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HOW ILLINOIS SERVICE PROVIDERS SUPPORT YOUNG VICTIMS OF CRIME: FINDINGS FROM AN ILLINOIS HEALS SURVEY

ILLINOIS CRIMINAL JUSTICE INFORMATION AUTHORITY
CENTER FOR VICTIM STUDIES

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Abstract: The Illinois Criminal Justice Information Authority was awarded a grant from the Office for Victims of Crime for the Illinois Helping Everyone Access Linked Systems (Illinois HEALS) initiative. The six-year initiative seeks to improve the recognition, connection, and service engagement of children, youth, and families impacted by violence in Illinois. Illinois HEALS program staff surveyed agencies in Illinois serving children, youth, and families to better understand how they learn about client victimization and exposure to violence, services available to victims, and referral and collaboration processes. Survey findings revealed service providers use varying methods to learn about clients' victimization, such as screening and assessment tools, and strategies for sharing information within and across agencies and systems, including collaboration networks and multidisciplinary teams. While many providers offer services to children and/or adults, victim-focused services are often not available for family members. Recommendations for how agencies can work to improve harm recognition, service connections, and service engagement are discussed.

Introduction

The Illinois Criminal Justice Information Authority was awarded a grant from the Office for Victims of Crime for the Illinois Helping Everyone Access Linked Systems (Illinois HEALS) initiative. The six-year initiative seeks to improve the recognition, connection, and service engagement of children, youth, and families impacted by violence in Illinois. Illinois HEALS program (i.e., non-research) staff conducted a survey of agencies in Illinois directly[1] serving children, youth, and families. The survey was administered during the project's planning phase to better understand how agencies learn about client victimization and exposure to violence, services available to victims, and referral and collaboration processes. The results will guide next steps during implementation of demonstration sites in different communities in Illinois.

Method

Procedure

Illinois HEALS program staff emailed invitations to take the survey to agencies providing advocacy, healthcare, and legal assistance services to children, youth, and families in Illinois; Illinois HEALS program and research staff's knowledge of programming in the state coupled with research to identify additional providers was used to generate the list of invited participants. Emails were sent to agency directors through the online survey's email distribution utility. While this function is useful, agencies may have been less likely to open the email with the survey invitation or to have the email reach their inbox because the email did not originate from Illinois HEALS program staff, negatively impacting survey participation.

The email invited directors to participate in the survey and encouraged them to forward the survey invitation to their networks and listservs to reach additional service providers. Agencies were instructed to select one representative (i.e., program director, coordinator, supervisor, or manager) to complete the survey. Staff inferred the agency representatives could most accurately answer survey questions; other staff with different agency roles may have able to more accurately answer certain questions. Agencies with two or more unique programs serving children, youth, and adults had the option to complete a survey for each program. Two follow-up emails were sent to remind the invited participants to complete the survey.

Survey respondents were asked about the services they provide to children, youth, and families, how they learn about client victimization and exposure to violence, referral and collaboration processes, and general agency information, including catchment areas and staffing.

ICJIA researchers received Institutional Review Board approval to conduct a secondary data analysis of the survey responses.

Sample

Individuals representing a total of 184 unique agencies serving children, youth, and families in Illinois participated in the survey. Most agencies reported serving Cook County (42 percent), followed by Central (39 percent), Northern (25 percent), and Southern Illinois regions (23

percent), and the Collar counties (21 percent).[2] Respondents largely described their agencies as either victim service- (37 percent) or social service-focused (33 percent). Fewer categorized their agencies as child welfare (7 percent), civil or family court (4 percent), education (4 percent), healthcare (5 percent), or juvenile justice based (3 percent). The remaining 7 percent of respondents did not indicate a category. Many agencies in Illinois did not complete a survey; few child welfare, civil or family court, education, healthcare, and juvenile justice service providers participated in the study. Thus, findings presented here are most indicative of victim service and social service agencies in Illinois and are not generalizable.

Analysis

Researchers conducted a secondary data analysis. Descriptive analyses were utilized to examine the data. Frequencies were obtained for categorical variables.

