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VICTIM SERVICE DELIVERY: ILLINOIS PROVIDERS' PERSPECTIVES ON VICTIM SERVICE BARRIERS AND AGENCY CAPACITY

ICJIA

Victim Service Delivery: Illinois Providers' Perspectives on Victim Service Barriers and Agency Capacity

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Key Findings

In June 2016, ICJIA researchers conducted a statewide study to better understand crime victim needs, identify service gaps, and measure the capacity of Illinois victim service providers. The study was initiated to inform ICJIA's strategic plan to establish victim service funding priorities for use of S.T.O.P. Violence Against Women Act (VAWA) and Victim of Crime Act (VOCA) funds. The larger project included a literature review, an analysis of administrative data, and surveys of and discussions with victims and their family members, victim service providers, and criminal justice practitioners. This report focuses on one aspect of the statewide study: surveys and focus groups with victim service providers about service delivery and capacity.

Victim service providers representing different regions of the state discussed their experiences providing services that respond to victims' needs. They discussed the importance of being able to serve victims holistically and reported encountering barriers to resources, service availability, and capacity.

Awareness of both victimization and victim services was identified as a barrier to service delivery. For victims of a crime, public awareness campaigns that address what victimization is and provide information about resources are particularly important to facilitate access. However, providers also suggested that awareness efforts, in addition to the general public, should target groups that may play a role in connecting victims to services. Additionally, training for providers and community members should incorporate best practices on disclosure responses and help-seeking in victim-centered, trauma-informed ways that can create an environment of support and safety for victims.

While providers saw awareness-raising as a priority, in an effort to improve victim self-identification and first responder education, they emphasized the need to first restore and rebuild capacity within their agencies and in social services around the state to holistically meet victims' needs. Without more staff, flexible funding, or consistent referral networks, agencies are struggling to provide quality services to all victims who seek help. With these constraints, providers are finding it difficult to coordinate with other agencies in the area to access services that address complex needs, such as therapy or legal assistance. Providers have had to make the difficult decision to triage, thereby prioritizing victims in crisis and limiting their ability to provide longer term services. In addition, administrative tasks, such as data collection and reporting, place a burden on agency staff. Staff who provide direct services often also are responsible for data collection and entry. Providers discussed how these practices impacted service quality and victim engagement in services.

Funding practices and restrictions also limited the types of services that agencies were able to provide and, as a result, who they were able to serve. In particular, providers discussed how fragmented and restricted funding made it challenging for service providers to address the complex, multifaceted experience and impacts of victimization. When services are fragmented victims must seek services from multiple providers to meet their needs.

Despite barriers to service access and provision, providers were resilient and strategized

around how to use limited resources to reach the most victims possible. Providers found collaboration to be a good approach to addressing awareness and delivery issues. Having a presence in the community also may help the community be more knowledgeable about victimization and decrease victimization-related stigma in certain communities.

Victim service providers expressed hope for the future of victims services, that agency capacity would be restored, allowing them to expand their services to reach even more victims and to provide additional services. Providers spoke consistently about the importance of prevention work and how more flexible funding could enable them to resume past prevention work or to expand the scope of their work to include prevention. They also had a strong desire to seek out new settings that might be appropriate for victim services and to incorporate the use of new strategies into their program design to reach victims unlikely to seek out or access services due to barriers.

Introduction

In June 2016, ICJIA researchers conducted a statewide study to better understand crime victim needs, identify service gaps, and measure the capacity of Illinois victim service providers. The study was initiated to inform ICJIA's strategic plan to establish victim service funding priorities for use of S.T.O.P. Violence Against Women Act (VAWA) and Victim of Crime Act (VOCA) funds. The larger project included a review of existing literature, an analysis of administrative data, and surveys and discussions with victims and their family members, victim service providers, and criminal justice practitioners. The recommendations from the larger project were restricted to allowable activities for VAWA and VOCA funds. For a summary report on the larger project, see the Ad Hoc Victim Services Committee Report available here.

This report expands upon one aspect of the statewide study: surveys and focus groups with victim service providers about service delivery and capacity.

ICJIA staff carried out an assessment of victim services providers' perspectives of victim needs and barriers, capacity to meet those needs, and strategies to overcoming the barriers. The main research questions were as follows:

- What do victims of crime need?
- What needs are providers unable to sufficiently meet due to programmatic and/or geographic gaps?
- What barriers inhibit providers' ability to meet victim needs?
- How have providers navigated barriers to service provision?
- How do providers envision the future of victim services?

This report focuses on provider capacity, barriers, and strategies to address victim need and providers' vision for the future of victim services. The report begins with a review of relevant research literature, followed by the study methodology and limitations. Next, the results of the study are presented, ending with a discussion of the findings and implications for policy and practice.

As a note, while the findings of the larger project report were restricted to allowable activities for VAWA and VOCA funds, this report presents the main findings from the survey and focus groups regardless of funding allowability. Where possible, this report draws upon data from the statewide victim needs assessment[1] asking victims about their needs following their victimization, whether those needs were addressed, and ways to improve victim services.

[1] The purpose of the survey was to document victimization prevalence and to learn from those victims what their needs were following their victimization, whether those needs were addressed, and ways to improve victim services. The survey was administered online to adult residents of Illinois (defined as persons 18 years and older) using a statewide consumer panel. Care was taken to match the sample to U.S. Census data, ensuring that the sample was representative of Illinois geography, gender, age, and socioeconomic status. About 1,042 persons completed the survey and 27 percent of them self-identified as having been a crime victim in the last 10 years. To supplement these data, Aeffect recruited additional victims from Chicago and victims who experienced specific crimes, such as child abuse, homicide, domestic violence, and sexual assault to ensure their voices were heard. When the state benchmark and supplemental samples are collapsed, the online survey represented the perspectives of 1,565 Illinois residents which can now be used to profile the prevalence of victimization and needs of crime victims.

Section 1: Literature Review

Extensive research is available on the effects of victimization on individuals, including the impact on one's physical, psychological, and overall well-being. Victims may experience severe bodily harm or disfigurement as a result of the crime or may experience debilitating health problems from psychological stress brought on by the victimization (Office for Victims of Crime [OVC], 2012b; Nemeroff, 2016). Victimization also can result in psychological symptoms and related mental health needs, including anxiety, depression, and PTSD following the loss of a loved one to a crime (Aldrich & Kallivayalil, 2013), elder abuse (Fisher & Regan, 2006), domestic violence (Black, 2011; Coker et al., 2002), sexual assault (Kilpatrick, Resnick, Ruggiero, Conoscenti, & McCauley, 2007), and childhood exposure to violence (OVC, 2012a; Nemeroff, 2016). Symptoms often emerge following the victimization and persist for years, impacting victims' overall quality of life (Yuan Yuan, Koss, & Stone, 2016). Taken together these impacts of violence can disrupt a victim's ability to engage in day-to-day activities, including work and school, which may cause financial burden or emotional distress that affects their long-term stability.

Following victimization, individuals may have a variety of needs that arise to address or mitigate the impacts of violence. Victim needs can be categorized in three ways: fundamental, presenting, and accompanying (Vasquez & Houston-Kolnik, 2017). At the most basic level, victims require services to help them meet fundamental needs, such as shelter, food, and employment assistance. Emergency housing has been identified as a need of both domestic violence and elder abuse victims in Illinois immediately following victimization (Houston-Kolnik, Vasquez, Alderden, & Hiselman, 2017). Other needs reported by domestic violence victims surveyed in Cook County include help with food and clothing and in getting work (Riger, George, Byrnes, Durst-Lee, & Sigurvinsdottir, 2016). In addition to fundamental needs, victims often have presenting needs, including those that require legal services, medical or mental health care, and longer term housing. Among crime victims in Illinois, Aeffect, Inc. (2017), found that crime victim needs include counseling (29 percent), civil legal assistance (19 percent), medical services (13 percent), and housing (7 percent). Furthermore, support services for victims are needed to address accompanying needs or those needs that, if left unmet, inhibit access to support services. Both victim service providers and victims expressed the importance of accompanying needs, such as transportation assistance, translation services, and child care, in order for victims to access or stay engaged in services (Aeffect, Inc., 2017; Vasquez & Houston-Kolnik, 2017).

Victim Help-Seeking

Following victimization, individuals may seek help from either formal or informal support sources for assistance in meeting their fundamental, presenting, or accompanying needs. Formal support sources include medical and mental health professionals, law enforcement, and victim service providers, whereas informal support sources are comprised of family members, significant others, or friends. Research suggests that victims are more likely to seek help from informal support sources than from formal support sources. Coker and colleagues (2000) found that female victims of domestic violence were most likely to seek help from a friend (75

percent), followed by a family member (69 percent). In comparison, data from the National Crime Victimization Study indicated that less than half (47 percent) of all violent crimes (e.g., robbery, assault, domestic violence) were reported to police in 2015, with sexual assault victims having the lowest rate of police reporting at less than a third (33 percent; Truman & Morgan, 2016).

