importance of “making sure they can recognize when someone may be dissociating and having some basic grounding skills to make sure that the person feels empowered not to screen them and send them into the real world with their skin turned inside out.” During interviews, stakeholders shared reports of clients becoming distressed by some of the questions on the pilot Assessment Tool. Altogether, the pilot stage allowed stakeholders at the QFJC to identify strengths to

build on and flaws to address in the final implementation stage of the Polyvictimization Initiative.

Final Tool Revision and Implementation

From Pilot Assessment to the Final Assessment Tool

Between June 2018 and November 2019, QFJC staff engaged in the Initiative-wide revision process turning the pilot Assessment Tool into the final version of the Assessment Tool, and developed and implemented a site-specific Polyvictimization Screening Tool (Screener).

QFJC Partner Agency staff and ENDGBV participated in the Initiative's revision process to create the Final Assessment Tool

Like the pilot Assessment Tool development process, the revision process engaged QFJC administrative and partner agency staff, and the Consulting Committee in a series of exercises led by the Alliance. During the pilot phase, QFJC staff provided feedback on the pilot Assessment Tool —and suggestions for the final Assessment Tool and its implementation—during monthly frontline staff calls with the Alliance. Additionally, once the revisions began, QFJC stakeholders and Urban researchers, along with all other Initiative sites, provided pilot Assessment Tool feedback through the 2018 OVC Polyvictimization Screening Tool Feedback survey. During this period, stakeholders also participated in Initiative-wide meetings, in which the individual questions, time periods, tool structure, and implementation features were decided on by all sites and the Alliance. At the in-person meeting, it was decided that sites could develop their own screening tools and implement them, along with the final Assessment Tool, in ways that fit each center best. As such, NYC worked with the Urban team to develop and implement a Screener that could work synergistically with the final-Assessment Tool.

Ultimately, the final version of the Assessment Tool consisted of 44 questions covering victimization events, other adverse life experiences, and symptoms over several time periods. In addition, at QFJC, staff completed a validation question asking to what extent the staff person perceived the client had experienced polyvictimization. The shorter length of the final version of the Assessment Tool was the main improvement identified by QFJC stakeholders, who considered the reduction in questions a huge success and benefit.

The Screener was piloted and finalized for implementation

In addition to contributing to revisions of the final version of the Assessment Tool, the QFJC piloted a site-specific Screener in September 2018. The Screener is a 7-item victimization-focused screening tool, includes questions on physical assault, sexual abuse and assault, stalking, strangulation, robbery, cybercrime, and witnessing violence across the lifespan. The Screener was designed to help staff identify polyvictim clients with the highest needs, so that staff could prioritize them for specialized services. The tool was implemented by Client Screeners, who used it with all clients during their routine intake screening session. Ultimately, 30 clients were screened with the Screener during its pilot implementation.

After the pilot phase, small changes were made to the Screener and its implementation; importantly, the scoring criteria for identifying high-needs polyvictims were adjusted, due to the high number of clients that were screening as such during the Screener's pilot implementation. After reviewing quantitative results from the pilot Screener data, QFJC stakeholders and researchers decided together to consider high-needs polyvictims those who reported four or more victimizations, or those who reported either stalking, strangulation, or sexual assault and at least two other victimizations.

Final Implementation of the Screener and Final Version of the Assessment Tool

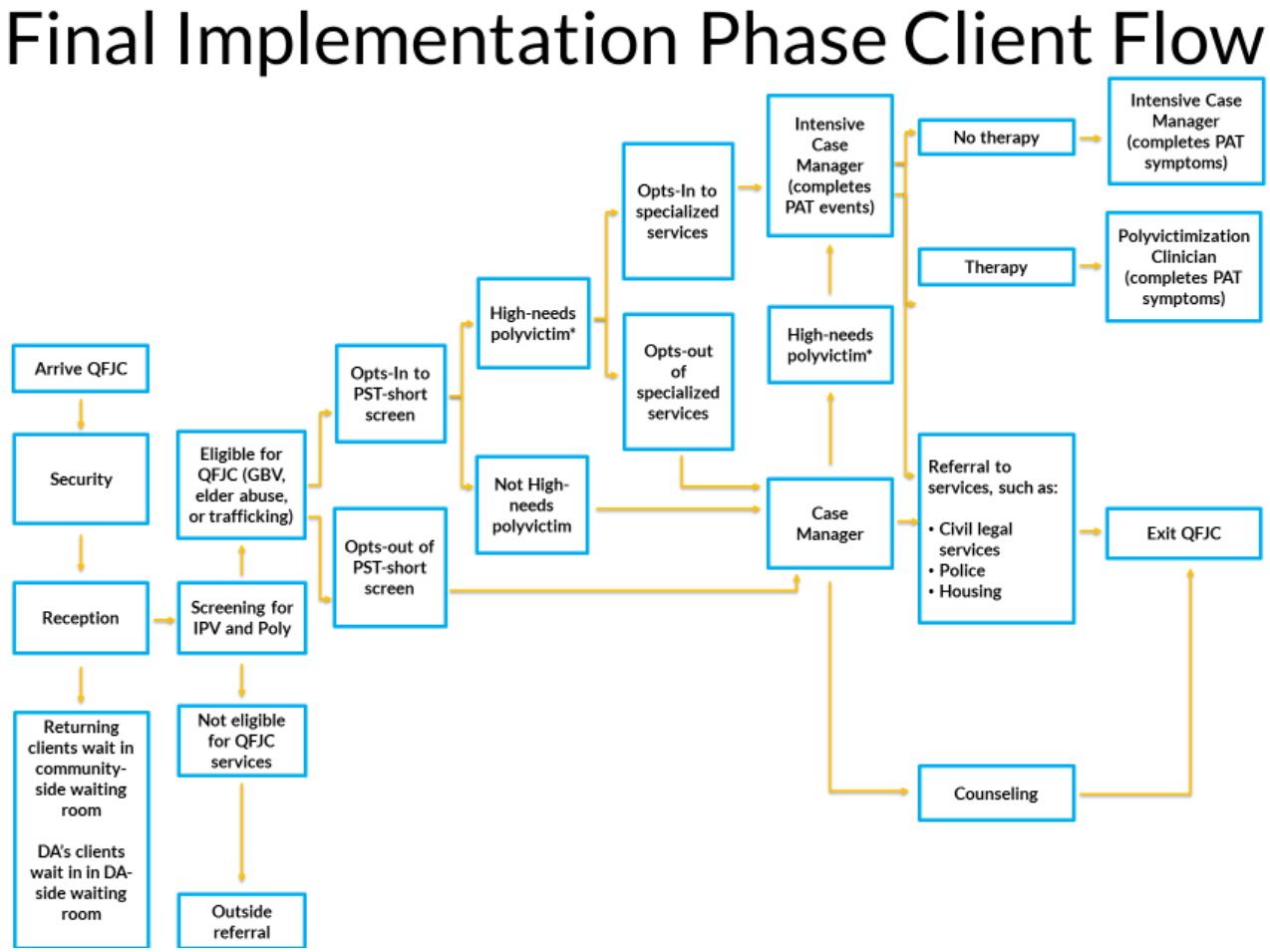
QFJC hired specialized polyvictimization staff to complete the final implementation phase

Implementation of the final version of the Assessment Tool was scheduled to occur at all six sites between December 1, 2018 and May 31, 2019. Implementation of the final version of the Assessment Tool occurred at QFJC between December 1, 2018 and March 31, 2019, at which point the QFJC had completed 75 tools as planned. The QFJC continued to provide specialized polyvictimization services through May 2019. Staff used the updated Screener with 89[35] adult clients and the final Assessment Tool with 75. Between the pilot and final implementation phases, QFJC agencies hired staff to work with the high-needs polyvictim clients: Safe Horizon hired an English-speaking Intensive Case Manager to provide long-term case management; Voces Latinas hired a Spanish-speaking Intensive Case Manager; and Mt. Sinai SAVI hired a Polyvictimization Clinician, a mental health counselor. Together, these staff formed the Polyvictimization Track designed to serve the high-needs polyvictims exclusively. In addition, the Initiative prompted the hiring of a Polyvictimization Specialist by the NYC Alliance Against Sexual Assault to focus on relevant training.

The typical client flow for clients entering and passing through the Polyvictimization Track at QFJC is described in Figure 1. Clients signed in at the reception desk, received the Screener from a Client Screener, and, if they screened as a likely high-needs polyvictim, received the final version of the Assessment Tool from an Intensive Case Manager and/or Polyvictimization Clinician, through alternative referral pathways also existed.

[35] Although 89 clients in total were screened for polyvictimization using the Screener, five clients did not consent to be included in the study. This resulted in a final sample of 84 clients.