Findings

Descriptive analyses of survey data were organized around three distinct and interconnected components to victim service delivery:

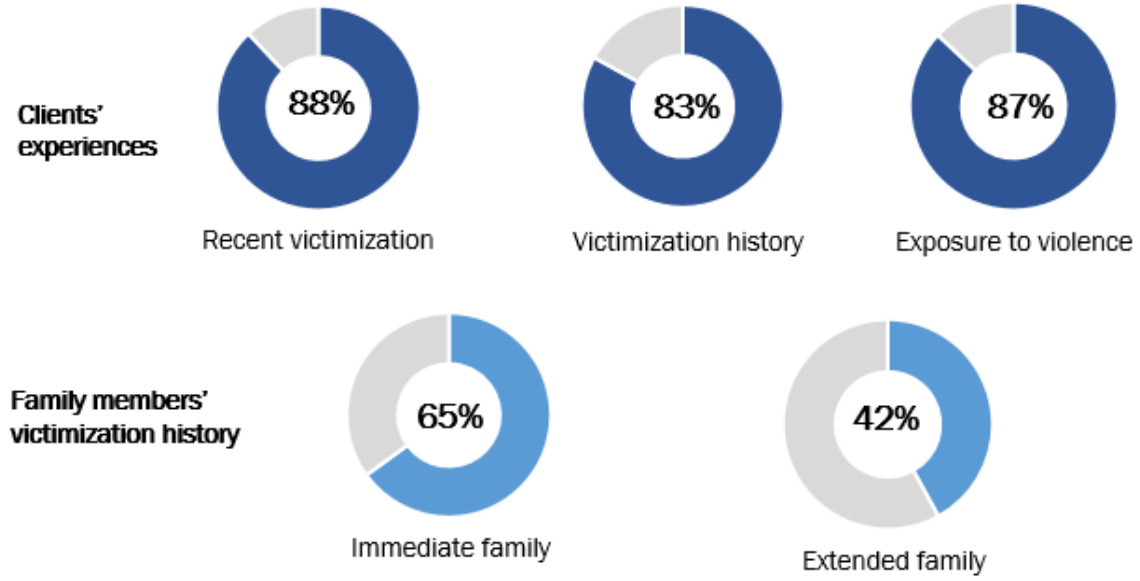
- *Recognize:* Learning that a child, youth, and/or family member has experienced recent or past victimization, including exposure to violence.
- *Connect:* Linking a victim to services or system providers to meet their needs, such as healthcare, advocacy, and safety, following victimization.
- *Engage:* Providing services, such as medical care, counseling, and legal assistance, to victims to meet their needs following victimization.

Recognize

Agencies were asked whether they routinely asked about the victimization experiences of their clients and the clients' family members. Most reported doing so (*Figure 1*). Victimization experiences included clients' recent victimization, including direct violence, abuse, or neglect experienced in the past year, victimization history (i.e., victimization occurring more than a year ago), and exposure to violence, including seeing or hearing violence.

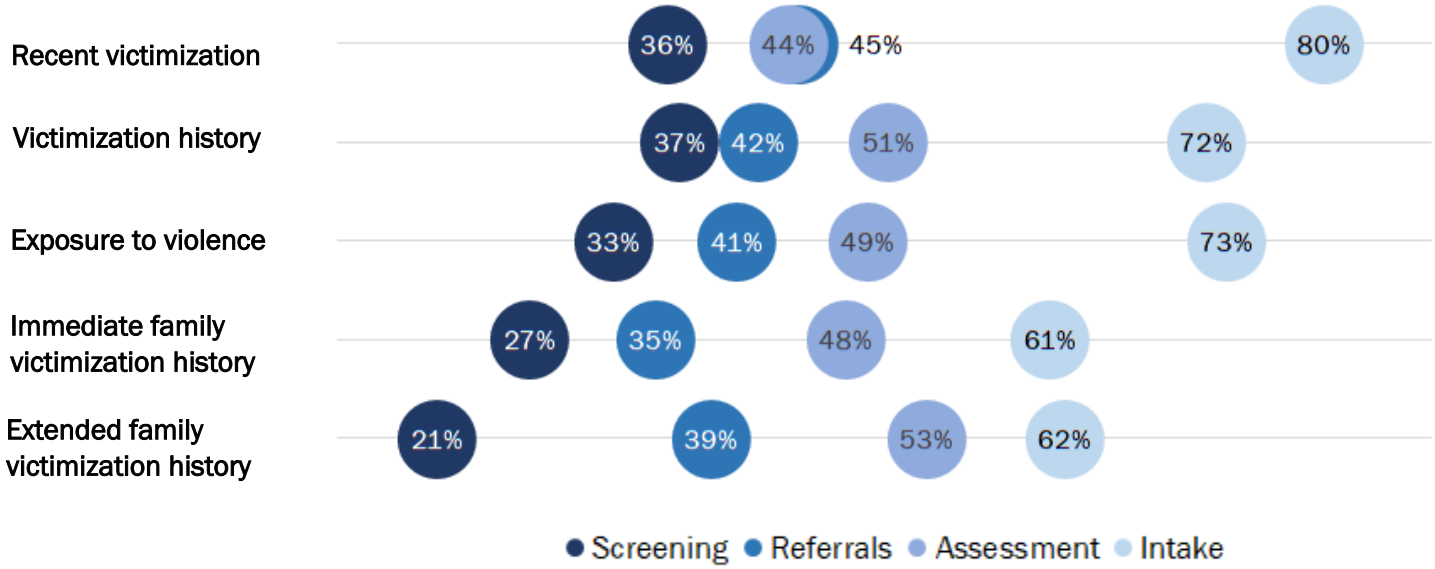
Providers were less likely to routinely ask about direct victimization experienced by their clients' family members during their lifetimes, including immediate family, such as caregivers or parents, siblings, and children, and extended family, such as grandparents and other relatives (*Figure 1*).