While reporting rates to formal support sources are lower than to informal sources, these rates vary across different types of formal support sources and may depend on victimization experiences. For example, research conducted with sexual assault victims found that 20 to 26 percent sought medical help for their victimization (Coker et al., 2000; Resnick et al., 2000). In comparison, only 15 percent of adult male community violence victims (Jaycox, Marshall, & Schell, 2004) and 11 percent of victimized adolescents (Guterman, Hahm, & Cameron, 2002) used mental health services post-victimization. And in a study of female and male domestic violence and sexual assault victims, rates of help sought from victim service providers ranged from 0 to 11 percent, varying by gender and victimization type (Coker et al., 2000). A range of different factors influence a victim's decision whether to seek help from informal and/or informal support sources.

Not all victims, however, need or want help from formal support sources. Research conducted with crime victims in Pennsylvania and Illinois suggests that approximately half of victims do not express a need for help from formal support sources following their victimization (Aeffect, Inc., 2017; Sims, Yost, & Abbott, 2005). Some victims may feel better equipped to cope with the victimization themselves or have a strong informal support network upon which they can rely (Sims, Yost, & Abbott, 2005).

Victims of violent crime are more likely to indicate a need for formal support as a result of their victimization, with 50 percent of domestic violence victims expressing a need for counseling and 43 percent of child abuse, domestic violence, and survivors of homicide victims reporting a need for civil legal assistance (Aeffect, Inc., 2017). These findings suggest that victim service providers serve an important role in meeting the needs of various types of violent crime victims following victimization. Research suggests that a majority of victims of interpersonal crimes who seek help from a victim service provider perceive that support to be helpful (Coker et al., 2000).

Barriers to Help-Seeking

Research has identified barriers that inhibit a victim's ability to receive needed services from victim service providers and other social service agencies. Ullman and Townsend (2007) have conceptualized barriers to service provision broadly as either direct service oriented (i.e., barriers that impact victims directly) or as organizational in nature (i.e., barriers that impact the quality of services offered and received). Their framework informs the findings from recent statewide victim needs assessments conducted in various states, including Illinois.

Direct service oriented barriers. Awareness of services and the related issue of victim identification, both for individuals and service providers, have been noted by multiple state need

assessments as barriers to formal help seeking, particularly as it related to victim service providers. In Illinois, the majority of victims (51 percent) reported that no one had informed them of services available for victims of crime following victimization (Aeffect, Inc., 2017). Myths about victimization, cultural beliefs, and societal norms all shape victim identification and help-seeking. Following a victimization experience, individuals may confront stereotypes and myths in themselves and others, such as doubting the individual's authenticity as a victim, feeling shame about the experience, or encountering victim-blaming responses that suggest it was an individual's fault (Liang, Goodman, Tummala-Narra, & Weintraub, 2005; Tsui, Cheung, & Leung, 2010).

These responses may be further shaped by individual characteristics such as age, disability, gender, legal status, race and ethnicity, sexual identity, or social class (McCart, Smith, & Sawyer, 2010). Male victims of sexual violence, as an example, may fear others will question their authenticity due to stereotypes that only women are victims of sexual violence or social norms of masculinity that suggest men should be able to protect themselves (Tsui, Cheung, & Leung, 2010). Negative responses as a result of these stereotypes and myths about victimization, or the fear of these responses, may discourage individuals from acknowledging their experience as a victimization and seeking help. Even if an individual identifies as a victim, awareness of services has been reported to be one of the key barriers to victim service-seeking, with 57 percent of victims in Illinois and 22 percent of victims in Oregon lacking knowledge of how to obtain services (Aeffect, Inc., 2017; Elliott, Cellarius, & Horn, 2013).

Victims who self-identify or have been identified by others as victims and who have knowledge of services may still face other barriers to formal help-seeking. Research suggests that fear or stigma and limited access to support services (e.g., transportation, child care) may negatively impact a victim's ability to obtain services (Aeffect, Inc., 2017; Elliott et al., 2013; Lowry, Reid, Feeley, Johnson, & Williamson, 2015). Specifically, Oregon victims and service providers ranked fear as the second most impactful service barrier (Elliott et al., 2013), and victims from Massachusetts also reported shame and embarrassment among the top barriers to engagement in help-seeking (Lowry et al., 2015).

Additionally, more than one-third of Illinois victims surveyed did not seek services due to fear of being blamed or not believed (36 percent; Aeffect, Inc., 2017). Also, Illinois victims cited a lack of transportation (22 percent) and child care (13 percent), and a need for language services (15 percent), as additional barriers to service seeking (Aeffect, Inc., 2017), suggesting support services are needed for victims to access and stay engaged in services. In Cook County, victims cited language as a barrier to service access, child care was viewed as a barrier among domestic violence victims, and transportation inhibited elder abuse victims' ability to stay engaged in services (Interdisciplinary Center for Research on Violence, n.d.). Victim identification, service awareness, fear and stigma, and limited access to support services all negatively impact a victim's ability to obtain services.

Organizational barriers. Organizational barriers can negatively impact a victim service agency's ability to deliver services to their clients in a comprehensive and holistic manner. Agency capacity to meet victim need, insufficient funding, and staffing challenges all threaten a

provider's ability to serve victims who have likely overcome the previously discussed barriers to service access. Research conducted with victims and/or providers in five states, including Illinois, indicate that a lack of services and staff, also known as reduced agency capacity, impede victim service delivery (Elliott et al., 2013; Institute of State and Regional Affairs-Penn State Harrisburg, 2014; Interdisciplinary Center for Research on Violence, n.d.; Lowry et al., 2015; Stromberg, Lambert, & Lambert, n.d.). Specifically, in Massachusetts, providers noted that the demand for services exceeded staffing levels (Lowry et al., 2015), and in Cook County, victims had difficulty accessing legal services and staying engaged in services due to a lack of attorneys (Interdisciplinary Center for Research on Violence, n.d.).

Agency capacity for assisting victims relies upon proper staffing, funding, and training. Agencies may struggle to build up capacity to serve victims without reliable funding, which in turn creates an organizational barrier to service delivery. In multiple states, funding was explicitly described as a critical organizational barrier (Lowry et al., 2015) or top issue facing providers (Institute of State and Regional Affairs-Penn State Harrisburg, 2014). In Illinois, stakeholders reported having to make strategic decisions around whom to serve (e.g., focusing on clients in crisis) due to limited financial resources and inconsistent funding streams (Aeffect, Inc., 2016a). In addition, low staff salaries, likely due to insufficient funding, have been recognized as a barrier to victim service provider capacity building (OVC, 2013) and service delivery (Stromberg et al., n.d.). Logan and colleagues (2004) drew a connection between low pay and provider qualifications, reporting that low pay contributes to an agency's inability to attract and retain qualified providers. Capacity can also be impacted by turnover and burnout. Aeffect, Inc. (2016b) described how providers in Illinois struggle to retain providers due to the emotional impact of working with victims in addition to low pay and funding insecurity. Similarly, in Pennsylvania, agency administrators identified staff turnover and burnout as challenges experienced by victim service agencies (Institute of State and Regional Affairs-Penn State Harrisburg, 2014). While training can help to equip staff and encourage best practices for both staff and client care, the need for consistent trainings can contribute to capacity issues due to turnover and the time and cost required to train new staff.

As discussed, the number of victims who seek services exceeds agency capacity. The Office for Victims of Crime (2013) highlights the importance of strategic planning in capacity building endeavors, but acknowledges that current agency capacity limits agency ability to engage in such a process. Findings from Pennsylvania's victim needs assessment underscores this point as the majority of providers surveyed indicated that funding (90 percent) and additional staff (67 percent) were elements needed to expand services (Institute of State and Regional Affairs-Penn State Harrisburg, 2014). Thus, victim service delivery relies upon strong organizational capacity to address both organizational and direct service oriented barriers that impede access and service quality. With increased capacity, providers can explore how to expand services to reach more victims and develop innovative strategies to increase awareness and access to victims.

Section 2: Method

The purpose of the study was to document victim services providers' perspectives of victim needs, barriers and capacity to meeting these needs, and strategies to overcome those barriers. Research questions included:

- What do victims of crime need?
- What needs are providers unable to sufficiently meet due to programmatic and/or geographic gaps?
- What barriers inhibit providers' ability to meet victim need?
- How have providers navigated barriers to service provision?
- How do providers envision the future of victim services?

To answer these questions, ICJIA staff applied a mixed sequential research design, in which quantitative and qualitative components of the study were carried out in different phases (Leech & Onwuegbuzie, 2009). The study involved two components: (1) a survey of victim service providers from across the state of Illinois (n=235) and (2) follow-up focus groups with victim services staff (n=28). This section will focus on the areas of the method that are relevant to this report, for a full description of the study method, go to the Victim Need Report available here.