Figure 1: Final Implementation Phase: Overview of QFJC Client Flow



*High-Needs Polyvictim: (of 7 victimizations) 4+ victimizations or 3+ victimizations including at least one of: strangulation, sexual assault, or stalking

High-needs polyvictims were typically identified through the Screener

First, identical to the process during the pilot phase, clients entered the QFJC through security and checked in at the reception desk (see pilot Assessment Tool Implementation for additional detail). New clients then met with a Client Screener who introduced the Initiative, obtained client consent to participate, asked the Screener questions to the client, and determined whether they met the high-needs polyvictim criteria. The Client Screener first conducted the routine intake session, which included describing and receiving consent for services, assessing the client's eligibility, and obtaining demographic and contact information. Then, the Client Screener introduced the Polyvictimization Track by telling the client what services were available, noting that it was voluntary, and asking them, if interested, to sign the consent form; unlike during the pilot phase, nearly all clients were introduced to the program, including those in distress.[36] If the client agreed to participate, the Client Screener read the Screener questions and recorded the client response on the spot.[37] Client Screeners then determined a client's eligibility for the Polyvictimization Track. As described above, the criteria for a high-needs polyvictim were having reported four or more victimizations OR any two victimizations in addition to either stalking, strangulation, or sexual assault. However, the research team could not confirm whether the criteria were uniformly applied as intended – for example, four clients who were identified as *not* high needs polyvictims on the Screener later completed a final Assessment Tool, indicating that they had been routed to specialized services. After making the determination that a client was a high-needs polyvictim, the Client Screener ascertained the availability of the Intensive Case Managers. If one was available, they would meet the client in the waiting room. If not, the client was offered the choice to wait, schedule an appointment, or to meet with a non-Polyvictimization Track Case Manager. Clients who opted for the latter could later be referred to an Intensive Case Manager for ongoing case management.

Intensive Case Managers and Polyvictimization Clinicians utilized the Final Assessment Tool with high-needs polyvictims and provided ongoing services

Eligible clients then met with the Intensive Case Manager who completed the final Assessment Tool entirely or completed it in part and then passed it to the Polyvictimization Clinician. During the initial weeks of the final implementation phase, this process was in flux; the key stakeholder team considered having the Clinician complete the entire tool or having it pass back and forth between the Intensive Case Manager and the Clinician before they landed on the final implementation plan.

The use of the final Assessment Tool at QFJC followed a similar structure as that of the pilot Assessment Tool, but varied somewhat by the staff member implementing it. First, the Intensive Case Manager would complete a routine case management session, as

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[36] The only exception was clients that already had been working with a Case Manager through family court.

[37] Notably, the Screener was only available in English. Accordingly, Screeners had to translate the questions to Spanish-speaking clients on the spot. As such, researchers cannot verify that the tool was administered using behaviorally specific language for Spanish-speaking clients.

described in the pilot Assessment Tool Implementation section. During this session, the Intensive Case Manager listened for events and symptoms listed in the final Assessment Tool. Then, after completing all referrals—including to the Polyvictimization Clinician—the Intensive Case Manager re-introduced, requested written consent for, and, if consent was given, implemented the final Assessment Tool. The implementers varied in their method of asking any remaining questions on the final Assessment Tool; some, typically those with more experience, used a conversational style as intended through the Initiative, while others started conversationally and chose to read remaining questions verbatim in order to complete the tool. In stakeholder interviews, staff reported that Intensive Case Managers typically completed the final Assessment Tool in one session, within two to three hours, while the Polyvictimization Clinician typically completed the final Assessment Tool in two to three sessions and completed the Symptom section in one or two sessions.

Clients in the Polyvictimization Track were eligible for ongoing services with the Intensive Case Managers and the Polyvictimization Clinician. The existence of consistent, long-term case management was new to QFJC, and addressed a service gap identified during the client mapping process. Additional service capacity for mental health services was also a much needed addition to the Center.

Service Delivery for Polyvictimization Initiative Clients

A major goal of the Polyvictimization Initiative at the QFJC was to provide intensive services to clients identified as high needs polyvictims. Overall, quantitative analyses of client administrative records indicated that the QFJC succeeded in providing **consistent, intensive, long-term case management services** to high needs polyvictim clients, relative to the average client who was served at the QJFC but who did not complete a Screener or final Assessment Tool.

Polyvictimization clients received enhanced services

Client administrative records also showed that clients served through the Initiative differed from other clients in several important ways. First, the 114 clients served through the Initiative **received a higher volume of services** at the QFJC. On average, these clients visited the QFJC **4.90 times** during full implementation phase, whereas non-Initiative clients visited the QFJC **1.95 times** during the same time period. Similarly, clients served through the Initiative were more likely to return to the QFJC after their first visit: approximately 21.1 percent of Initiative clients completed one visit and *did not* return during the final implementation phase, whereas 57.2 percent of non-Initiative clients completed one visit and did not return. Stated differently, approximately **4 in 5** Initiative clients completed two or more visits for services to the QFJC, while just **2 in 5** typical clients complete two or more visits.

Notably, in nearly one-third (29 percent) of visits by typical QFJC clients (i.e., non-Initiative clients), the purpose of the visit was to meet with a prosecutor at the District Attorney's Office. By contrast, a far lower percentage of visits by Initiative clients (about 6 percent) were for the same reason. At the same time, close to half (about 46 percent) of the services received by Initiative clients included intensive case management and counseling. Overall, Initiative clients were returning more often, receiving a higher

number of services on average, and were receiving more therapeutic services, compared to their non-Initiative counterparts. These findings suggest that the Initiative was working to shift the QFJC service delivery model as intended, from one that focused on short term intervention – such as meeting with an Assistant District Attorney to discuss the next steps in the criminal justice process - to a model that allowed staff to provide intensive, longer-term services via case management and counseling for a subset of clients.

Polyvictimization services track staff received training and supports for implementation of the Final Polyvictimization Assessment

Lastly, throughout the implementation process, frontline staff (i.e., Intensive Case Managers and the Polyvictimization Clinician) received support in the form of continued wellness events, supervision sessions, group trainings, and individual consultations. First, staff wellness events continued from the pilot phase, including a dance class, yoga classes, the presence of a therapy dog, and others. Second, supervision sessions from the frontline staff's supervisors included regular observation of client interaction and as-needed supports. In addition to this, as part of the Initiative, the organizations central to implementing the final Assessment Tool—Safe Horizon, Voces Latinas, and SAVI—held joint meetings on a bi-weekly basis. These meetings included the polyvictimization track staff responsible for implementing the final Assessment Tool (the Intensive Case Managers and the Clinician), their three direct supervisors, and the QFJC Executive Director from ENDGBV. They discussed individual cases, issues, and potential responses.

Supports also included trainings and consultations from the Polyvictimization Specialist employed by the Alliance Against Sexual Assault and other partner agencies. Staff could attend trainings such as Creative Interventions for Trauma Survivors, Working with Angry Traumatized Clients, Trauma and Child Sexual Abuse, and Administering the Assessment Tool. Some staff also took advantage of individual consultation on a one-time or bi-weekly basis, in which they could discuss cases and receive suggestions from the Specialist.

Results from Screener and Final Assessment Tool Analyses

Urban researchers analyzed data obtained from 84 Screener and/or 75 final Assessment Tool responses, for a total of 114 unique clients who received Initiative services during the final implementation phase.

Screener Findings

At the screening stage, clients reported an average (median) of four victimizations[38]. Clients reported as few as zero and as many as seven lifetime victimizations. The most

[38] Note that clients were asked whether they had ever experienced victimizations of different types. It is possible that in some cases, a client experienced multiple forms of victimization (e.g. assault and strangulation) during the same

frequently reported type of victimization was assault by any person, including an intimate partner, family member, or stranger, which impacted 69 clients (82 percent). Among the 84 clients screened with the Screener, 58 (69 percent) met the criteria for a high needs polyvictim by (a) reporting four or more out of the seven Screener victimization experiences; and/or (b) reporting an experience of strangulation, stalking, *or* sexual assault, as well as any two additional victimization experiences.

Assessment Tool Findings

Clients who completed the final Assessment Tool reported experiencing anywhere from zero to 17 events during the past year, and between 5 to 21 events across the lifetime[39]. On average (median), they reported 9 past year events and 13 events across the lifetime. Clients most frequently reported past year and/or lifetime experiences of victimization, including emotional/verbal abuse by a family member or other person (84 percent – past year; 100 percent – lifetime), assault by a family member, caregiver, or partner (83 percent – past year; 100 percent – lifetime), and strangulation (60 percent – past year; 87 percent – lifetime). Past year neglect, stalking, and financial abuse were also reported by the majority of clients. See Figure 2 for final Assessment Tool victimization frequencies. Notably, missing responses (primarily due to clients electing not to respond to particular questions) ranged from 2 to 32 per question, for past-year events questions, and ranged from zero to 31 per question, for lifetime events questions. This means that the results reported here are likely to *underestimate* the extent to which clients have experienced the final-Assessment Tool events.