Figure 1
Percentage of Surveyed Agencies Who Ask About Client and Family Member Victimization, by Victimization History Type (*n* = 184)



Agencies were asked how they learn about the victimization experiences of clients and their family members. Providers reported learning about victimization through screening tools, referral sources, such as other agencies, intake questions, and assessment tools. Screenings tools were described as brief sets of questions for identifying victimization and/or exposure to violence. Assessment tools refer to formalized and validated questionnaires for measuring behaviors or symptoms consistent with victimization. Most providers reported using intake questions to learn about their clients' and clients' family members' victimization experiences (*Figure 2*). The fewest agencies reported using a screening tool to learn about victimization, with more learning of victimization through assessment and referral sources.

Figure 2
Percentage of Surveyed Agencies Using Different Approaches to Learn About Victimization, by Victimization History Type (*n* = 77 to 161)[3]



The screening and assessment tools used by agencies to document victimization varied greatly. Providers reported using over 25 different tools, most commonly the Adverse Childhood Experiences (ACEs) Questionnaire and Youth Assessment and Screening Instrument (YASI). Providers also reported using tools developed internally to screen or assess clients.

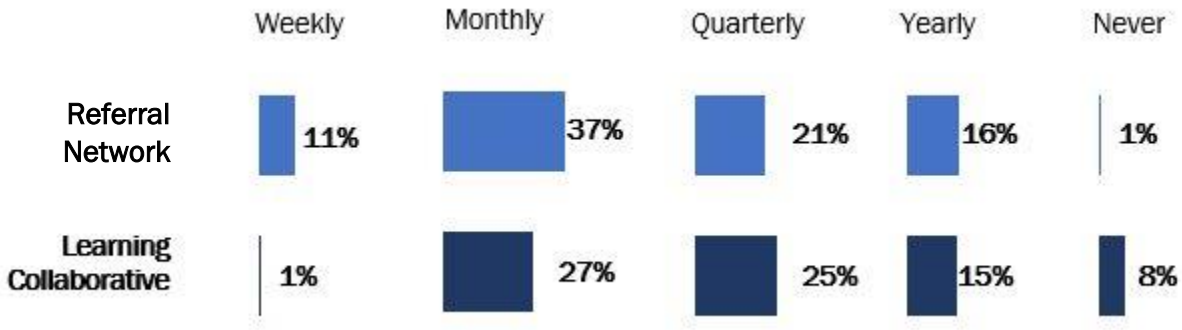
Further analyses suggest providers may be unfamiliar with the distinct purposes of screening and assessment tools. Screening is intended to assist providers in deciding whether to assess a client for services through the identification of specific problems, such as victimization, whereas assessments are designed to obtain more detailed information about a client's symptoms and needs to aid in developing a service plan.[4] Some providers indicated they use an agency-created assessment tool to screen for victimization. Others reported using screening tools, such as the ACEs Questionnaire, a set of 10 items for identifying childhood abuse, neglect, and other potential stressors[5] and the Trauma Symptom Checklist for Children (TSCC), a screening tool for identifying symptoms resulting from trauma,[6] as victimization for assessment. Neither the ACEs Questionnaire nor the TSCC elicit the comprehensive client information needed to inform client service plans.