Measures

Survey. A survey of victim services providers aimed to collect information on a variety of questions about victim need, availability of services, and the current capacity of agencies to provide services. The following questions were analyzed for this report:

Multiple victimization experiences. Participants were asked how frequently their agency sees "victims who experience multiple forms of victimization" using a Likert scale from 0 (Never) to 4 (Always).

Changes in internal capacity. Participants responded to a question about how their capacity to serve victims of crime within their service area had changed within the past year. Response options included: 'decreased significantly,' 'decreased slightly,' 'did not change,' 'increased slightly,' and 'increased significantly.'

Focus groups. Several broad questions guided focus group discussions with participants. These questions centered on the needs of crime victims, barriers to victim access and provider service delivery, and service capacity. For the purposes of this report, responses that provided insight on the following questions were analyzed:

- What barriers inhibit providers' ability to meet victim need?
- How have providers navigated barriers to service provision?
- How do providers envision the future of victim services?

Analytic Strategy

Researchers analyzed both quantitative survey data and qualitative focus group data using analysis techniques described below. The qualitative data was more heavily drawn upon during the analysis phase of the study or had a dominant status. In studies that use mixed method research design, Leech and Onwuegbuzie (2009) distinguish between research approaches that give equal status to quantitative and qualitative methods or that give greater weight to one method (i.e., dominant status) in answering research questions. Administrative data, where appropriate, also was used as a supplement to qualitative research findings.

Survey analysis. Researchers conducted descriptive analyses to analyze survey data. Frequencies were obtained for categorical variables (e.g., service need, service availability) and descriptive statistics (e.g., mean, range, standard deviation) were computed for ordinal variables.

Focus group analysis. Focus groups were recorded with a digital audio recorder and transcribed verbatim. The transcripts were then analyzed using NVivo 9, a qualitative software package. Researchers used a combination of structural and descriptive coding during the initial coding period.[2] Structured codes, such as victim need and gaps, aligned with study research questions, whereas descriptive codes, such as shelter, legal services, and transportation, were topics referenced by focus group participants. During the second phase of coding, researchers used axial coding to determine how codes identified in the initial coding phase could be organized, according to similar or dissimilar characteristics, into larger categories (e.g., fundamental needs, presenting needs). Theoretical coding also helped to structure how all codes and sub-codes were connected (e.g., transportation need in a rural area). Each transcript was coded by one researcher trained in qualitative data analysis and was reviewed by a similarly trained researcher. Coding disagreements were discussed until consensus was reached.

Administrative data. Researchers analyzed administrative data on victim service utilization, available through InfoNet, the state's central repository for statewide victim service data specific to sexual assault, domestic violence, and child abuse. These data were used to further inform study findings on victim need.

Limitations

No research study is without limitations. First, this study focused on provider perspectives on victim needs and their capacity to meet those needs and does not incorporate victim's perspectives on these topics. During this same time period, ICJIA contracted with Aeffect, Inc. to conduct a victim needs assessment that incorporated victims in their sample. While this project parallels much of what that study found,[3] it is important to acknowledge that victims and, more specifically, victims who do not seek help from formal service providers may have needs that are not reflected in this report. This is a common limitation in victimization research because a lot of victims never disclose their experiences formally, whether to criminal justice agencies or victim service providers.

[2] For a discussion of coding techniques see Saldana, J. (2009). *The Coding Manual for Qualitative Researchers.* London: Sage Publications, Ltd.
[3] Aeffect, Inc.'s report, 2016 Victim Needs Assessment Summary Report, is available here: http://www.icjia.state.il.us/assets/articles/2016_ICJIA_Victim_Needs_Assessment_Summary_Report.pdf

Second, the sample of victim service agencies may not be representative of all providers in Illinois. The recruitment strategy for the victim service provider survey involved both paper and email outreach. Agencies that had moved, closed, or merged with other agencies may not have received recruitment materials and thus, did not participate in the study. While some of these individuals may have been forwarded the link to our survey, researchers could not identify who participated because the survey was anonymous.

Lastly, this research took place following an Illinois budget crisis, which impacted the time providers had to participate in this study. Due to capacity issues and funding cuts, some providers did not have the time or funding for staff back-up coverage or travel to participate in focus groups. Thus, the focus groups may not be representative of all providers.

Section 3: Study Findings

Service providers were asked about their capacity to meet victims' needs, including barriers they experienced and strategies they used to overcome those barriers. Within these themes, providers discussed three different stages: awareness, access, and delivery. The results that follow will explore the main themes at each of these stages related to provider capacity, barriers, and strategies to meet victims' needs. Within each stage, the results are categorized by Ullman and Townsend's (2007) framework of direct service and organizational barriers. Direct service barriers are those that impact the accessibility or availability of services, such as stigma, geographic location, or a lack of services. Direct service barriers also include resource barriers that reduce or restrict direct services, such as funding constraints that limit services or paperwork and reporting that take staff time away from services. Organizational barriers include lack of funding, training needs, capacity concerns, such as burnout, and practices or policies that impact services. Within each stage, the direct service barriers are discussed first followed by organizational barriers and then strategies to address barriers.

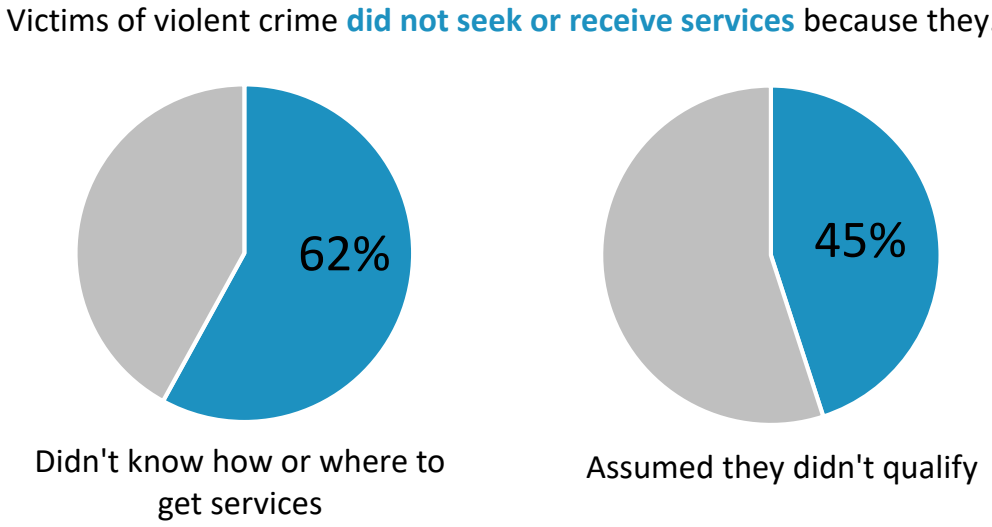
Direct Service Barriers: Awareness

A lack of awareness about crime and victimization as well as a lack of knowledge about available services for victims were noted as barriers to service delivery. Related to their direct services, identification as a victim and knowledge of services were awareness barriers that providers experienced.

Identification as a victim. Before a victim can receive services, they have to self-identify or be identified as a victim. Providers highlighted identification as a barrier, especially for at-risk, highly victimized populations, such as homeless and runaway youth. When providers were ask about what a victim needs following a victimization, one hotline provider from Cook County described how some victims may not identify as a victim of crime: "I think further up the line is, since we work so much with runaway and homeless youth, is first even **recognizing that they're a victim** of crime" (FG7). Individuals may not identify as victims for a variety of reasons such as not knowing a crime has occurred or not feeling comfortable identifying as a victim. Victims also may not seek support from a formal service provider who could identify that a crime has occurred and direct victims to services. Thus, if victims do not self-identify or share their experiences with someone knowledgeable of victimization, points of access to services are not available.

Knowledge of services. Information on and awareness of available services for victims of crime was another key theme. Victims may be unsure of where to seek help. Others do not know they are eligible for services. Aeffect, Inc.'s (2017) assessment of victims' needs found Illinois victims of violent crime did not seek or receive support services because they did not know how or where to get them or assumed they did not qualify (see *Figure 1*).

Figure 1. Violent Crime Victims' Reasons for Not Seeking or Receiving Services.



Additionally, 56 percent of all individuals surveyed, including victims and non-victims, indicated they would not know where to access services if they or a family member were to become a victim of violent crime. Providers who participated in focus groups also recognized this need. A provider serving primarily older adult or disabled victims in the southern counties of the state highlighted the importance of: "public and professional awareness campaigns. Most **people don't know that my services exist**" (FG5). Providers discussed wanting to make their services more visible and known to the public through campaigns and trainings with professionals who interact with victims of crime. Providers discussed how these activities are limited by funding restrictions and time constraints.