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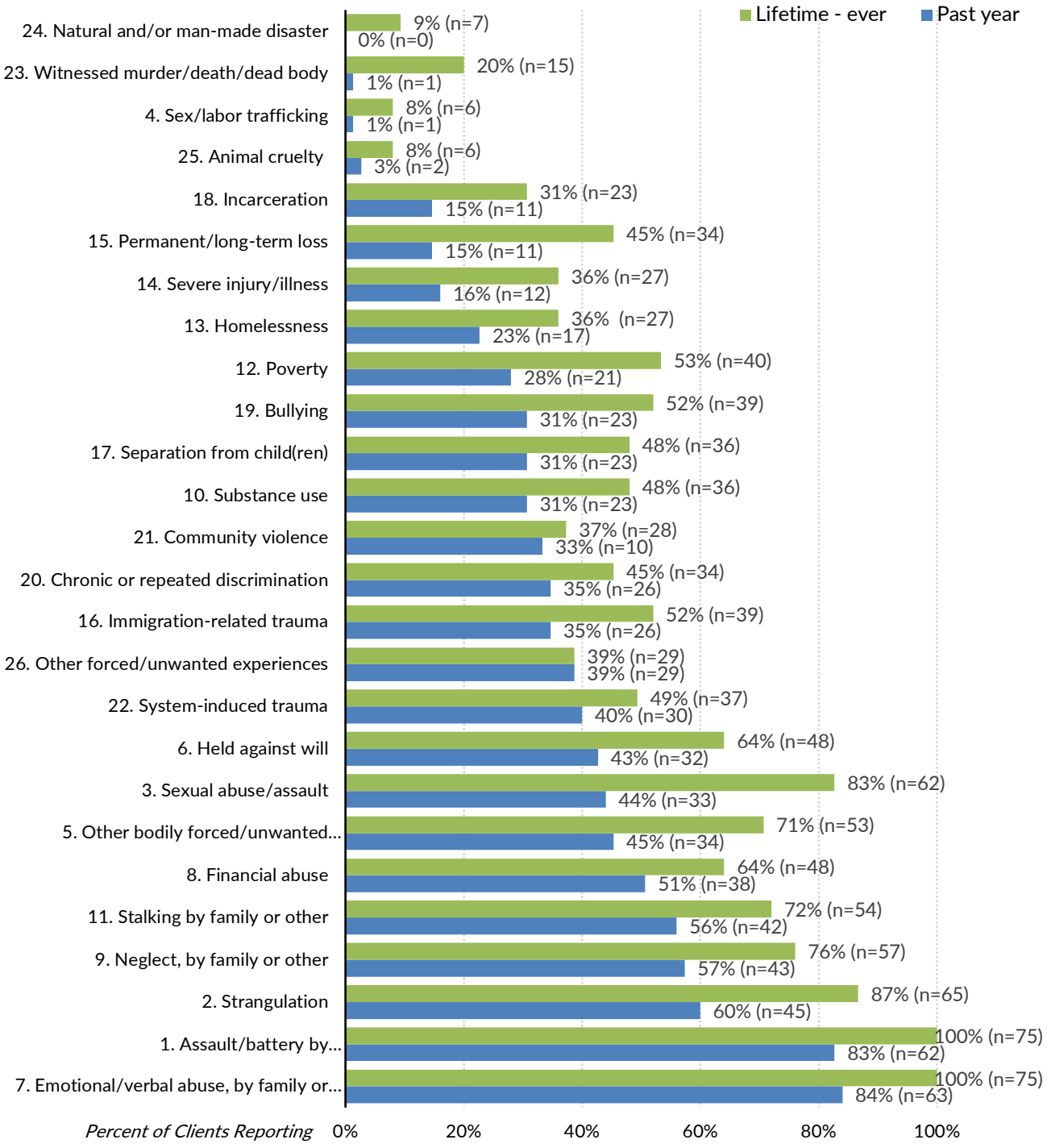
victimization event. Unfortunately, the data do not allow us to make distinctions about the timing of various victimizations – we are only able to distinguish between victimizations that occurred in childhood versus adulthood, but do not have information about timing at a more granular level.

[39] The Assessment Tool had categories for clients to report experiences that had occurred during the past year, as an adult, and/or as a child. For these analyses, if a client reported a victimization or adverse life experience that occurred during childhood and/or adulthood, it is reported in the single category of an experience that occurred during the client's lifetime.

Figure 2: Final Assessment Tool Event 'Yes' Responses, Past -Year and Lifetime (n=75)



Source: Urban analysis of QFJC final Assessment Tool data, 2019
Notes: Missing responses (the majority of which were due to clients electing not to respond to particular questions) ranged from zero to 32 per event question.
Assessment Tool question numbers are listed on the left hand side of each label.

Successes and Challenges During Final Implementation

By the final implementation phase, stakeholders across the board felt that they better understood polyvictimization and the needs of polyvictims. Additionally, during this phase, the Initiative's resources allowed QFJC to hire more staff to serve high-needs polyvictim clients and the final Assessment Tool allowed those staff to better identify the clients' experiences and service needs, which translated to enhanced services for polyvictims. The final Assessment Tool also contributed to enhanced service provision by enabling better information sharing, improved relationship building, and psychoeducation.

Stakeholders better understood polyvictimization through the Initiative

A key benefit of the Initiative was increased knowledge from stakeholders about polyvictimization as a concept and about the needs of polyvictim clients. In stakeholder interviews during the final implementation phase, many underscored that they now understood the importance of polyvictimization. Further, results from the stakeholder surveys after the pilot and final implementation phases indicated that on average, stakeholders were more likely to agree that the Initiative increased their knowledge of polyvictimization during the final implementation stage, relative to the pilot stage. Similarly, on average, stakeholders were more likely to agree that the Initiative increased their awareness of how QFJC could meet polyvictims' needs during final implementation, compared to the pilot stage. In other words, some stakeholders saw a growth in their knowledge and awareness of polyvictimization at the pilot phase, and continued to increase their knowledge and awareness as the Initiative moved forward.

Changes to staffing structures in the final implementation phase improved services for high-needs polyvictims

Several Initiative-driven changes in the QFJC's staffing structure were also viewed as improvements by QFJC stakeholders. First, because of the Initiative's added resources, **QFJC partner agencies were able to hire staff with the specific training and backgrounds to work with high-needs polyvictims, which was seen by stakeholders as a real improvement**. This was considered a strength because these staff were hired for the Initiative, and therefore felt ownership of the work, and because they had the specialized skills necessary to work with high-needs clients. During focus groups, clients who had screened as high-needs polyvictims expressed feeling supported and heard by these staff. One client shared, "I like the trust you build with the case worker and therapist. You have someone who isn't just judging and saying, 'I understand.' They're not just sympathetic. They really give you good advice."

Relatedly, having staff devoted to long-term case management and an additional therapist meant that there were more resources to offer clients, which helped address stakeholder concerns about lacking sufficient support services during the pilot stage. Previously, QFJC did not have consistent, long-term case management services to offer clients, and having an additional, specialized clinician meant that high-demand mental health services were available for clients in the Polyvictimization Track. As described above—under Final Implementation of the Screener and final Assessment Tool—clients

in the Polyvictimization Track *did* receive a higher volume of services and complete more return visits to the QFJC. High-needs polyvictim participants in the focus groups reported utilizing a range of services, including psychiatry, therapy, legal services, DA connections, long term case management, and medical services. They also reported positive experiences with these services.

Stakeholders reported the Final Assessment Tool aided efforts to recognize polyvictims and identify helpful services for them

Stakeholders also noted the utility of the final Assessment Tool in identifying high-needs polyvictims—by uncovering experiences and symptoms that might otherwise have gone unnoticed—and recognizing services the client may need. Stakeholders shared that asking specific questions helped the clients speak about issues or symptoms that they had not otherwise disclosed. Stakeholders reported that, as a result, the final Assessment Tool was helpful in identifying the appropriate services with which to connect clients. Most stakeholders agreed or strongly agreed that the tool was well-designed to identify polyvictims, and most agreed that the tool helped to connect polyvictim clients with services.

The Screener and Final Assessment Tool helped staff share information, guide conversations to learn more about client experiences, and provide psychoeducation to clients

Stakeholders also perceived benefits from the use of tools while providing services to high-needs polyvictims. Across the board, stakeholders at the QFJC saw real value in the Screener as a mechanism to share information between partner agencies. During final implementation, the Screener was shared with some partner agencies—though not consistently—and they used it to prioritize clients based on the victimizations they reported (e.g., clients with high-lethality victimizations, like strangulation, could be seen first). Stakeholders reported seeing value in sharing the Screener with additional partner agencies in the future, to potentially address the shortcoming identified during the Client Mapping Process that clients were required to repeat their stories multiple times to different service providers.

Stakeholders saw value in the final Assessment Tool as a conversation guide and as a form of psychoeducation. First, stakeholders noted that the final Assessment Tool was a useful conversation guide, particularly for staff with less experience, as it provided structure and discussion topics. Second, as with the pilot Assessment Tool, stakeholders saw psychoeducation as a benefit of the final Assessment Tool. One stakeholder shared how a client described the relief that came with understanding her situation and that support was available.

Stakeholders still faced challenges during final implementation

During this phase, QFJC stakeholders still faced several challenges such as making adjustments to workflow as relationships among Initiative staff became more collaborative, and responding to distress triggered by the final Assessment Tool. In addition, Additionally, final implementation highlighted a longstanding issue at the QFJC, namely, constraints on resources. Though clients in the Polyvictimization Track

received new and more services, stakeholders knew—and data confirmed—that most QFJC clients were polyvictims; yet limited resources, among other challenges, limited the QFJC's ability to best serve everyone identified as a polyvictim by the Screener.