Connect

Agencies were also asked to report how often they meet with other providers to improve cross-agency or cross-system relationships through referral networks or learning collaboratives. Referral networks meet to review and discuss programming, whereas learning collaboratives are comprised of small groups of professionals who learn and practice specific approaches and/or clinical interventions together. Most providers met as part of a referral network or learning

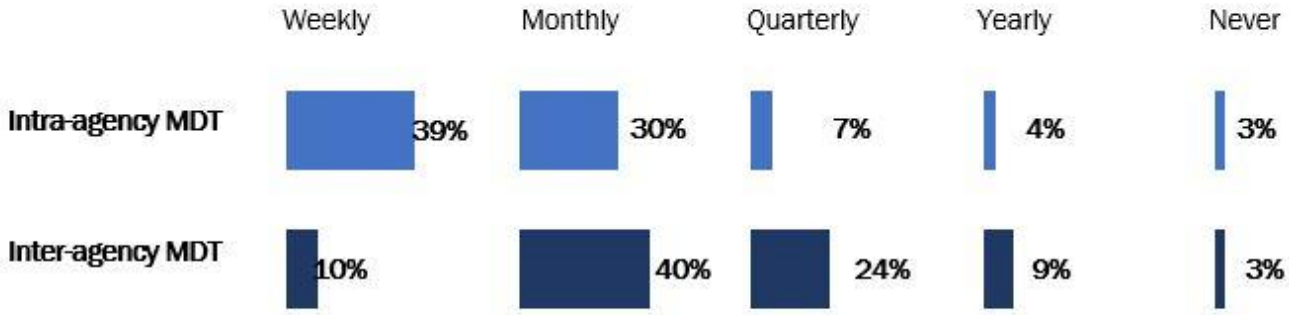
collaborative either monthly or quarterly (*Figure 3*), with referral network meetings occurring more often than learning collaborative meetings.

Figure 3
Collaboration Types and Frequencies Reported by Surveyed Agencies (*n* = 184)[7]



Providers also were asked how often their agencies met as part of a multidisciplinary team (MDT) in which groups of professionals from different disciplines, such as victim services, law enforcement, and education, come together to discuss clients and how to best coordinate their care and support. Agencies indicated the frequency with which they participated in *intra*-agency MDT meetings, held with representatives from within their own agency, and/or *inter*-agency MDT meetings, with representatives from within their own agency and with other organizations. *Intra*-agency MDT meetings occurred either weekly or monthly for most agencies, whereas *inter*-agency meetings occurred either monthly or quarterly (*Figure 4*).

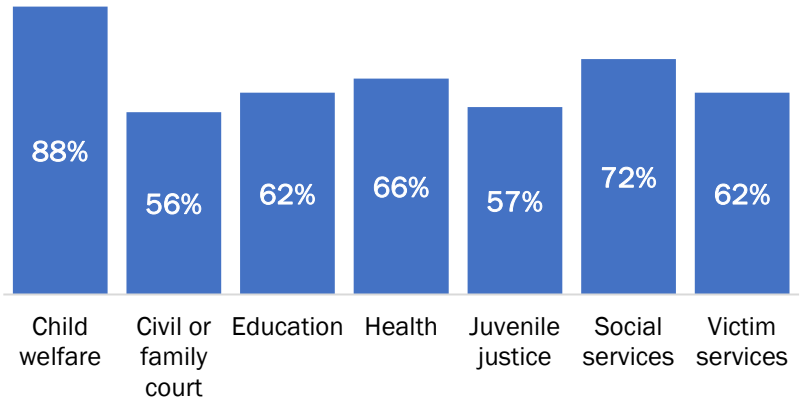
Figure 4
Multi-Disciplinary Meeting Frequencies Reported by Surveyed Agencies (*n* = 184)[8]



Given that a primary goal of the survey was to better understand how young victims and families are connected to services, referrals between victim service providers and child welfare, civil or family court, education, healthcare, juvenile justice, social services, and other victim service providers also were examined. These analyses revealed that more victim service agencies reported receiving referrals from child welfare than any other type of provider with nearly nine in 10 victim service providers receiving referrals from child welfare providers (*Figure 5*). The fewest victim service agencies reported receiving referrals from civil or family court providers or

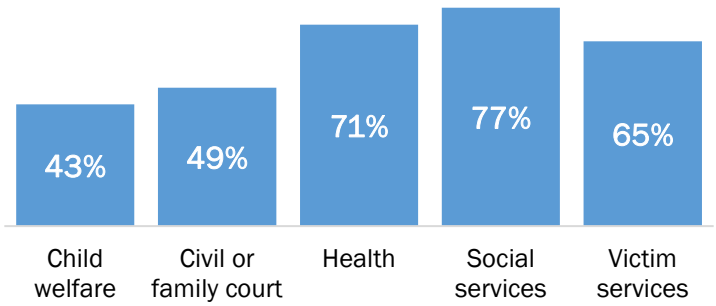
the juvenile justice system. Approximately two-thirds to three-quarters of victim service agencies reported receiving referrals from the remaining providers types, including education, victim services, health, and social services.