Organizational Barrier: Awareness

Providers also discussed the need for service provider trainings to increase their knowledge of victimization and available services.

Formal service provider education about victimization. Formal service providers, such as hospital staff and law enforcement officials, are one group of individuals that may identify victims of crime and link them to services. The focus groups identified the need for greater education and training for formal service providers, particularly for first responders. One Collar county domestic violence service provider emphasized the need for training to better identify victims, specifically victims of human trafficking:

> "What's needed, I think even before we can even figure out how to respond, is we **need to train our first responders** on how to **identify** [victimization] and then start to eliminate a lot of the myths around it, especially some of the myths around

> trafficking. I think until people are trained up, the mentality is still it's all about prostitution and johns and there's no concept of what this trafficking issue really is beyond the street level." (FG3)

Training and support for first responders were emphasized by focus group participants, as these responders can connect victims to further support, and their positive or negative responses may impact future help-seeking. One Cook County provider discussed how more training is needed to increase informed, trauma-sensitive responses:

> "We really struggle with some [responders] who are investigating **understanding a crime has taken place**. If they don't recognize it as a crime, [providers] don't get access…I really think there is a disconnect in [responders] **understanding and recognizing trauma** and what constitutes a crime. I mean specifically, child abuse. [Child victims] are not lying about certain things." (FG7)

Responder awareness of services. Participants said first responders such as health care professionals and law enforcement officers need education and training on existing services, resources, and laws to assist victims. First responders are in a unique position to connect victims to resources and services because they interact with a large number of individuals during critical engagement points (i.e., points when help seeking is actively occurring for many victims). Within their role, these formal service providers have the ability to provide information to help them connect to service providers. Personal relationships between victim service agencies and other formals responders facilitated through trainings or networking opportunities were perceived as improving formal system responses and increasing the knowledge of services among individual responders. While relationships were seen as ideal in fostering information exchanges between providers and systems, at minimum, providers felt said if they were able to give a brief presentation and get a card in the hand of a first responder perhaps "[responders would] at least remember our names, and they have our card, so they might pass [it] on to a victim" (FG5).

Also, first responders often are unaware of legislation designed to assist victims. One Collar county provider said medical practitioners are unaware of an amendment to the Illinois Sexual Assault Treatment Act related to hospital billing procedures for victims of sexual assault. Practitioners need training on proper implementation:

> [The law is] supposed to have some reimbursement [for medical services], unfortunately, the need for education among hospitals, clinical staff, even law enforcement [is needed because] **a lot of people do not know anything about it** when the victim asks for a voucher, or handed out a voucher, it is just not informed in the community yet. (FG3)

Another provider discussed how orders of protection may not meet the needs of victims because a lack of knowledge about orders of protection and high turnover of previously trained criminal justice practitioners, particularly judges, contribute to a knowledge gap:

> "The other piece to the order of protections is that you've got a lot of judges that really **don't understand the intent of what those orders are for**. And so it seems that I am seeing in [names of locations] the judges…may be on the bench a year or two but when they start to understanding the purpose and what the need of the orders are, [they] get rotate outta that court, so then we started all over again." (FG1)

Without knowledge of the reliefs available, services tailored to assist victims are not utilized to their fullest extent.

Strategies: Awareness

Providers cited awareness campaigns and collaboration as key strategies to increase knowledge of services. Campaigns that target the general public, carried out by victim service agencies or by organizations focused on awareness raising around specific victim groups were seen as one way to increase awareness of services. These campaigns might increase knowledge of available services and facilitate connections between victims and providers. Beyond these campaigns, providers discussed participating in local and state committees and councils to spread knowledge of available services and to develop stronger networks. At these councils, first responders, victim service providers, and other key stakeholders can inform and train one another about victim service delivery to coordinate better services for victims. A provider in the central region said she and her staff join councils as a way to learn about other resources:

> "I usually encourage our volunteers, and have done it myself, to research any and all community resources or any potential resources we could utilize for a child or a family. I have made a point to become involved in **different human service councils,** things like that **so I know who is doing what**, even if there's a [name of provider] that does rides." (FG4)

By participating in these group meetings, providers are able to share the services they offer to victims and assist with training efforts as agencies equip one another to improve services provision.

Direct Service Barrier: Access

While victims may be aware of and seek services, some are unable to access them. ICJIA's report on victim needs discusses these accompanying needs, or those needs that facilitate help seeking, in great detail. Accompanying needs are those that, when unmet, inhibit access to support services, such as transportation assistance, translation services, and child care support. Victim service providers note that meeting these accompanying needs assist victims in accessing or staying engaged in services (Aeffect, Inc., 2017; Vasquez & Houston-Kolnik, 2017). For a full understanding of these needs, refer to the Victim Need Report available here. This report focused on other issues of accessibility and help-seeking, namely stigma and fear experienced by victims.

Stigma and fear. Survey findings indicated stigma and fear impact victim help-seeking and service access. Aeffect (2017) found that victims of violent crime did not seek services because they were not sure if services would be sensitive to their religious beliefs (16 percent) or their disability (13 percent), or if they would be available in their primary language (13 percent). This may be particularly salient for certain victims of crime such as second language learners, individuals with disability, or those residing in rural communities. The stigma associated with mental health care services or substance treatment and lack of privacy in some communities also deters victims from accessing services. In rural areas or smaller population groups, concerns about service accessibility and confidentiality, was seen as a service barrier, particularly for elderly adults living in such communities:

> "Certainly for the elderly population there is no in–home treatment available for mental illness and substance abuse. And they're often **very reluctant** to go to an agency due to **stigma issues** or whatever… many people don't seek treatment because of the **fear** in these rural areas, neighbors seeing them going to a mental treatment facility or substance abuse treatment." (FG5)

In smaller communities, providers also highlighted how the tightknit nature of these communities can be both positive and negative. In some areas, a small community may isolate victims, perhaps through victim-blaming or shaming responses. While in other areas, a tight knit community may assist service providers in meeting victims' needs through close relationships among providers that facilitate service access for victims. One provider from the Central region summarizes this concept how relationships can facilitate service coordination:

> "I think some of these folks are, if they're living in one of the small towns or really remote, and how that **location really impacts the availability of services**, getting help, feeling safe. I think while small communities can be **very small knit** and really rally around someone they can also do the opposite very, very well, and **isolate."** (FG4)

Immigration status also contributes to whether a victim accesses services. For undocumented victims, the fear of deportation may negatively impact disclosure, specifically reporting to police: "I think immigration status **prevents people from seeking services**…and part of that is being concerned about how Law Enforcement will respond to them." (FG2). The unknown of how victims who are undocumented will be received and served may inhibit them from accessing victim services.

Organizational Barriers: Access

Providers also discussed how their organizational structure or practices may impact access to services, particularly high barrier requirements and the use of wait lists to prioritize victims in crisis.

High barrier requirements. Accessing services may be particularly difficult given certain programmatic requirements or eligibility criteria. Providers reported income levels create a barrier to obtaining legal aid. Many legal aid agencies impose income restrictions to serve victims who fall below the poverty line. However, a gap still remains between those below the poverty line and those that can afford private legal counsel:

> "We see that **financial gap** too and I mean the people that they **don't qualify** for low-income services but they don't make enough to pay full price. So we have a large number in that **middle gap** that just **don't get services**." (FG6)

While these restrictions are intended to ensure services are available to those most in need, domestic violence providers noted that these requirements may particularly impact victims whose abusers control access to financial resources:

> "If you are trying to get **low cost or pro bono services** and you are a victim of domestic violence and they are looking at your **marital assets** and you don't know what bank your money is in, your name isn't on [anything], so you have access to nothing but…your income is being looked at as though you are somehow sharing 50/50 in the marital asset." (FG3)

As a consequence, victims who do not fall below the poverty line but are unable to afford legal services are forced to represent themselves in their legal cases. Without legal counseling, victims are less successful in obtaining legal protections, they encounter additional biases, and experience longer delays due to their lack of representation (Adams, 2005; Durfee, 2009).

Providers also discussed eligibility for services tied to demographic characteristics, reporting **gender, immigration status, and age** can be a barrier depending on what the service is." (FG7). Eligibility criteria was most frequently discussed in relation to shelter and housing:

> "I've seen it can only be men, but it has to be eighteen above. Or it can be a women's shelter, but they can only have so many kids. If it's a male child age above 12, he can't be there. I mean, it is like, **where would you like them to go?** It's make no sense to me sometimes, a lot of times." (FG1)

Another provider from the Collar counties noted transitional housing often is inaccessible to people who are undocumented: "And then there is an additional layer of challenge for our battered immigrant victims, because a lot of [transitional housing locations] won't accept them based on their **undocumented status,**" (FG3). These criteria were seen as burdensome by many providers who said they seemed arbitrary or subjective. For victims who are marginalized, providers described the current systems and requirements as particularly high barrier and as inhibiting their access to needed services.