Changes between the pilot and final implementation phases created additional challenges during the latter phase

Despite the numerous benefits of the Screener and final Assessment Tool implementations at QFJC, a number of challenges remained to be addressed. **Importantly, the pilot implementation and final implementation processes varied, which meant that some complications had to be worked out during the final implementation.** Several changes between phases involved the staffing structure. During the pilot phase, the grant-funded partner agencies had not yet hired Initiative-specific staff. This meant that: (1) the pilot phase involved implementation solely by Safe Horizon staff, meaning the other partner agencies (i.e., Voces Latinas and SAVI) had not experienced the implementation process prior and, (2) the new hires did not get to practice tool implementation during the pilot phase. Additional variations related to the implementation structure: (1) because the aforementioned staff had not been hired, the QFJC did not have additional, specialized polyvictimization track services to offer clients during the pilot phase, meaning the referral processes and sharing of clients between long-term case management and mental health counseling had not yet been ironed out, and (2) during the pilot phase, the absence of a short screener (i.e., the Screener) meant the partners were unable to practice the screening process for the Polyvictimization Track.

Some stakeholders perceived challenges in the newly close collaborative relationships between QFJC Partner Agency staff and QFJC Administrative staff. This was potentially due to the changes in staffing between the pilot and final implementation phases. Stakeholders shared the perspective that the relationships between these organizations were developing throughout the final implementation phase, as the partners learned each other's' personal and organizational communication styles, workstyles, and boundaries. Stakeholders emphasized that there were differences in these traits by organization that had to be navigated by the partners as they worked together more closely than they had previously. As part of the Initiative, the organizations had more shared clients—such as those receiving intensive case management and mental health services simultaneously—which created the need for additional communication about the clients and coordination about how to best meet their needs. This type of work was considered productive but time consuming, as it prompted the bi-weekly meetings, as well as ad hoc conversations.

QFJC was still not fully able to respond to trauma triggered by the Final Assessment Tool

As with the pilot Assessment Tool, the final versions were perceived as triggering or challenging for some clients and, while therapy was more readily available during full implementation, not all clients were able to access immediate support for trauma responses. First, during interviews, stakeholders expressed the potential for the final Assessment Tool (and even the Screener), to re-trigger past client traumas and activate a trauma reaction by being reminded of/or asked about their experiences. During

interviews, stakeholders reported that this problem was exacerbated by several factors, including: (1) the fact that Client Screeners and Intensive Case Managers—the staff completing the tools—did not typically have the clinical experience or substantial formal training needed to ground clients after a screening or assessment section. Additionally, (2) stakeholders pointed out that although some clients received mental health counseling, most did not receive it immediately.

In addition to those limitations to responding to the reactions of the clients, frontline staff were challenged to manage their own reactions. Some stakeholders held concerns that the sensitive content of the final Assessment Tool was leading to vicarious trauma for the services providers.

Stakeholders perceived that improved services had a limited reach

Stakeholders expressed that there were limits to the reach, or capacity, of the improved polyvictimization track services. On the one hand, as described above, the Initiative did have positive impacts on client services at QFJC, for instance: (1) **staff generally agreed that the** final Assessment Tool **succeeded in identifying clients that had experienced polyvictimization**, (2) the Initiative increased the availability of long-term case management and mental health services, and (3) the administrative records demonstrate the clients in the polyvictimization track returned to QFJC for services ultimately still had limitations, for a few reasons.

First, stakeholders noted that QFJC had already offered a wide variety of services prior to the Initiative, as is described in the Pilot Tool Development and Implementation section above. As indicated above, stakeholders observed that the Initiative made consistent, intensive, long-term case management and mental health services available to clients; however, they also underscored that the Initiative did not otherwise increase service options at the QFJC. A second challenge inherent to the QFJC and any client-centered service model was that service referrals at QFJC are always optional for clients. Stakeholders believe that some clients arrived at QFJC with a plan for what services they want, and that they would therefore decline additional services suggested as part of the Polyvictimization Initiative. The issue of service refusal was seen by stakeholders as a limit to the improvements in services to high-needs polyvictims. Lastly), stakeholders emphasized that many services—like affordable housing placements—are simply in limited supply, even for high-needs polyvictims. And, while services like long-term case management and mental health counseling became more available to those in the polyvictimization track, stakeholders generally believe that all or nearly all clients at QFJC are polyvictims. Therefore, the services were still limited, because they were only available to the highest needs polyvictims, and resource constraints limited the ability of the QFJC to provide the specialized services to all polyvictim clients.

Overall, stakeholders had greatly improved perceptions of the Initiative from the Pilot stage, but a number of challenges to enhancing the access to services for all polyvictims remained in place.

Key Findings

The Polyvictimization Initiative presented QFJC administrative staff and QFJC partner agency staff opportunities to reflect on the nature of their service provision and to forge a new path to serve clients who have complex, long-term needs for trauma-informed services due to experiences with polyvictimization. These opportunities led to a number of steps forward and successes; at the same time, they presented some challenges, some of which are yet to be resolved.

The Initiative provided opportunities for staff training and increased resources for QFJC clients.

The resources that came with participation in Initiative were a major boon to the QFJC. In particular, hiring four dedicated staff and implementing training on trauma-informed service provision were aspects of the Initiative that staff widely regarded as beneficial to QFJC clients. The increase in staff was especially important because it allowed the QFJC to continue to provide crisis-focused services to clients who need it, while also providing intensive, longer-term services to a smaller group of high-needs polyvictims. Client administrative records supported staff perceptions by showing that clients served by the Initiative received a higher volume of services on average and tended to participate in more intensive case management and counseling, compared to typical QFJC clients.

Staff relationships improved via opportunities for enhanced collaboration and coordination.

The Initiative required that QFJC staff focus more on coordination and collaboration in order to develop and implement the new service delivery model, and to coordinate services for clients served as part of the Initiative. Staff largely reported that having dedicated biweekly meetings was a benefit to them and their clients, increasing the quality of services. However, there were some challenges adapting to the new service model. The increase in coordination that was needed also meant that roles needed to be delineated more clearly, as staff move away from a focus on crisis-intervention to longer term services and overlapping work with clients.

The service delivery model improved for those clients interested in specialized polyvictimization services

Staff reported that increased attention to coordination and information sharing for polyvictim clients with high needs was helpful for service delivery. Additionally, in some instances, staff found the Screener useful for sharing crucial information on clients' backgrounds between partner agencies, and staff overall found that the final Assessment Tool was helpful for psychoeducation, building relationships with clients, and raising staff awareness of client needs. However, for certain clients, staff reported that the Screener and final Assessment Tool presented some difficulties. For a subset of clients, the sensitive nature of the tools' questions caused distress, and in other cases, clients were confused by polyvictimization terminology. These challenges suggest that more could be done to bolster staff's skills in immediately identifying

situations where clients are not ready for these tools; similarly, staff's capacity to explain the availability of specialized services in a manner that was accessible to even more clients could be strengthened. Finally, it is important to underscore that due to the QFJC's client-centered approach, the service delivery model worked well for those clients who were ready and willing to engage in more intensive services. By contrast, for clients who preferred to focus exclusively on a specific and/or immediate need (e.g. seeing a lawyer), the extra services were less relevant. Using the Screener to route clients from the start should continue to help address the diverse needs and preference of clients.

Conclusion

The Polyvictimization Initiative at the QFJC led to a number of successes in terms of serving polyvictim clients, but also presented some challenges. The resources that were provided to the QFJC as part of this Initiative (e.g. dedicated polyvictimization staff and trauma-informed training) were a major benefit. Coordination and collaboration were also important to the implementation of the final Assessment Tool/Screener and other Initiative components. However, staff noted that the coordination of client services required clearly defined roles that still needed to be established. Results from Urban's analyses also indicated that although tools were useful in many regards, further refinement of the final Assessment Tool would be helpful. The Screener proved useful for routing polyvictim clients with higher needs to specialized services, and the final Assessment Tool was helpful for building relationships with clients and raising awareness of their needs.

Overall, the Polyvictimization Initiative brought attention to the needs of polyvictims and the importance of trauma-informed service provision. Through the lessons learned, challenges to implementation, and recommendations described above, Urban has provided a roadmap for the QFJC to enhance the response to polyvictim clients moving forward.

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Chapter 11

Lessons Learned

Authors: Alliance for HOPE International

CHAPTER 11: Lessons Learned

Throughout the Demonstration Initiative, the collaborative process that evolved to develop the Assessment Tool was as important as the creation of the Assessment Tool itself. Struggling through the challenges, having open and transparent discussions, and listening to the actual needs of survivors was invaluable in building understanding to meet the complex needs of polyvictims. The Initiative provided members with the dedicated staff and time required to think through and challenge notions and assumptions, question policies, and create innovative solutions to the obstacles faced. Valuable lessons were learned not only about polyvictimization but about the Centers and the systems necessary to meet the needs of survivors with complex histories of victimization. These lessons can help guide other Centers in successfully implementing a polyvictimization framework.