Figure 5
Percentage of Surveyed Victim Service Agencies *Receiving* Referrals, by Provider Type (*n* = 68)



The percentages of victim service agencies that provide referrals to other providers were also examined. These analyses did not include referrals made to education providers and the juvenile justice system because it is not necessarily appropriate for victim service agencies to make referrals for services to these types of providers as they are unlikely to offer services that could provide additional help and support to families impacted by victimization. Victim service agencies reported providing referrals to social service providers more often than to other providers, with over 75 percent of them making these referrals (*Figure 6*). About two-thirds of the respondents reported making referrals to healthcare or other victim service agencies. Fewer victim service providers made referrals to child welfare than any other provider type followed by civil or family court; less than half made referrals to either of these provider types.

Figure 6
Percentage of Surveyed Victim Service Agencies *Providing* Referrals, by Provider Type (*n* = 68)



Engage

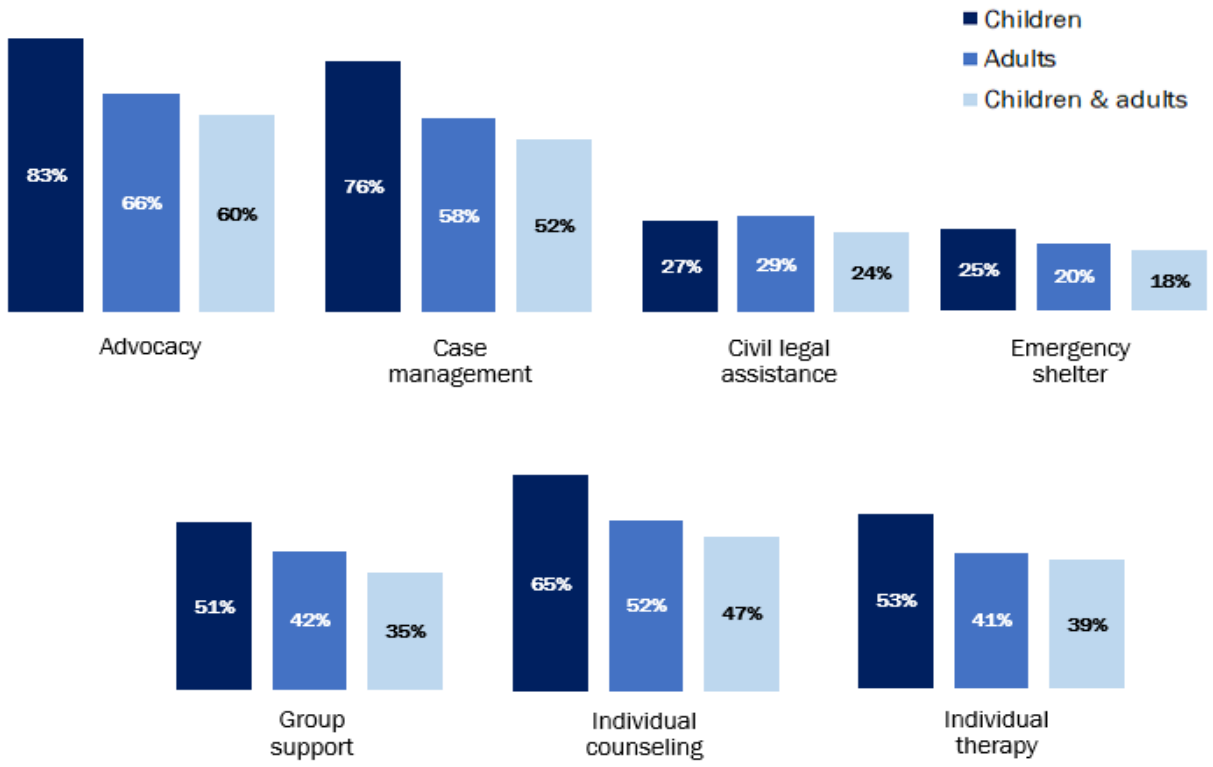
Providers were asked whether their agencies provided services to meet needs children and families commonly have following victimization. These services include:

- *Advocacy*: Someone to help provide information, referrals, or emotional support.
- *Civil legal assistance*: Help with non-criminal legal issues such as acquiring identification or replacement documents, family, financial, or immigration matters, or orders of protection.
- *Emergency shelter*: A safe place to stay for a short time.
- *Case management:* Help coordinating care to meet the needs of the client or of the client and their family.
- *Group support*: A group of people with similar experiences who meet to offer one another support.
- *Individual counseling*: Someone to talk to about how clients are feeling.
- *Individual therapy*: Someone who is trained, such as a counselor or therapist, to talk with clients about stressful experiences.