Waiting lists. Providers discussed waiting lists as a strategy they use to prioritize the immediate needs of clients, but noted that it creates a barrier to addressing long-term needs of service seeking victims. Despite being at full capacity for the work they are budgeted to do,

multiple providers discussed how they have to utilize waiting lists in order to prioritize immediate support for victims in crisis. Victims in crisis need to be seen immediately and victims with longer-term needs may be overlooked as the immediate needs of victims may be prioritized by staff due to low agency capacity:

> "Our **numbers are high** and **our capacity stays the same** and we continue to have a waitlist for people…as crisis [clients] come in those **people on the waitlist are just staying there** and crisis clients need to be seen right away. It is difficult and we don't flex our staffing to reflect on that. We are following the budget. We are fully staffed right now, but **we've got a waitlist of about 90 clients**, both children and adults, for counseling services." (FG3)

Prioritizing immediate intervention is a strategic decision to serve victims in crisis, but providers expressed uneasiness with this decision. One provider noted the lack of follow-up beyond the immediate need for services is inconsistent with the message providers wish to send about the importance of long-term healing and services:

> "Sometimes it's not consistent with our message, all this trauma has happened, this crisis intervention, and **we can't provide services for a couple of months** because the waiting list is so long." (FG7)

Strategies: Access

External barriers, such as lack of funding, cultural myths or beliefs, and referral agency requirements, make strategizing to address issues of access difficult. Providers focused on strategies that could increase the availability and accessibility of services through gas cards or satellite offices.

Providers discussed creative fundraising strategies to fill gaps in their services, such as asking for donations in the form of gas cards or giving club presentations for cash donations. Other strategies discussed frequently were opening satellite offices and offering services where victims are located, such as at their homes, in the courthouse, or in the police station.

The desire to place offices in communities was expressed by multiple providers and was seen as a strategy to reduce the burden of service-seeking for victims. By taking up a presence in a community satellite office, providers not only reduced travel times, but they also made themselves available to victims who may not otherwise have sought services. Providers said their presence through satellite offices in the community encouraged victims to seek services:

> "As soon as we go put ourselves in the community, we hang a shingle and put a sign up and let people know we are there then they will go: Oh, yes we need that service. In order to really effectively reach our entire service community **we have to be able to get out in the community**. It is unfair to expect clients to drive or take the bus or whatever it is for hours or 30 or 45 minutes to get to us." (FG3)

Beyond satellite offices, providing support and services to victims where they are located at was another key theme. Providers said by offering in-home services or putting advocates in more places, specifically within the criminal justice system, access points and service connections are increased. Some discussed placing victim advocates in police departments to connect victims to services and to increase a victim-centered response within the criminal justice system: "What a great idea to have that kind of service in a police department…but it's a way to really get at the **initial access point and making a connection**…" (FG5).

In another focus group in the Central region, participants also talked about the importance of advocates and how they can support agencies in outreach efforts through being placed in more locations, interfacing with both potential victims and responders. One provider stated that more advocates equip "programs to be able to do more outreach and get out into the communities. Which means more [advocates], you don't need more space but you need more [advocates]…to go to where people are at and learn to network more with others" (FG6). This strategy was seen to benefit both victims and other formal service providers as relationships are fostered and care could be better coordinated and access burdens eased through stronger networks and connections.

Direct Service Barriers: Delivery

Providers also discussed barriers to their ability to respond to victim needs. Direct service barriers to delivery highlight ways that services may not serve victims comprehensively, despite a desire to provide holistic care. These barriers include fragmented systems due to funding constraints, rural barriers to offering specialized services and reporting requirements that take away time from direct services.

Fragmented systems. While service providers have a desire to provide integrated, wrap-around services, they cited a fragmented system that prohibits them from doing so. First, the way funding is structured often limits services providers are able to offer. Funding guidelines require providers to place individuals into distinct categories based on victimization type that may not address the complexity of victims' experiences or needs. One provider whose agency serves both sexual assault and domestic violence victims said it was problematic to have to label a victim with a specific crime type to determine who could serve them:

> "One of the things that's hard for us is, so we do both issues, but strangely enough, we are like **two silos because of our funding**. If somebody walks in the door we have to put a label on them and go, 'Oh, [sexual assault victim], you go to the left, [domestic violence victim], you go to the right.' We can't even integrate our own services in a way that really meets the needs of our clients because the funding is so **strict**. So many **restrictions** on staff, like if they work in domestic violence they can't work in sexual assault." (FG3)

The need to label clients or only serve one crime victim type poses a barrier to providers who see

clients with multiple types of victimization. Seventy-seven percent of Illinois providers surveyed in 2016 reported the victims that they served always or very often have experienced multiple forms of victimization (*Figure 2*).

Figure 2. Multiple Forms of Victimization.

Aeffect's (2017) report showed that 57 percent of victims, regardless of whether the crime was violent (e.g., physical assault, homicide, sexual assault) or non-violent (e.g., identity theft), had experienced more than one type of crime. However, when narrowed to just victims of violent crime, the number increased to 72 percent, meaning victims of violent crime experienced a higher percentage of multiple victimizations.

While providers recognized the importance of specializing in services for particular crime types, they also discussed how, at times, it limited qualified providers from serving victims:

> "Sometimes we feel like we really have to **stay right in your lane** and don't touch anything that is not in your lane but **refer out**, but here we are back to that **fragmented system of services**. Like we could help you, we have the skill set and the knowledge to help you internally, but we are not allowed to so we are going to send you over there to get that service." (FG3)

Another provider said due to fragmented systems, victims with multiple victimizations, along with their children who may have witnessed violence, need to be referred to multiple service providers to address both the adult and child victimization experiences. This fragmentation was linked to victim disengagement as providers said those barriers kept victims from engaging in services that address all of their needs.

Rural barriers to specialization. For rural providers, long travel times and fewer referral agencies have been compounded by a lack of specialized services, such as trauma-focused counseling or specialized forensic medical exams for victims of child sexual abuse. The Central and Southern regions of the state have multiple counties and areas with higher crime rates.

Providers from rural areas emphasized that, while they see a wide array of victims, there is not enough time or a sufficient population to specialize in a given approach to service delivery:

> "They are dealing with elder abuse cases, they are dealing with clients with mental health illness or physical disabilities…male victims…gay, lesbian, transgender…I mean, we are dealing with whole gambit. **There is no time to specialize**. There is not necessarily a sufficient population specialize." (FG2)

This lack of specialization impacts the types of services that agencies are able to provide victims, particularly those from traditionally underserved groups. Without specialized services, some victims may not feel safe or comfortable accessing services, further isolating rural victims from systems of support and care.

In addition, certain specialized services are difficult for service providers to access for victims, specifically for child abuse victims needing specialized exams conducted in a timely manner due to evidence collection standards. However, given the lack of providers who are able to provide these services, particularly in the Southern counties of the state, providers have leveraged other out-of-state providers who may or may not accept the child's insurance:

> "Access in the southern part of the state for specialized medical exams is becoming a problem for us. We have the [name of children's resource network] but it serves 43 counties and that's just a little much for one agency. So some of us like [name of southern county] area will transport to St. Louis, which is becoming a little bit of a problem now because the medical card won't pay for it now. So the **specialized medical exam is key for us**, for the child abuse investigation and if they can't access it, it's going to become a problem." (FG5)

These specialized services provide the highest level of care and evidence collection for children, and with limited access to them, victims can be asked to travel long distances or receive care from a provider who has less expertise or training.

Data collection and reporting requirements. While providers recognized the importance of reporting requirements and data collection, they also discussed how these activities take time away from serving clients and burden agency staff who are extending beyond their current capacity. One provider from the Collar counties talked about how reporting requirements are increasing and the resulting impacts on their agency's service delivery:

> "And the **expectations of funders continue to increase**, I mean the expectations of the kinds of assessments you are doing, the kinds of outcome you are doing, the kinds of reporting you are doing…they should want quality services, they should want some proof that we are doing what we say we are doing. But...the people who are doing all those assessments, doing all those outcomes, doing all the surveys, doing all the tracking, providing all the reporting are all the same people that are doing the services. Everybody is stretched way too thin, and all of the things you are adding on top just **siphon energy away** from the service that

we're there to provide to people in crisis." (FG3)

Providers expressed frustration with multiple mandated requirements on reporting and data collection. With evidence-informed, outcome-driven programs being emphasized by funders, agencies acknowledge the importance of activities that track and document their process. However, the pressure to adopt evidence-informed practices or engage in evaluation has not been coupled with the necessary funding and staff support for agencies to fully engage in these activities. Two providers from Cook County discussed their concerns with program evaluation and reporting:

> P2: "Sure we can throw some data in an excel spreadsheet and run some averages, but it takes a lot of **education and time and resources to do a proper evaluation.**"
>
> P6: "I think we're actually over-evaluated, too, sometimes, because we have so many different funders with so **many different requirements** and it would be really helpful if they could talk to each other. I know that's been talked about quite a bit, that foundation funders are going to get together and the government funders are going to get together and come up with uniform outcome measures and evaluation tools. We've heard that for a long time and it's not happening and it really puts a burden on our staff and our agencies." (FG7)

Overall, agencies need greater support to engage in these activities and expressed a desire for funders to streamline requirements.