Lessons Learned

Below is a list of the most critical lessons learned that should be considered before implementing a polyvictimization framework.

Assess a Center's Level of Readiness for a Polyvictimization Framework. Not every FJC is ready to implement a polyvictimization framework. While a polyvictimization framework greatly expands and improves service delivery for survivors, it requires an extensive commitment to change, innovation, training, and enhancing staff capacity. Additionally, not every Center has the necessary governance structure or staffing requirements to bring about the changes responsibly. Prior to implementation, it is recommended that Centers read through the Applied Book and these lessons learned and truly evaluate if their Center is ready for such a significant change. During the Demonstration Initiative, it became clear that the varying governance structures and existing policies around intake were a challenge to successfully implementing the framework. Family Justice Centers participating in the Initiative had various staff positions ranging from advocates, to volunteers, to graduate interns, to mental health professionals, that conducted client intakes and assessments. This varying degree in skill and training influenced and affected the implementation of the Assessment Tool, and greatly impacted the level and intensity of training at each Center. Centers were asked to review memorandums of understanding and partnership agreements prior to the Demonstration Initiative and build commitment from partner agencies to bring about the necessary changes to the processes, protocols, and roles of their staff. Additionally, the Alliance conducted a site visit at every Center participating in the Initiative to document their current process, assess any potential gaps and challenges in structure, and develop recommendations critical to the successful implementation of the framework. The site visit process was pivotal for success and allowed leadership at Centers to clearly understand some of the challenges they would face.

Assign a Point Person to Take Lead on Implementing a Polyvictimization Framework. Successfully implementing a polyvictimization framework is not easy and requires changes, innovation, and new policies at all levels within a Center. While the framework can be implemented by Centers in a phased manner, the level of engagement from partners and frontline staff is critical to its success. The Initiative sites who designated a full-time staff person, separate from the Center Director, to focus on implementing the polyvictimization framework and the changes it entailed, were more successful in creating buy-in from partners and addressing key issues early on in a seamless manner. Centers with dedicated leaders (high and mid-level) committed to implementing the meaningful changes were critical at both the systemic and organizational level. Centers who created mid-level management positions dedicated to addressing polyvictimization and implementing trauma-informed approaches saw drastic changes not only in the operations of their Center, but in advocacy and frontline staff buy-in. By creating leaders and point people responsible for implementing the polyvictimization framework at all levels of the agency, strides can be made in improving intake and integrating trauma-informed approaches into organizational practice.

Ensure that Center Processes and Protocols Support a Polyvictimization Framework. Once the Assessment Tool is implemented, specific needs will be identified and services that were previously never discussed by survivors will be requested. In addition, staff may encounter new situations and types of disclosures that they have not previously addressed with clients. As such, it is critical that frontline staff and those supporting client processes and services look at the Assessment Tool and develop processes on how to handle disclosures regarding symptoms and events. (See Polyvictimization Resource Guidebook for additional information and recommendations on immediate actions for certain events/symptomology). In particular, leadership staff and frontline staff should discuss possible disclosures that could lead to mandatory reporting. Alliance for HOPE International and all Centers involved ensured that disclosures and actions taken were survivor-centered and that processes and protocols within the Center did not take away survivor agency and decision making ability. Information on the Assessment Tool should never be used against survivors and all possible negative repercussions from such disclosures should be discussed with clients prior to the utilization of the Assessment Tool. In particular, planning for the implementation of the Assessment Tool should lead to important dialogue around the protocols Centers have for survivors who disclose suicidal ideation, substance use problems, and/or those who may need higher levels of care due to mental health illnesses. While most Centers have strong and clear policies for responding to domestic violence, sexual assault and child abuse, suicide protocols and/or training around substance use have not always been central to FJC staff training. As such, training around these topics is critical for successful implementation. Exploring how Centers can provide a broad range of services needed by polyvictims must be an ongoing conversation as the framework is implemented.

Develop Learning Exchange Teams or Teams Focused on Thinking About and Facilitating Difficult Conversations. Many of the successes in this Initiative were a result of difficult and challenging conversations about roles, perspectives, and where staff saw this Assessment Tool being used in service delivery. Challenging

conversations and dissent created innovation and change in participating Centers. However, the process was difficult and challenging and often required facilitation. Therefore, it is recommended that Centers embarking on this journey have stakeholders or parties that can help moderate discussion for seemingly entrenched perspectives. In this Demonstration Initiative, researchers played this critical role. Researchers, both local and national, challenged sites to think about the long-term impact of their work. Researcher involvement infused a desire to better understand research and literature in the field as well as a focus on evidence-based practices. During those difficult conversations, it was often researchers who played a key role in facilitating dialogue, asking the right questions, and playing "devil's advocate" to question historical practices and relationships. Researchers asked questions about service delivery, efficacy, and gaps in service. Their input and expertise was called upon in more than one Center during the Client Process Mapping exercise. Involvement from a third party, whether through researchers, strategic planners, or others in the community, allows staff, leadership, and partners to critically think about the way they are providing services and begin to think outside of the traditional scope of their responsibilities.

Needs Assessment and In-Depth Training for Frontline Staff is Critical. Frontline staff are critical to the successful and trauma-informed implementation of the Assessment Tool. As such, investments of time, resources, and training must be made to ensure their success. During this Initiative, Alliance for HOPE International developed and distributed a needs assessment to understand the gaps in knowledge FJC staff had on topics covered by the Assessment Tool. Many staff found the training's initial focus on trauma-informed care was foundational to the success of the Initiative and to the creation of a shared language and understanding of the importance of addressing polyvictimization.

As mentioned above, there was a huge variety in the make-up of frontline staff from site to site at the beginning of the Demonstration Initiative, including disciplines and levels of training. Ultimately, most of the frontline staff who administered the Assessment Tool were not mental health professionals. The Initiative took great care to ensure staff had the resources and skills necessary to implement the Assessment Tool once pilot-testing began. This was accomplished through hours of webinars, dialogue, and extensive one-on-one work. Leadership staff in Centers also dedicated countless hours helping to ensure frontline staff felt comfortable with the extended scope of their work. Even with these efforts, frontline staff faced challenges and Centers engaged in difficult conversations about what portions of the Assessment Tool were necessary or appropriate for frontline staff to complete, as opposed to which portions were more appropriate for service providers to complete later in the service delivery process.

In the beginning, some staff members and leadership were concerned that the Assessment Tool would be too invasive or triggering for survivors. To help navigate this conversation, the technical assistance and research teams explored and presented national research that indicated clients were not often triggered by direct questions from staff (Finkelhor et al., 2011). Initiative members engaged in conversations around how frontline staff could support clients and restore trust if triggering occurred. Similarly, it became important to help staff acknowledge and understand that they themselves may

be triggered by some of the questions on the Assessment Tool or by a client's responses to their questions.

During the training phase, frontline staff were asked to practice how they would listen for or ask questions on the Assessment Tool in a conversational manner. Frontline staff were subject matter experts and comfortable asking many of the questions surrounding interpersonal violence but often had difficulty with questions which covered a more diverse set of victimizations. For example, frontline staff found it awkward and uncomfortable to ask about events such as community violence, discrimination, and natural/manmade disasters with survivors who did not bring up these topics on their own. Often, frontline staff were unsure of an appropriate response or what they could do if there were no services to provide around something that was disclosed. When pilot testing ended, frontline staff felt much more comfortable with the range of questions and were often surprised by the positive responses from their clients. However, becoming comfortable with the Assessment Tool was not a linear process. The process was frequently iterative for frontline staff, requiring consistent use and regular debriefing with other staff members.

Hope-Centered Approaches Work. It is recommended that leadership and frontline staff focus on the power of hope when working with survivors. Hope is the belief that your future can be brighter than your past and that you play a role in making it so by the goals you set and achieve (Gwinn, Hellman, 2017). Increasing hope in the lives of survivors clearly produced positive outcomes around wellbeing. During the last year of the Initiative, most staff at Centers received a day long training from Dr. Chan Hellman on the science of hope. This training provided staff with a practical application of a hope-centered approach with survivors and how it can be applied to intakes and case management. After this training took place, Centers found it easier to connect the Assessment Tool with client progress and saw how they could better engage survivors in goal setting. This became incredibly powerful for survivors as they were able to imagine a different future for themselves and set goals to see that future become a reality. (See later recommendations for more on this process).