Agencies reported they were most likely to provide advocacy (90 percent) than any other service, followed by case management (82 percent), and individual counseling services (70 percent). Respondents were least likely to offer emergency shelter (27 percent) or civil legal assistance (32 percent). More than half of the respondents provided group support (57 percent) or individual therapy (55 percent) to clients.

When asked who they provided these services to, providers indicated that, with the exception of civil legal assistance, services were most commonly offered to children (i.e., young persons under 21 years old) than adults (*Figure 7*). Additional analyses revealed fewer providers offered the same service to both children and adults. For instance, while 83 percent of respondents offered advocacy services to children, just 66 percent provided the same service to adults, and only 60 percent of respondents offered the service to both children and adults. A single provider was less likely to offer the same service to both children and adults than to either children or adults.

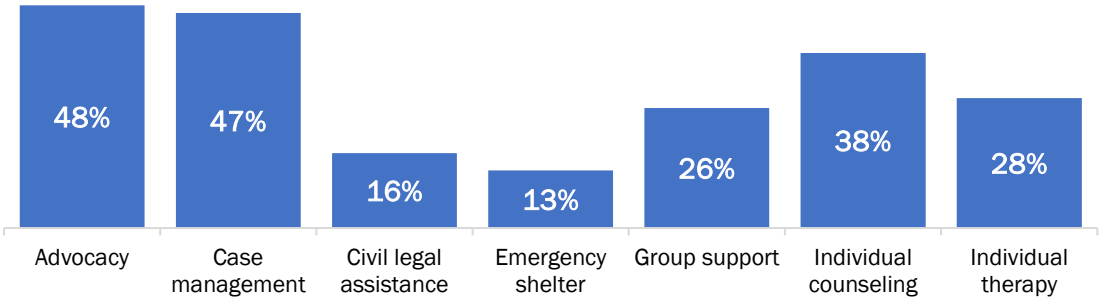
Figure 7
Percentage of Surveyed Agencies Offering Services to Children and Adults, by Service Type (*n* = 184)



Most respondents reported offering victim-focused advocacy (72 percent), case management (65 percent), and individual counseling services (61 percent). Fewer than half reported offering individual therapy (47 percent) and group support services (44 percent) designed to address victimization. Far fewer providers offered victim-focused civil legal assistance (29 percent) or emergency shelter (21 percent).

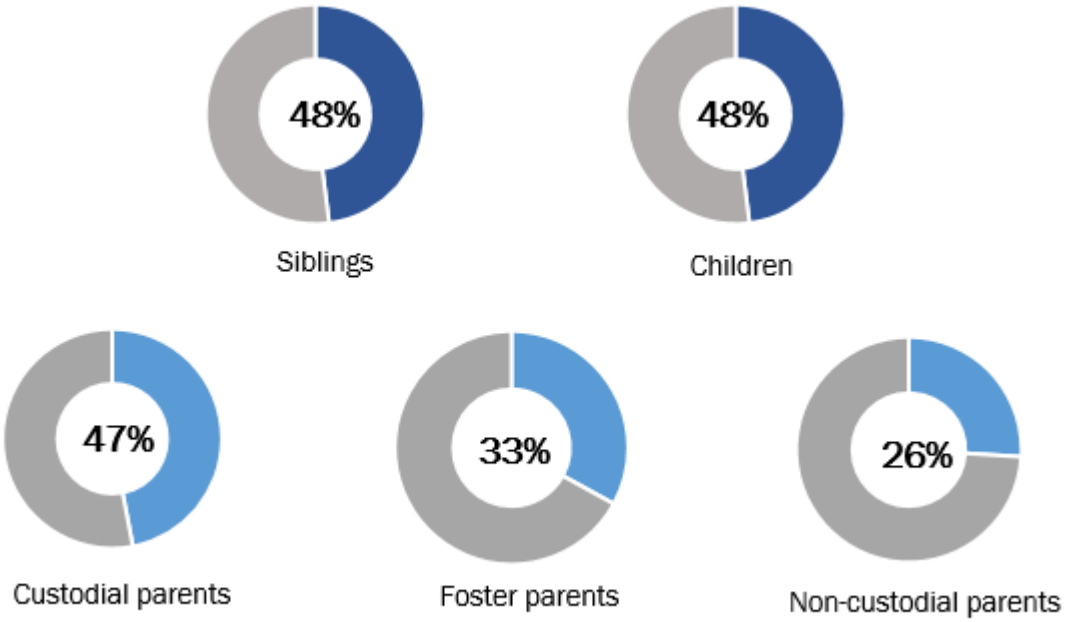
Providers also were asked whether they offered victim-focused services to family members, such as parents, children, and siblings. Nearly half of the respondents reported offering victim-focused advocacy and case management services to family members (*Figure 8*). While more than 25 percent of agencies provided individual counseling, individual therapy, and group support to family members in a way that attended to victimization, fewer had victim-focused civil legal assistance and emergency shelter for family members.