Organizational Barriers: Delivery

Organizational barriers to service delivery also were discussed. Providers shared ways in which internal capacity, high turnover, need for trauma-informed services, and diminished referral sources impact victim service delivery within their organizations.

***Demand vs. capacity*.** In the survey, providers were asked about how capacity has changed in the past year (2015-2016). Capacity refers to the agencies' ability to provide services that meet the needs of their clients, taking into consideration organizational factors such as whether or not the agency is fully staffed or adequately funded. Capacity also includes knowledge or training of staff as providers may be aware of needed services, but do not possess the needed training to meet that need. Thirty nine percent of providers stated that their capacity decreased from 2015 to 2016 and 27 percent stated their capacity did not change (*Figure 3*).

39 percent of providers experienced a decrease in their capacity in the past year.

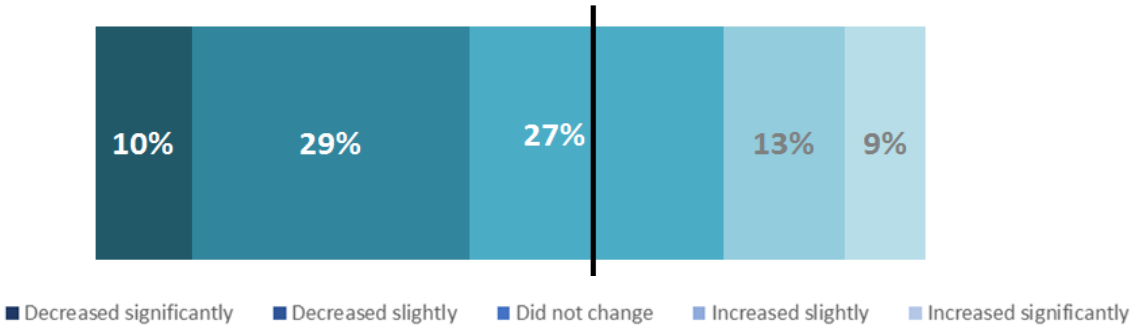


Figure 3. Provider reported decrease in capacity in the past year.

In focus groups, providers said while capacity remains stable or decreases, an increasing demand for assistance is impacting their ability to provide comprehensive services for all victims. One Cook County provider noted that for many agencies, a growing waiting list and limited capacity likely means they are unable to add any more clients to waiting lists.

> "You just have to **shut the door** in the sense that you can't let them come in there and wait forever and get frustrated, say not available at this time. And that's bad cause you told them you're gonna be there or you have something to offer that they need." (FG7)

Legal service providers in particular noted their resources are thin and complex cases take up much of their limited time:

> "For us, a lot of it is just **sheer demand versus capacity**. There is one of our attorneys working full time, handling most of the domestic violence work in six counties area…and you get into one contested custody case involving a child who's been sexually abused and that's most of the time. So I mean, just resources, **resources are an issue**, generally just **not having enough staff** to respond." (FG2)

Indeed, other victim service providers noted that many legal providers are not taking cases related to family law because of their complexity. The limited capacity of referral agencies who provide specialized services make it difficult for an advocate to facilitate access to meet a victim's needs.

High turnover and burnout. In the field of victim services, high turnover and burnout is a common problem (Middleton & Potter, 2015; Ullman & Townsend, 2007).

Turnover can negatively impact victim healing and the therapeutic process. Providers

linked capacity and turnover with the quality and level of care they are able to provide clients and to how families engage in services.

> "There is such **turnover** in the field and it's really **difficult to deal with**. Because …I mentioned before having consistency with the family, a lot of service providers- it's hard enough to find somebody with the credentials and experience that you actually think does a good job, and then the turnover is such that **you never have consistency**. I don't know if that's also a capacity issue where we aren't paying people enough to stay in their jobs and provide services, or where everyone is going exactly." (FG5)

Turnover and burnout impacts the consistency of services delivered to victims. A result of limited capacity and staff turnover, some providers said the lack of staff consistency contributed to victim disengagement. For instance, providers in the Southern region discussed how high turnover among counselors impacts victims:

> P1: "Yeah I mean if [a victim] starts with a counselor and then they have turnover once, which is very likely. In our area, the **turnover [with their counselor] is likely to be three-four."**
>
> P2: "That's ridiculous. Like you can't make progress therapeutically with four therapists. There are a whole lot of families who walk out the door that never want to talk to anyone ever again. I think that those **people could be engaged if we had the right services** in place at our center to engage them while they are there and then continue on with them after, some consistency." (FG5)

When discussing turnover and burnout, a lack of quality pay and inflexible staffing plans due to budget restrictions were noted as problematic for staff retention. Providers continually cited difficulty in retaining staff due to high expectations and low pay.

> "[Inadequate pay] is huge and the turnover just keep hurting us. They get great experience with us and they are here for a year and they move on, and there are ones that are burned out from being with us…It takes a great talent to be able to maintain the work and to take the organization to where we want to go but if you can't pay them **a living wage with good benefits..**.We have a huge competition with the county [for staff]…We have that as a huge barrier to us, the county pays well, has good benefits. We don't." (FG3)

Turnover hurts organizations in the number of clients they can serve and the quality of care they can provide and strains organizational capacity through a continual need to spend time recruiting, onboarding, and training new staff. Ultimately, providers linked turnover to the sensitive nature of the work combined with a lack of compensation.

Trauma-informed services. As providers discussed services for victims, many highlighted the need for trauma-informed programs they could refer victims to in order to

provide comprehensive care. Traditional models of care that serve the general population may not be appropriate for victims given their traumatic histories. One provider in Central Illinois who provides counseling for sexual assault victims emphasized the importance of trauma-informed substance use treatment:

> "[Addiction recovery support programs] are a big need and sometimes the kind of addiction recovery support that is available may not be entirely compatible with the needs of a sexual assault victim. If it is a **morality-based program, 12-step program**, that is focusing on things like character defects and what have you done wrong, I'll be honest, I spend time in counseling undoing the damage that's being done by those addiction recovery programs because they're really **not appropriate sometimes for victims**." (FG6)

By not incorporating this lens for victims, such messages may encourage or reinforce victim-blaming responses. Such services should be provided with victimization in mind and tailored to account for trauma histories, rather than encourage a narrative that inadvertently harms victims.

The criminal justice system was consistently mentioned as one in need of better service delivery because of a lack of communication with victims and engagement in practices that re-traumatize victims. Examples included prosecutors moving forward with plea deals when it was against the wishes of the victim, judges who were hostile to victims, and procedures that dragged out cases and delayed healing for victims. One provider relayed that a victim's statement in a civil order of protection may be used against them in further proceedings to discredit them:

> "Well, the problem with that is if [the DNA swab taken by police] takes six months, eight months, nine months down the road, you will have this offender walking around and so now what comes into play: do we get an order of protection or civil no contact order? If the order protection comes first, **anything in the document** at the time of trial **can be used to impeach that victim**. So if everything doesn't match exactly in that document they will impeach her, the victims. And so it's a wonderful tool when it is used as it's intended to. But it also has that **double-edge sword** where it gets used against them." (FG1)

This participant noted that the lack of knowledge among judges about the intent of the orders further adds to the complexity of the issue for victims. As a whole, providers felt information about the criminal justice system available to victims and criminal justice practitioners' knowledge and awareness of trauma of were both lacking.

Diminished referrals. As barriers to delivery were discussed, the lack of referral agencies arose as a consistent theme. The referral networks of providers in Illinois have dwindled due to lack of capacity or closed doors. As various agencies have experienced cutbacks, the impact is felt by the broader network of victim services:

> "Cutbacks impact everybody else. That's what we see in the medical field and

> you wanna refer out to counseling, now the waiting list is six months. Well that's not great for the family or the child or anybody. Whole programs closed and so all the referrals that you could have made in the past, it's really difficult to find timely, effective, trauma-informed, all the things you want for your clients is almost impossible now." (FG6)

In trying to meet the needs of victims comprehensively, providers lamented the current landscape of their referral networks and the funding climate that has contributed to agency closures. While providers are doing their best to meet victims' needs, the interplay of various barriers to delivery amidst inconsistent funding has made meeting victims' complex needs in a timely manner all the more challenging.

Strategies: Delivery

Providers identified particular strategies they used to address service delivery issues. These strategies included triaging their responses, collaborating with other service providers, leveraging non-traditional resources, such as health clinics, and accessing national and local networks to expand their knowledge and access expertise.