Trauma-Informed Approaches are the Basis for Change and Successful Implementation of a Polyvictimization Framework. One of the first in-depth trainings held for the Centers was an intensive three day "Train the Trainer" program on trauma-informed approaches. Raul Almazar, a National Advisor for this Demonstration Initiative, helped ground representatives from each of the six sites in understanding the tenets of trauma-informed approaches and how to apply them in FJCs. Raul based his training on the principles as defined by the Substance Abuse and Mental Health Services Administration (SAMHSA). Participants learned ways to assess the level of trauma-informed approaches in their Centers and identified tools for training other staff and leadership in their communities. This training was transformational and foundational to the changes that occurred over the next three years. It also helped staff better navigate some needed changes such as: 1) Processes and protocols; 2) aesthetics and client flow; 3) training and capacity building; and 4) enhanced staffing. Some Centers used their new knowledge of trauma-informed approaches to train other onsite partners including prosecutors, civil legal staff, etc. on the concepts of trauma-informed care and made significant headway on how attorneys were working with survivors. Other Centers

utilized their trauma-informed training to pursue additional funding and donations from their communities to implement significant changes in their Centers. Donations and support helped change the aesthetics and environment in the Centers and provide for tangible needs of survivors, such as refrigerators and televisions. Centers also used their training to evaluate staff performance and their roles at Centers to determine if staff members were in the appropriate positions. Some Centers found that it was helpful to relocate staff and were intentional about who filled what roles in order to increase trauma-informed responses. Finally, some Centers developed specific interview questions and requirements for positions, such as receptionists, in order to bring in new staff who better fit the requirements of various positions.

Client Mapping is Critical to Better Understand Client Flow and Process. One of the most valuable exercises during the Initiative was a client mapping process. Each Center was asked to complete this process in order to understand their client flow and potential improvements. This was critical to understanding what changes had to take place and what benefits frontline staff and survivors were receiving from each interaction. The process map was used to identify gaps between what was actually happening during intake at Centers and what the ideal process should be. It was used to track potential improvements by providing visual representations of before and after (Southern Institute on Children & Families, 2009). Process mapping was used to build buy-in among partners, increase collaboration, and develop a shared decision making process. Centers were asked to collaborate with their partner agencies, which ultimately promoted a deeper understanding across functional areas of the Center (Southern Institute on Children & Families, 2009). The communication that took place between staff and partners through the client mapping process helped to clearly define tasks and allowed everyone to see how their roles intersected. This was particularly helpful during the implementation of the Assessment Tool since additional care had to be given to who was inputting information, when the Assessment Tool would be updated, and what service delivery would look like as a result of the information gathered. In addition, the process mapping helped Centers identify bottlenecks, repetition, and delays, as well as define boundaries, ownership, responsibilities, and effectiveness measures (“What is Process Mapping”, 2017). For some Centers, this resulted in higher participation and motivation among staff and partners and helped improve ownership and team performance. Read the Family Justice Center Client Mapping Process Toolkit to learn more about how to conduct this process.

Engage Survivors. One of the guiding principles of the Family Justice Center Alliance is ensuring accountability to survivors. This principle was embodied by the Demonstration Initiative. Throughout the three years, it was critical for the Alliance and the demonstration sites to find consistent ways to engage survivors around the polyvictimization concept, the services at the Center, and general feedback. This was done through focus groups with survivors every year of the Initiative. At the beginning, sites used focus groups to better understand how the polyvictimization framework resonated with survivors. Many professionals were fearful of introducing a new word that could potentially label clients, however, many survivors expressed that the term actually helped describe their experience. The Alliance and the Centers engaged survivors in sharing their perspective of the Assessment Tool and how it was going to

be implemented. In addition, some Centers worked to pilot the Assessment Tool with a small subset of returning clients. This allowed staff to practice listening and asking questions that were traditionally perceived as outside the scope of their work. Towards the end of the Initiative, survivors were asked to provide feedback on changes that occurred in the Centers and how existing holistic services were meeting their needs. During the three years, Centers and the Alliance found that many survivors were excited and willing to participate in this process because they felt it would be helpful for others in the future. Giving back to the Center was another step in a survivor's healing process.

Identify Who Will Utilize or Complete the Assessment Tool. The Assessment Tool was often described by frontline staff as a basket for information collected. One of the utilities it offers is the ability to organize information previously disclosed to frontline staff that had never before provided context or helped guide service delivery. But due to the extensive nature of the Assessment Tool, Center leadership and staff must openly discuss how information gathered and/or shared can be beneficial to or negatively impact survivors. Care must be taken to ensure that clients are made fully aware of how their information will be used and that any disclosures do not negatively impact a client. It is recommended that those conducting the Assessment Tool be limited only to staff whose communications are protected by confidentiality and/or legal privilege.

Engage Partners in the Use of the Assessment Tool and Educate them About Polyvictimization. From the outset, it is critical to build buy-in around the polyvictimization framework and an understanding of how the resulting shift in service delivery models can be beneficial to frontline staff roles. This training and buy-in will impact engagement in the long run. As mentioned above, while it is critical to discuss confidentiality, informed consent, and survivor choices, for those clients where portions of information were shared with partner agencies, it was a huge asset and benefit. Client-authorized information sharing helped improve communication between partner agencies and reduce the number of times survivors had to tell their story. In some Centers, the Assessment Tool also helped increase engagement, collaboration, and camaraderie among partners. However, in order to do this responsibly, and for the benefit of the survivor, conversations among leadership about how the Assessment Tool's information will be maintained and/or utilized by frontline staff and/or partners is paramount.

During the Initiative, a challenge faced by Centers was the inclusion of new partners and staff in the utilization of the Assessment Tool. Since many professionals were not trained during the pilot testing phase, there were varying levels of buy-in and understanding among staff and partners. The Learning Exchange Teams (LETs) at each of the Centers had to play catch-up with staff and partners who were not initially involved, and there was some resistance from new staff members. Therefore, it is important to have those difficult conversations with partners and frontline staff from the beginning, identify potential areas for collaboration within the utilization of the Assessment Tool, and train all partners about polyvictimization when they join the Center.

Train, Train, and Do More Training. Training plays a critical role in implementation of the framework. During the Initiative, it was clear that one training event was not sufficient. Rather, a gradual, recurring, and ongoing approach had to be used. This applies to a variety of topics, including the definition of polyvictimization, trauma-informed and hope-centered approaches, confidentiality protections and information sharing, and mental health. It is critical that training be repeated multiple times per year and that ongoing support and reminders for staff/partners be provided. The amount of information being provided to frontline staff in Centers as they implement the Assessment Tool is tremendous, and the shift that is required to embrace a polyvictimization framework is so large that the capacity to learn, process, and implement new concepts requires repetition, intentional dialogue, and regular conversations. This was particularly evident when training frontline staff on how to use the Assessment Tool and teaching advocates who specialized in either sexual assault or domestic violence intervention how to ask more general trauma-related questions.

> "We've seen an increase in: communication/ check-in's between staff; Advocates develop more self confidence in their roles; Advocates offer more opportunities to educate Clients around trauma and its effects."
>
> **- Stephanie Birr, Milwaukee**

Build Overall Service Capacity. During final implementation, sites faced an interesting reality: almost every client arriving at Family Justice Centers was a polyvictim. Sites who developed Screeners had to continuously adjust their polyvictimization criteria since everyone was “screening in” as a polyvictim, with most being classified as high-risk (see site chapters for additional information). As a result, the essential conversation at Centers implementing a polyvictimization framework must focus on how Centers build capacity for and sustain services. Knowing that most individuals accessing services at Centers are polyvictims with in-depth needs, Centers must learn how to adapt to the demand and create a structure for success. This need is exacerbated by the fact that most Centers will see an increased number of returning clients as a result of the connections and relationships built through the use of the polyvictimization framework.

Address Staff Support and Vicarious Trauma. One of the more difficult lessons learned during this Initiative was the significant toll the use of the Assessment Tool had on frontline staff. Most of the frontline staff participating in pilot testing were staff members for several months/years at the Centers; however, during pilot testing they often mentioned how utilizing the Assessment Tool was particularly difficult as they were exposed to more violence, trauma, and sadness from survivors than they were accustomed to. Staff were often shocked and upset by the high levels of victimization clients suffer throughout their lives. Listening to these accounts often left staff feeling drained and exhausted. As a whole, the Initiative saw an increased reporting of vicarious trauma and burnout.

During the early stages of the Initiative, frontline staff also shared their frustration with their inability to offer services, support, or solutions to all the problems survivors were disclosing through the Assessment Tool. This difficulty led to wonderful and rich

conversations around secondary trauma, self-care, support at Centers, and the importance of debriefing and trauma-informed supervision. At many Centers, advocate debriefings and intensive supervision were sporadic, unplanned, and not always intentional. Centers who had debriefing meetings regularly, with a planned method, and with intentional dialogues showed less secondary stress and fatigue. As a result, the Initiative dedicated time to unpacking secondary trauma and offering ways Centers can better support frontline staff. Centers must address staff support structures prior to implementation and provide ongoing space for frontline staff to share their experiences. This Initiative found that one-on-one supervision and regular debriefs with all frontline staff were a successful way to reduce secondary trauma and provide additional support when needed.

Document the Process. While Centers took a proactive approach in setting up structures to support staff (debriefing, supervision, self-care activities, team building activities, etc.), turnover among frontline staff still occurred. Every Center experienced change and transition of frontline staff implementing the Assessment Tool. Some Centers also experienced transition at the top, whether it was Executive Directors or key staff members helping lead the Initiative. While transition and turnover are normal among frontline and programmatic staff in high stress human service organizations, there is always a loss of information. This can sometimes create a gap in knowledge. For this reason, it is critical that there be a clear process for onboarding and training staff on the polyvictimization framework as they replace others.