Figure 8
Percentage of Surveyed Agencies Offering Victim-Focused Services for Family Members, by Service Type (*n* = 184)



Respondents reported the types of family members they provide victim-focused services to, including siblings, children, custodial parents, foster parents, and non-custodial parents. Fewer than half reported offering victim-focused services to the siblings and children of direct victims of crime (*Figure 9*). Primary caregivers were even less likely to be offered victim-focused services by respondents, with fewer than half of agencies surveyed reporting they offer these services to custodial parents and even fewer respondents reporting these service offerings to foster parents and non-custodial parents.

Figure 9
Percentage of Surveyed Agencies Providing Victim-Focused Services to Family Members, by Family Member Type (*n* = 184)



Implications for Policy and Practice

Based on findings from a survey of agencies serving children, youth, and families in Illinois, researchers suggest the following to identify opportunities to strengthen service delivery for young victims and families. These suggestions may require additional training or resources.

Learn more about how providers are using different approaches and tools to recognize victimization

Validated victimization- or trauma-specific screening and assessment tools help service providers accurately identify victimization and victimization-related symptoms and ensure appropriate referrals and service plans. While respondents indicated they are most likely to learn about victimization during intake, they reported using screening and assessment tools created internally. It was unclear whether the intake questions or the agency created screening or assessment tools providers used incorporated elements from validated tools, such as the TSCC. Validated tools have empirical evidence to show they can accurately identify problematic behaviors or posttraumatic stress symptoms that are not easily observable.[9] Agencies can benefit from learning more about how other providers are utilizing intake questions and screening and assessment tools to recognize victimization. These benefits include ensuring that providers are using the shared language needed to make meaningful service connects by knowing more about the types of victimization and associated symptoms and/or needs partnering providers or those with similar catchment areas are asking about and the tools utilized.

It is appropriate for victim service and child welfare service providers to use an assessment tool, given their primary focus is to provide services to victims. Education or healthcare providers may not be adequately equipped to address victimization. Therefore, screening for victimization and then connecting clients to victim-focused services may be a more appropriate use of time and resources. This could help to mitigate frustration clients may feel as they undergo repeated assessments with different service providers, some of whom are not equipped to provide needed services. Agencies across different systems should consider working together to identify strategies for ensuring screening and/or assessment is being conducted at the appropriate time and by the appropriate system provider.

Understand how current information sharing practices within and between agencies and systems both facilitate and inhibit victim and family member connection to and engagement with services

More than one-third of responding agencies reported learning about a client's victimization through referrals. This suggests some providers are sharing information across agencies, alleviating some of the burden of finding appropriate services and facilitating provider connections. Further exploration of the information sharing processes and practices being employed by these agencies among providers or through researcher-practitioner partnerships may help to inform strategies, including approaches to overcoming barriers, providers can apply to improve how they connect with other providers and how they connect clients to other providers. A working group focused on information sharing is one way providers can learn more

about current information sharing practices, opportunities for improvement, and the feasibility of implementing changes.

Nearly half of the responding agencies met with others at least monthly to review and discuss programming through a referral network. In contrast, less than a third of the respondents reported participating in a learning collaborative at least monthly and 8 percent had never attended a learning collaborative meeting. Referral network meetings enable providers to share information about eligibility criteria, service availability, and referral practices to ensure meaningful connections, but learning collaboratives are also important because they offer opportunities for providers to learn about how others are using or adapting promising or evidence-informed practices to engage victims.

Providers also participated more often in intra-agency MDT meetings than in inter-agency MDT meetings. Given victims and families are often unable to have all their needs met by a single agency, both intra-agency and inter-agency MDT meetings allow case-level information sharing about clients and an opportunity to strategize collectively on how to best meet their needs. Therefore, providers should examine whether they have the capacity to increase the frequency with which they participate in learning collaborative and/or inter-agency MDT meetings to better facilitate service connection and engagement.