To address limited capacity and high demand, providers discussed triaging their response to victims by prioritizing victims in immediate need. For example, a provider in the Collar counties discussed how her agency realized that trying to provide longer term services was at the expense of victims with immediate needs; thus, they restructured their model to focus on victim in crisis:

> "We are really **focusing on that front line crisis emergency services** and we were at a place where trying to provide some of longer term services was at the expense of the people in crisis. But that doesn't change the fact that many of them have really complex trauma, childhood abuse issues, and sexual assault issues, and that really they need longer term supports than we can't provide and it's really hard to find them in the community." (FG3)

This triage response was seen as a way to leverage limited resources well and to serve those victims most in need of services. However, providers also acknowledged that this left a gap where services that addressed long-term needs or complex trauma were not available in their communities.

In addition to triaging, collaboration was noted as a key strategy to fill service gaps and improve service delivery. Through networks, collaborations, and partnerships, agencies are coming together to respond to and meet victim needs. Whether these groups are focused on training or on creating policies to coordinate, providers discussed the positive influence these types of relationships can have on their ability to serve victims. For instance, one provider from the Collar counties discussed how they are collaborating to create seamless service delivery for domestic violence victims:

> "We have formed a partnership that is called [partnership name] in response to this very specific issues that you brought up, to **try to create systems changes** within our county. There are about 32 organizations and individuals who have joined to work on domestic violence. The three priorities are service coordination, awareness and advocacy. And under the **service coordination** we are trying to find a way we can work among ourselves in a way that it can be **seamless."** (FG3)

Through leveraging each other's resources and coordinating services, providers are strategizing to meet victims' needs effectively and efficiently. Partnerships between providers and coordinated responses to victims may be particularly important to improve overall response to crime victims.

Leveraging non-traditional resources and relationships was another strategy providers used to improve victim services. From creative fundraising strategies, such as going to wine clubs or churches to raise funds to referring to clinics that offer low-income health services, providers found innovative ways to meet victims' needs. One example of leveraging non-traditional resources was shared by a provider in Cook County. The provider partners with a large utility company to provide well-paying jobs for victims of domestic violence:

> "We have a program that we work for **non-traditional jobs** that pay much higher for women, so [Name of utility company] is one of those program. They will get [trained and] after they graduate and they are in working for the company, they can start at $45 an hour. We have taken on two or three other companies that will start this process that will help women grow. We want to make sure that they are **not just surviving**, but have the **opportunity** to live a life that provide all their needs and wants at that point." (FG1)

Through this partnership and other partnerships in the community, providers are able to address both immediate and longer-term victim needs. These collaborative relationships make resources and services available that victim service agencies either do not have the funds or the capacity to provide. Through leveraging non-traditional resources and relationships, providers are able to fill key gaps in victim services.

Rural networks were noted as a key way to access specialized knowledge and resources. As noted earlier, some agencies are not able to specialize in providing specific services, such as specialized medical exams, or culturally-specific services as there are not numbers to justify or maintain that specialization. For instance, in the Northern counties, one provider said, "When you get outside Chicago, there are not the populations that you can have…[this] organization that only deals with hearing impaired victims, [another that] only deal with Muslim victims, we have to **respond to whatever comes up,"** (FG2). Networks were one way that providers accessed specialization and training to better serve all victims of crime. Both national and local networks were seen as particularly useful, as webinars and trainings allowed these providers to tap into knowledge and expertise nationally and from around the state.

Future and Expansion

Researchers asked providers how they might expand their work to better meet victims' needs. The main themes that arose were restoring capacity, expanding capacity and options, and adopting new programs or strategies.

Restore. When asked about the future, multiple providers emphasized a need to restore agency capacity. In light of budget cuts and layoffs, providers expressed a desire to re-build capacity: "...so you're question asks about expanding and my thought is **restore where we were two years ago**" (FG7). For many providers, being fully staffed was seen as a future focus area as one provider from the Collar counties emphasized:

> "You are talking the staff: trained people, paying competitive wages and competitive benefits to everyone and really being fully staffed. When the economy hit us in 2006 we made substantial layoffs. Here, we have a shelter with 35 beds and I only have one staff during the day or at night covering it, I mean **we're down to the bones here**." (FG3)

Agencies expressed how they would like to rebuild capacity to respond to victims' needs holistically. Perhaps linked to turnover, providers continually emphasized that the future of their work needed to incorporate competitive salaries and a deeper investment in staff to retain employees and provide service continuity. Restoring this capacity and investing in their staff were areas of future work crucial for agency expansion.

In addition to restoring capacity, providers talked about a need to restore prevention efforts that have either been cut from funding or had to be reduced in light of limited staff hours. Prevention was identified as a need across the state and providers discussed how limited funds have been allocated to such activities. The importance of prevention work was regularly discussed and linked with reducing the number of victims:

> "I would love to see us be able to **put money toward reducing victims**, which means prevention [affirmative sounds]. And nobody wants to pay for prevention. It takes too long, you can't do it on a budget year, you know, but that's really where we need to go. We really need to go there, which means educating the systems [affirmative sounds]. First and foremost, prevention is educating the systems to understand what people are dealing with." (FG6)

Education across systems, in schools, and of the general public were prevention strategies that providers discussed a need to restore or expand. Funding was noted as a key challenge.

Expand. Providers noted ways they wanted to expand their service delivery. This included adding prevention education, providing services after hours, and providing more service options within the agency. In particular, there was a desire to provide more services, such as counseling, mental health, and legal services, at more accessible times, including after school or on weekends: "I think we would have an **onsite counselor,** even if it was for **after hours** where the kids could come to that and we would be able to finance" (FG5). By doing so, providers would be able to meet victims' needs at times that were convenient. Other providers expressed a desire to contract services to access others' expertise:

> "I would want to **expand our mental health services** to have more providers. We don't want to provide it ourselves, I prefer to contract out to those that are experts in that. But I would like to have funding to have a contract to purchase those services or something like that so I can help support another agency in the field who is an expert to do that." (FG5)

Providers discussed how they would expand services with more funding and emphasized strategies that would better link victims to services and reduce barriers. They expressed a desire to expand current services by increasing access or by providing services where victims are located, whether that be in a law enforcement agency or in a victim's home. Providers desired to connect to existing systems and specialists to better address the complexity of trauma and victimization.

Adopt. Beyond restoring and expansion, providers brainstormed future strategies they would like to adopt to better meet victim needs. Providers discussed filling key gaps in their communities, such as providing advocacy to victims in university communities. Others discussed taking on new programs that would better meet the whole spectrum of victims' needs, such as employment and training services. One provider linked these services to the long-term well-being of victims: "I would love to have an employment and training department…because **employment and training is the key for self-sufficiency**" (FG3). These types of expansions focused on new programs that would extend beyond traditional service delivery.

Another expansion identified by providers was the utilization of mobile services and of technology to increase options for victims. To better serve rural areas, providers discussed utilizing mobile units to provide specialized medical care:

> "I think all of the [child abuse agencies] down south of Mt Vernon would like to have a **mobile medical unit** that would go from [provider to provider] and provide these medical exams on site." (FG4)

Other providers throughout the state discussed how greater flexibility to send their staff out to meet victims at home or to utilize technology to provide specialized services were worth exploration. One provider who serves victims of elder abuse noted this strategy was an idea their agency had discussed:

> "We've talked about having, possibly, our own in-home service providers to do

> **in-home advocacy and case management**… In-home counseling would be amazing [affirming sounds in the room] I don't think anyone provides that anymore." (FG4)

Mobile advocacy and services may increase access for victims and reduce strain on providers who struggle to meet the needs of victims requiring specialized services. Using innovative technologies and strategies that bring services to victims also was discussed across focus groups; agencies emphasized wanting to reduce the burden on victims:

> "It...just takes people a long time to realize that they need [services], what kind of services they need, and that they exist and then where do you go to get them. **We don't really want to make people do all the work to come find us anymore**." (FG3)

Section 4: Summary and Implications for Policy and Practice

Summary

Victim service providers representing different regions of the state discussed their capacity to provide services that respond to victims' needs. Victim service providers discussed the importance of being able to serve victims holistically and encountering barriers in resources, service availability, and capacity. Agencies discussed how their capacity and the barriers they experience impact the awareness, accessibility, and delivery of victim services as well as their abilities to expand services.

Identification as a victim and awareness of victim services were identified as barriers to service delivery. For victims of a crime, public awareness campaigns that address what victimization is and provide information about resources are particularly important. Research has shown that many victims do not seek services because they either do not know what services are available or where to access them (Aeffect, Inc., 2017; Logan, Stevenson, Evans, & Leukefeld, 2004). Training of first responders to recognize the signs and symptoms of trauma is important in connecting victims to services. Victims may respond to trauma in a variety of ways, and stereotypes about how individuals respond may shape whether or not both informal and formal support providers recognize trauma and provide referrals to services.