Shift Focus from Triage and Crisis Intervention to Long-term Relationships and Community. Often Centers are focused on triage and crisis intervention in the clients they are serving. Through this Initiative, sites were challenged to expand their view and the focus of their work toward a more long-term approach. Clients were disclosing events and/or symptoms that often reached far outside of the “traditional” scope of services and often times did not require immediate services but rather a more informal and flexible approach to long-term healing and community building. Sites were challenged to approach disclosures of discrimination or system-induced trauma with thoughtful understanding, but without a need to immediately try to “solve” the issues. This was important since staff were often frustrated upon realization that there was no way to “fix” these experiences for survivors; rather, staff and leadership at Centers had to find ways to support and walk alongside survivors and create alternative programs to help facilitate healing. See individual site chapters for additional information around these services. Some examples of positive community building included: development of Camp HOPE America at Centers, creation of VOICES Survivor Advocacy Committees, singing groups, yoga, and peer-to-peer support groups, among many others.

Build Relationships with Non-Traditional Partners. Due to the varied disclosures and experiences shared by survivors, staff and leadership had to think creatively about services and various modalities of healing. To do this effectively, Centers had to develop relationships with other service providers in the community. Often, this involved reaching out and nurturing relationships with “non-traditional” partners such as: substance use providers; prison/parole service providers; culturally specific community groups (support groups, advocacy groups, service providers etc.); faith community

partners; and others who approach healing through yoga, acupuncture, and singing groups. In addition to bolstering non-traditional services, Centers saw the need to address the prevalent adverse experience of community violence. This was many times outside the scope of work for frontline staff and Family Justice Centers; however, it was central to the lived experiences and intersections of victimization survivors faced. As such, it is important for leadership at Centers to integrate work around addressing community violence prevention if real meaningful change is to occur in the everyday life of survivors. This process, however, takes relationship building and time, and often creative approaches to adding non-traditional Center partners and primary/secondary prevention programming.

There Will Be an Increased Number of Returning Clients: Plan Accordingly. Many of the Centers experienced a dramatic increase in returning clients. While national data does not clearly illustrate or explain why this may have happened, anecdotes from frontline staff revealed that the Assessment Tool led to increased rapport and relationship building between staff and clients. Staff believe that clients felt more heard, understood, and supported through the use of the Assessment Tool and the conversations which were held and were subsequently more apt to return to the Center.

> "I went from seeing an average of 3-5 returning clients per month; but in June during pilot-testing of the [Assessment] Tool I saw 21 returning clients."
>
> **- Maria Thomas, Sonoma County**

Changes for Frontline Staff

Shift to a Polyvictimization Framework. This Initiative challenged the lens through which Centers and staff viewed service delivery and the assumptions they held about client needs. The current system of service provision is often based on a linear model of problem solving which focuses on one victimization at a time, such as domestic violence, sexual assault, substance use, or homelessness. Even at Family Justice Centers, many professionals still provide services focused on a particular type of victimization or category, thus ignoring the high prevalence of co-occurring trauma. Unable to capture the full spectrum of co-occurring victimizations, service providers fail to identify complex trauma histories and symptomology that affect survivors' ability to navigate situations. The Polyvictimization Assessment Tool has shown the importance of having advocates in Centers who not only specialize in domestic violence or sexual assault, but also have a broad understanding of many areas of violence and oppression. A more holistic approach to advocacy allows staff at Centers to identify more than just interpersonal violence and seeks to address the mind-body connection that is critical to holistic service delivery. This Initiative began to build capacity for frontline staff and challenged advocates to step outside of their traditional roles and to learn about all types of trauma and victimizations. This was a personal and professional journey for many of those participating in the Initiative and created space for dialogue and thinking about new ways to support survivors.

Changes to Intake: From Crisis Intervention to Long-Term Case Management. In addition to expanding their advocacy scope, Center frontline staff developed a much more long-term approach to working with survivors. Guided by the use of the Assessment Tool, staff who met one-on-one with a polyvictim engaged in deeper conversations about the client's life experiences with trauma. This resulted in addressing longer-term case management needs rather than simply the immediate crisis-intervention issues. The Assessment Tool, used with a trauma-informed approach, created a safe space for frontline staff and clients to further explore the linkages between past traumas and current physical and emotional symptoms. It allowed staff to see the survivor not just as a domestic violence, sexual assault, or human trafficking victim, but as a whole person. By helping a survivor explore their lifetime experience of abuse, it helped them contextualize the trauma they had experienced, and provided a better understanding of relationships between various victimizations. It also helped to identify, more holistically, the unique array of long-term case management needs to support a client's pathway to justice, healing, and hope. For some Centers, this greatly shifted the intake process from triage to an ongoing relationship. Centers found that rather than simply serving as a one-time navigator, those completing the Assessment Tool became case managers and long-term supporters for survivors. Survivors clearly embraced the Assessment Tool and found much more context for their lives and past experiences.

> "Thank you for asking me about my whole life!"
> **- Survivor**
>
> "This explains what has been happening to me."
> **- Survivor**
>
> "While some of these questions seem unrelated, they are an important part of my experience."
> **- Survivor**

Survivors Want to Tell Their Whole Story. It is Cathartic, but it Takes Time. At the beginning of the Initiative, there was a concern about how the use of the Assessment Tool would impact survivors. Would it cause more trauma? Would it over-emphasize their prior victimization? While the benefit of identifying polyvictims from the research was clear, Centers were concerned about labeling victims or causing undue distress, triggering, or even hurting the relationship being developed between survivors and staff. None of these concerns became a reality with the use of the Assessment Tool. Throughout the three years, staff found that when a trusting relationship existed between frontline staff and survivors, the Assessment Tool helped deepen the connection and survivors often felt relieved and honored when telling their whole story. For many clients, the Polyvictimization Assessment Tool was the first time they were able to tell their entire story from start to finish without shame or blame. The conversations that arose from the Assessment Tool allowed clients the space to share things they never had before, make connections between their physical and lived experiences, and build trust with staff. It was often the same questions frontline staff

struggled in asking that were most meaningful and engaging for survivors. The Assessment Tool has been a helpful way to broach subjects that previously may have been overlooked. For example, in New Orleans, frontline staff shared the importance of being able to meaningfully discuss experiences of discrimination. While discrimination was a reality that all staff and clients were aware of, simply acknowledging that these challenges and barriers existed in their communities opened the door for healing. Frontline staff became experts at holding space for survivors and walking alongside them in their healing journey, truly allowing for an intersectional approach to service delivery in Centers.

Connections are Built on Empathy and Understanding. The biggest feedback received from frontline staff implementing the Assessment Tool was the increased connection between frontline staff and survivors. This connection led to greater empathy and understanding. All frontline staff shared the incredible empathy they felt for each client after hearing their entire story. They were shocked at the levels of victimization endured by throughout the lives of the people they served and the strength these survivors have shown. Many staff members now have a deeper understanding and appreciation for survivors and the difficult choices they had to make.

One of the most memorable ideas presented during the Initiative was that Centers were merely a pathway to help survivors heal, and that survivors have, on their own, already overcome these terrible experiences. This strengths-based perspective served as an inspiration to frontline staff. In addition, the Assessment Tool helped staff understand some of the “difficult” or “strange” behavior survivors may have exhibited during their healing journey. Many staff mentioned that understanding the events survivors experienced, along with the symptoms they were experiencing, made it clear why some survivors may be unresponsive, not trusting, and hesitant to make the changes service providers often encourage.

Symptomology Assessment Can Require Additional Training. Adding symptomology questions to the Assessment Tool was a critical step in holistically addressing polyvictimization. While this was agreed upon at all six Centers, the symptomology questions initially posed a great challenge for frontline staff. While some sites embraced utilizing symptomology questions to screen for high-risk survivors or polyvictimization, other sites struggled with how to integrate symptomology questions into their intakes. Much of the variation was impacted by who utilized the Assessment Tool and the level of training they received on how to ask symptomology questions. One of the more successful tactics to build capacity among frontline staff was to work through each question and find different ways staff could ask them. In addition, Centers were encouraged to engage mental health professionals in their communities to support ongoing training with frontline staff around symptomology and understanding these concepts.

Psychoeducation is Key. Giving staff the ability to connect mind and body for clients, and giving clients insight and personalized psychoeducation, was a significant success in the implementation of the Assessment Tool. The Assessment Tool became much more of a platform for increasing conversations and sharing information than it did a tool simply leading to services. The power in dialogue facilitated by the Assessment Tool is

the process of deeper connections, education, and tailored services that arise between service delivery staff and the client. To this end, staff must learn and feel comfortable providing psychoeducation to clients around the events and the symptoms in the Assessment Tool. Survivors also found encouragement in knowing the Assessment Tool was being refined even as it was being used to help them.