Improve connections between victim service agencies and systems positioned to play a crucial role in recognizing victimization

The juvenile justice system works with child and youth populations that often have extensive trauma histories with studies estimating that over 90 percent of youth with juvenile justice system involvement have experienced at least one traumatic event and that these youth on average have experienced five different forms of trauma,[10] yet only about half of victim service providers surveyed reported receiving referrals from juvenile justice agencies. In a national study, researchers found that 61 percent of children from birth to 17 had experienced at least one type of victimization, such as physical assault and witnessing community violence, in the past year.[11] Approximately two-thirds of victim service agencies received referrals from educators and from healthcare providers. Given all educators and healthcare providers have regular and frequent contact with children and youth likely to have experienced victimization, efforts should be made to strengthen services connections between victim service agencies and both the education and healthcare systems. Juvenile justice, education, and healthcare systems have the potential to serve as important partners in recognizing victimization and in making service connections. More information is needed to better understand whether potential barriers, such as lack of victimization screening or eligibility criteria, may be inhibiting linkages and how to strengthen information sharing and service connections between these systems and victim service providers can be strengthened.

Examine the needs of children, youth, and families impacted by victimization and the current capacity of agencies to meet those needs

More agencies reported providing advocacy or case management than civil legal assistance and emergency shelter, but it is unknown if current service levels are sufficient to meet client need

and the capacity of providers to expand quality services. Even though most providers indicated offering advocacy and case management services they may be providing those services at or over capacity making it difficult for victims to access these services; there may also be promising or evidence informed practices providers may not have the knowledge or resource to fully implement.[12] Therefore, it is necessary to conduct further research to better understand not only the needs of children and adult victims, but the availability and capacity of agencies to provide needed, quality services to all service-seeking victims.

Explore the capacity of providers to engage the whole family in services

Research suggests that trauma impacts the entire family unit. Some families may experience the same traumatic events. Other family members may feel stress after learning of another family member's victimization or when interacting with victimized family members exhibiting trauma-related symptoms.[13] As a result, agencies should strive to understand the victimization histories of the entire family and to make services available to all family members.

The survey data analyzed suggested agencies in Illinois may not be equipped to serve entire families. Agencies are less likely to provide the same services to both adults and children. Additionally, less than half of agencies reported providing victim-focused services to family members. Therefore, families may be unable to access services for the entire family from a single provider. This lack of centrally located services for the entire family may create a barrier to service engagement for families.[14] Further follow up is needed to better understand the resources providers need to build provider capacity to engage the whole family in services at one site in a way that attend to the impacts of victimization. Increasing capacity to engage family members in services may also lead to an increase in the number of providers asking about family members' victimization history. The inability to address client victimization directly or through referrals can lead to provider frustration and an approach to service delivery that prioritizes other needs over victimization impacts.[15]

Conclusion

This survey of agencies in Illinois serving children, youth, and families revealed they utilize many practices to recognize, connect, and engage children, youth, and families impacted by violence. Providers from these agencies reported using different methods to learn about client victimization and share information within and across agencies and systems. It remains unclear, however, whether tools used by agencies to recognize victimization are valid and whether current identification and information sharing practices result in service connections.

Agencies provide many services to children, youth, and families impacted violence, but services are offered at the same location and to all family members are limited. This creates barriers to services that care coordination could alleviate.

The present study emphasized the need to better understand the needs of victims, the availability of services to meet these needs, and how services are coordinated among providers. Additional research to better understand how current approaches to recognizing victimization, connecting victims to services, and engaging them in services facilitate or inhibit the healing of children,

youth, and families impacted by violence can improve service delivery and ultimately outcomes for young victims and families.

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[1] Direct services are support or assistance a provider gives to a client requiring direct contact with a client, e.g., providing medical care for an injury or therapy, whereas indirect services refer to activities providers engage in that don't necessitate interaction with the client, but support them and their access to direct services, e.g., supervision of staff providing direct services, administrative functions, etc.
[2] Percentages exceed 100 percent because some agencies reported serving more than region of the state.
[3] Sample size varied based on the number of agencies that reported asking about client and family member victimization: recent victimization (n = 161), victimization history (n = 152), exposure to violence (n = 160), immediate family member victimization history (n = 119), extended family member victimization history (n = 77).
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[7] Percentages do not total to 100 percent because not all survey participants responded to these survey items.
[8] Percentages do not total to 100 percent because not all survey participants responded to these survey items.
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