> "I love using the tool because it helps the education about polyvictimization. It is very affirming to clients. A client once said 'I really hope this helps other people'."
>
> **- Walesa Kanarek, New Orleans**

The Science of Hope and Looking Towards the Future. Even though the Assessment Tool offered many powerful benefits, the Initiative found that it was not enough to just ask what happened – but also important to help survivors identify aspects of themselves and their lives that were positive. During the last year of the Initiative, there was a concerted effort in utilizing the Assessment Tool and then helping survivors identify the strengths and assets they held. The conversations frontline staff had with survivors became much less about looking back and more about how survivors could look forward and strengthen the hope in their lives. Hope is a future-oriented, goal setting mindset (Gwinn, Hellman, 2017). Staff broached subjects like: What goals do you have? What does success look like for you? How do you care for yourself? What things and people bring you joy? What does healing look like for you? Frontline staff were encouraged to help survivors set small goals and celebrate their successes, no matter the size. In some Centers, frontline staff and their clients revisited the Assessment Tool, revisited symptoms, and looked at initial goals set by survivors. This led to a tangible sense of accomplishment for both survivors and staff, while also directing conversations away from victimizations and toward healing and the future.

Shifting the Funding Framework to Better Serve Polyvictims:

One of the key findings of OVC's Vision 21: Transforming Victim Services Initiative was the need to provide more flexible federal grant funding to allow service providers to offer victims the full array of support needed in navigating the many complex issues in their lives that intersect with violence and victimization. OVC's Polyvictimization Initiative further underscores this need and provides an ideal opportunity to envision a greater focus on collaborative funding approaches. Addressing polyvictims holistically may require Family Justice Centers and their allied partner agencies to pull together multiple sources of funding and align different funding streams intended for different purposes to meet all existing gaps in serving polyvictims. There are important and substantial federal and state resources that are available to combat domestic violence, sexual assault, child abuse, elder abuse, human trafficking, or other forms of crime victimization. In addition, private foundations continue to support innovative initiatives that have advanced the Family Justice Center movement and the broader fields of family violence, sexual assault, and other areas of crime victimization. Yet there is not one core funding source that will consistently support the collective efforts of a Family

Justice Center and other co-located multidisciplinary victim service models to meet the holistic needs of survivors coping with a lifetime of adversity and violence.

Funders and donors have a significant influence on the direction for programming in the support of Family Justice Center operations and service provision but are often limited by the allowable uses of funding. On the federal or state level, funding parameters are often driven by statute, programmatic requirements, departmental policies, and/or agency directives. In October 2003, President George W. Bush announced the creation of a special initiative, modeled after the San Diego Family Justice Center, to develop 15 Family Justice Centers across the United States, testing the model in diverse settings including tribal, urban, rural, and suburban locations. The President's Family Justice Center Initiative (PFJCI) was administered by the United States Department of Justice Office on Violence Against Women (OVW), supported with grant funding from three OVW grant programs, and focused on the development of co-located service delivery models for serving victims of domestic violence and their children. Some of the participating PFJCI sites had more expansive visions for their Centers that included onsite collaboration with Child Advocacy Centers and/or sexual assault services, collaborations that are quite common in FJCs today. At the time, however, all PJFCI sites had to limit the scope of FJC services to a domestic violence service delivery model, focusing on adult victims, in order to meet the requirements of the PFJCI and the limitations of their funding.

As more funders support collaborative, coordinated responses on the ground, the following question arises: is there a new frontier on the horizon in the approach to philanthropy? What might it look like for federal agencies and/or private foundations to come together to pool funds or leverage existing efforts to more holistically support collaborative efforts such as Family Justice Centers or other multidisciplinary victim service frameworks? While a collaborative funding model is not commonly used to address crime victimization, there is precedence. In 2015, a multi-federal agency, multi-year collaborative was established that pooled funds and coordinated efforts between OVC, OVW, the U.S. Department of Health and Human Services Family Violence Protection and Services Act Office (FVPSA), and U.S. Department of Housing and Urban Development Special Needs Assistance Program (SNAP), to establish the national Domestic Violence Housing Training and Technical Assistance Consortium (the Consortium). The Consortium allowed for a greater reach and impact than any one agency alone could have in addressing the intersections of housing and homelessness in the lives of domestic violence and sexual assault survivors (U.S. Department of Justice Office of Public Affairs Press Release, 2016). Representatives from each agency share a role in the oversight and guidance of the Consortium and ensure that federal grant funds, activities, and efforts are coordinated rather than duplicated. The Consortium received an initial three years of funding which was renewed in FY 2018.

Private foundations are also engaged in a variety of innovative funding alliances for more strategic and less siloed approaches to addressing a variety of societal issues. Examples include: collaborative grant making where donors leverage and pool resources, make decisions collectively, and document the collective impact results of their efforts (The Ms. Foundation for Women, 2002); and braided funding pools where multiple funding streams are allocated toward one purpose while separately tracking

and reporting on each source of funding (Urban Institute, 2019). These models offer new and different pathways for funders to evaluate how they might consider realigning their approaches to grant making and giving in support of flexible funding options that support a more holistic approach to meeting the needs of adult and child polyvictims. Such an approach will be beneficial in helping Family Justice Centers or other multi-service agency collaboratives to more effectively serve polyvictims.

What Does this Mean for the Family Justice Center Movement?

The Family Justice Center movement continues to dream big. From the early days of the movement, there has been a continual focus on supporting the pulse of innovation, growth, adaptation, and evolution fueled by the ultimate shared goal of providing safe, confidential, relevant, comprehensive, wraparound services to meet the needs of adult and child survivors of violence and abuse. At its core, the Family Justice Center framework is about providing the most effective, efficient, meaningful and compassionate services to victims of domestic and sexual violence and their children. The Family Justice Center movement has evolved from one of comprehensive, co-located centers for victims of domestic violence and their children, to communities of hope for those who have experienced domestic violence, child abuse, sexual assault, elder abuse, stalking, human trafficking and/or other intersecting traumatic experiences at some point in their lives. The FJC movement has worked hard to break down the silos and build bridges with practitioners working across the domestic violence, sexual assault, and child abuse fields. The Polyvictimization Demonstration Initiative further shifted the FJC framework for the delivery of holistic services for survivors from one based on a client's presenting victimization to one of survivor-focused, trauma-informed, hope-centered, long-term advocacy and case management. Within this framework, survivor safety remains paramount during crisis intervention, taking precedence over a polyvictimization assessment process. However, OVC's Polyvictimization Demonstration Initiative demonstrates that the effective use of the Polyvictimization Assessment Tool can facilitate a comprehensive understanding of polyvictims and their needs, provide FJC staff the opportunity to deliver broader services to meet the long-term needs of survivors, and help to mitigate risk factors for future victimizations.

Alliance for HOPE International wants to challenge other Family Justice Center communities to think through how they may continue to evolve to address the complex trauma experienced by the many survivors who walk through their doors. The Alliance also cautions other Family Justice Centers from moving forward too quickly to implement a polyvictimization service framework. A great deal of thought, intentionality, deliberation, organizational and individual soul searching, planning, and training have gone into shaping the implementation of a polyvictimization framework within each participating Center. Not all Family Justice Centers are ready to make this shift right now. This year, OVC plans to expand the work and lessons learned from the FY 2016 Polyvictimization Initiative by supporting five Family Justice Centers or similar co-located service model agencies as they begin or continue to transform service delivery to more effectively meet the needs of polyvictims. Over the next three years, the FJC movement will continue to learn from the experiences of the original Initiative pioneers. Centers who are newly funded in FY 2019 will also inform the FJC movement as they engage in new partnerships, expand case management, and enhance their capacities.

The FJC movement will continue to create and expand hope-centered, trauma-informed, and culturally responsive services for polyvictims.

Conclusion

The OVC Polyvictimization Demonstration Initiative has charted the course forward for the calling of Family Justice Centers to do trauma-informed and hope-centered work. Centers must help survivors contextualize the complex trauma they have experienced in childhood and adulthood and then find pathways forward to hope and healing. The ability of a survivor to tell their whole story is crucial to the healing journey. To be trauma-informed means to be willing to ask the question, “What happened to you?” and then listen to the entire story, not simply the most recent incident that brought a survivor to a Center for services. To be hope-centered means one must support a survivor’s goals. One must assist a survivor to develop the pathways and strategic thinking necessary to identify the steps and overcome the barriers to achieving their goals. Hope not only mitigates, but heals trauma. This truth points the way forward for working with survivors of numerous types of victimization in the months and years ahead.

The goal of Family Justice Centers therefore must be to increase safety, offender accountability, and survivor hope in order to see transformative healing in clients served by Family Justice Centers. The Demonstration Initiative has also shown that hope is central to those working in Family Justice Centers. In the words of Alliance President Casey Gwinn, “If you don’t have hope in your own life, it is impossible to give hope to others in need. You cannot give what you do not have.” This means every Center must invest fully in staff wellness, training, and self-care initiatives to ensure that hope remains high in the lives of the hopegivers. The exciting findings and lessons learned from the Polyvictimization Demonstration Initiative have provided a roadmap forward for the next wave of Centers willing to invest in a polyvictimization framework and offer hope and healing in a comprehensive, trauma-informed, hope-centered approach.

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