However, providers also suggested awareness efforts need to extend beyond the general public, targeting groups that may play a more prominent role in connecting victims to services, as the responses of support providers have been shown to impact access to services and victim healing (Campbell et al., 2001). Educating the community and formal service providers about victimization can help to reduce negative responses to victims. Negative responses that blame victims, minimize their experiences, or stigmatize victims have been shown to decrease the likelihood of future reporting and help seeking (Liang et al., 2005). Negative interactions with providers and an inability to access services may contribute to additional stress and trauma, or secondary victimization, which is related to negative mental health outcomes, including more PTSD symptomatology (Campbell, 2008). Secondary trauma can further exacerbate the impact of the victimization of an individual's emotional well-being. Training providers and community members to respond to disclosures and help-seeking in victim-centered, trauma informed ways can create an environment of support and safety for victims that may otherwise not exist in the community.

While providers saw raising awareness as a priority, in an effort to improve victim identification and first responder education, they emphasized the need to first restore and rebuild capacity within their agencies and in social services around the state to meet victims' needs holistically. Without more staff, flexible funding, and consistent referral networks, agencies are struggling to provide quality services and reliable referrals to victims. Research has found that greater organizational capacity, such as increased budget size and staffing levels, impacts how successfully service providers are able to address the needs of their community (Donaldson, 2007). Furthermore, with referral networks having dwindled and long waiting lists, providers are finding it difficult to coordinate with other providers in the area to access services, such as

therapy or legal assistance, that address complex needs. Coordination is a key strategy that agencies use to fill service gaps and increase victim access to services, but when funding, capacity, and available services are limited across partner agencies, this strategy is less effective (Johnson, McGrath, Miller, 2014; Payne, 2007). On top of this, funders require data reporting that can burden agencies; data entry tasks may take staff time away from direct services. Providers discussed how these practices impact service quality and also victim engagement in services, especially when services are inconsistent due to insufficient staffing or there are long waiting lists for services.

Funding practices and restrictions limited the types of services that agencies were able to provide and, as a result, who they were able to serve. In particular, providers discussed how fragmented and restricted funding makes it challenging for service providers to address victimization holistically, specifically for victims with multiple types of victimization. Aeffect, Inc.'s (2017) report showed that 57 percent of all crime victims had experienced more than one type of crime. However, when narrowed to just victims of violent crime, the number increases to 72 percent. These findings, along with the themes from the focus groups, suggests the need for providers to be supported, both through trainings and funding, to address multiple victimization experiences and to treat complex trauma that likely follows experiences, especially violent victimization.

Despite barriers to service access and provision, providers were resilient and strategized around how to use limited resources to reach the most victims possible. Providers found collaboration to be a good approach to addressing awareness and delivery issues. To mitigate barriers to access, providers tried to integrate themselves in the community through satellite offices and other community locations. In addition, having a presence in the community may help the community to be more knowledgeable about victimization and decrease victimization-related stigma within communities, specifically in more rural communities (Logan et al., 2004). Placing more advocates in more places was a strategy seen to benefit both victims and other formal support providers because care could be better coordinated and barriers to access mitigated. Both agencies and funders should consider how they might support strategies that equip advocates and providers to deliver services in traditional and non-traditional settings, such as victim service agencies, court services, law enforcement entities, or hospitals. Nonetheless, providers had to make the difficult decision to triage, thereby prioritizing victims they accepted to receive immediate services to those primarily in crisis, limiting their ability to provide longer term services.

Victim service providers expressed hope for the future of victims services, that agency capacity would be restored, allowing them to expand their services to reach even more victims and to provide additional services. Here providers spoke consistently about the importance of prevention work and how more flexible funding would enable them to resume past prevention work or to expand the scope of their work to include prevention. They also had a strong desire to seek out new settings, including law enforcement entities that might be appropriate for victim services. They also discussed incorporating the use of new strategies, like mobile services, into their program design to reach victims with a limited capacity to actively seek or access services, such as older victims with limited mobility or victims in rural areas.

Implications for Policy and Practice

Prioritize funding to restore services and rebuild agency capacity. Providers emphasized the need for funding to restore services both within and outside their agencies. Due to a reduction in their internal capacity and in the capacity or existence of their referral sources, providers emphasized a need for funding to prioritize core needs for both victims and providers over innovative practices and programs. While agencies desired to be innovative, providers emphasized the importance of a strong foundation and network in order to expand to new areas and use innovative practices.

Address barriers to service utilization by incorporating supportive services into victim service programming design. Victims' needs are multifaceted and intertwined. Wraparound services and support for services that facilitate access to a variety of services are needed. The availability of supportive services, such as child care and transportation assistance, reduce barriers that may prevent or discourage victims from accessing or staying engaged in services. Therefore, victim service providers should strive to incorporate these supportive services into all victim service programming and funders should encourage providers to address these elements in their program design.

Prioritize the integration of trauma-informed care at all points of victim contact. Direct services providers, as well as government entities, such as law enforcement, should make a commitment to incorporate trauma-informed practices in their everyday interactions with victims and funders should support these efforts. Providers and agencies can build internal capacity to engage in these practices by inventorying their use of trauma-informed practices and by setting a realistic goal for improvement. The integration of these practices can help to minimize the risk of re-traumatization that can occur when a victim receives a negative response (e.g., being blamed, treated like a child) upon reaching out for help. This approach also may increase the likelihood that a victim will engage in service seeking in the future. Furthermore, trauma-informed practices encourage a culture of self-care among service providers, helping to mitigate the risk of burnout and turnover. As a result, victims may be less likely to disengage from services as experienced advocates, medical professionals, lawyers, and others will be providing quality services.

Explore innovative strategies. As providers seek to reach more victims and provide them with more services, many will need to increase capacity. Additional funding will be needed to support increased staffing levels. Putting more direct service workers in more places is only part of the solution. Providers can benefit from an exploration of innovative strategies that can help sustain programs during periods in which financial resources are particularly sparse. Innovative strategies, such as mobile unit-based service delivery and in-home treatment, can enable providers to make the best use of limited resources.

Encourage efforts to coordinate services and leverage existing resources. Collaboration was noted as a key strategy to improve service delivery, and funding should support these efforts. Through networks, collaborations, and partnerships, providers can

strategize on how to meet victims' needs effectively and efficiently. Collaboration may be particularly important in the current landscape; agencies have had difficulty connecting victims to providers outside of their agency due to limited service options. Leveraging non-traditional resources, such as community health clinics and relationships or coalitions, was a strategy used by providers to improve victim service delivery. Through partnerships in the community, providers are able to address both immediate and longer-term needs for victims, thereby improving service delivery. These collaborative relationships make resources and services available to agencies that might not have the funding or capacity to provide. By leveraging non-traditional resources and relationships, providers are better situated to fill service delivery gaps, and funding should be used to support the time and effort required for agencies to participate in such efforts. Furthermore, coordinated responses may also encourage trainings and foster relationships with first responders and justice officials to facilitate better care and support for crime victims.

Coordinate funding and standardize reporting requirements. The majority of victim service providers depend on a variety of different funding sources, both public and private. Each funder has different requirements to delineate how funds can be spent. To maximize the impact that a given funding source can have, funders with more flexible spending requirements should strongly consider funding pieces of service provision that are unsupported by other funding sources. For example, VOCA, a large funding source for most providers, cannot support prevention work. Other funders with less restrictive funding policies should consider funding prevention work.

In addition, not only do different funders have different guidelines for how dollars can be spent, but they may also have different reporting requirements. Funders have a responsibility to ensure that the money earmarked for victims is being used as intended, and reporting is one way for them to do that. However, disparate reporting requirements can unnecessarily burden providers, taking away time and resources that could be spent on direct service work. Funders should consider the burden of certain program or reporting requirements and strategize on how to reduce this burden. Funders may want to consider how to coordinate funding and standardize reporting, while better equipping providers with the knowledge and resources to satisfactorily meet requirements. All victim service funders have the same goal of helping victims and can collaborate to use staff time productively in a manner that aligns with best practices in victim service programming.

Conclusion

Across Illinois, victim service providers expressed difficulties in meeting the needs of crime victims holistically, but they also discussed effective strategies to adopt in the future to improve the awareness, accessibility, and delivery of services. Exterior pressures, such as reporting requirements, funding restrictions, and partner agencies' service availability, made it challenging for victim service agencies to access services or provide the level of coordinated care they desire for their clients. In light of the service landscape at the time of the present study, providers demonstrated resiliency in continuing to address victims' needs and in their collaboration with others as they worked to address key service barriers in their communities. As

new funding becomes available and capacity is rebuilt after the end of the State budget crisis in July of 2017, this study sheds light on areas for restoration and expansion that will enable victim service providers to effectively and comprehensively meet victims' needs in Illinois.

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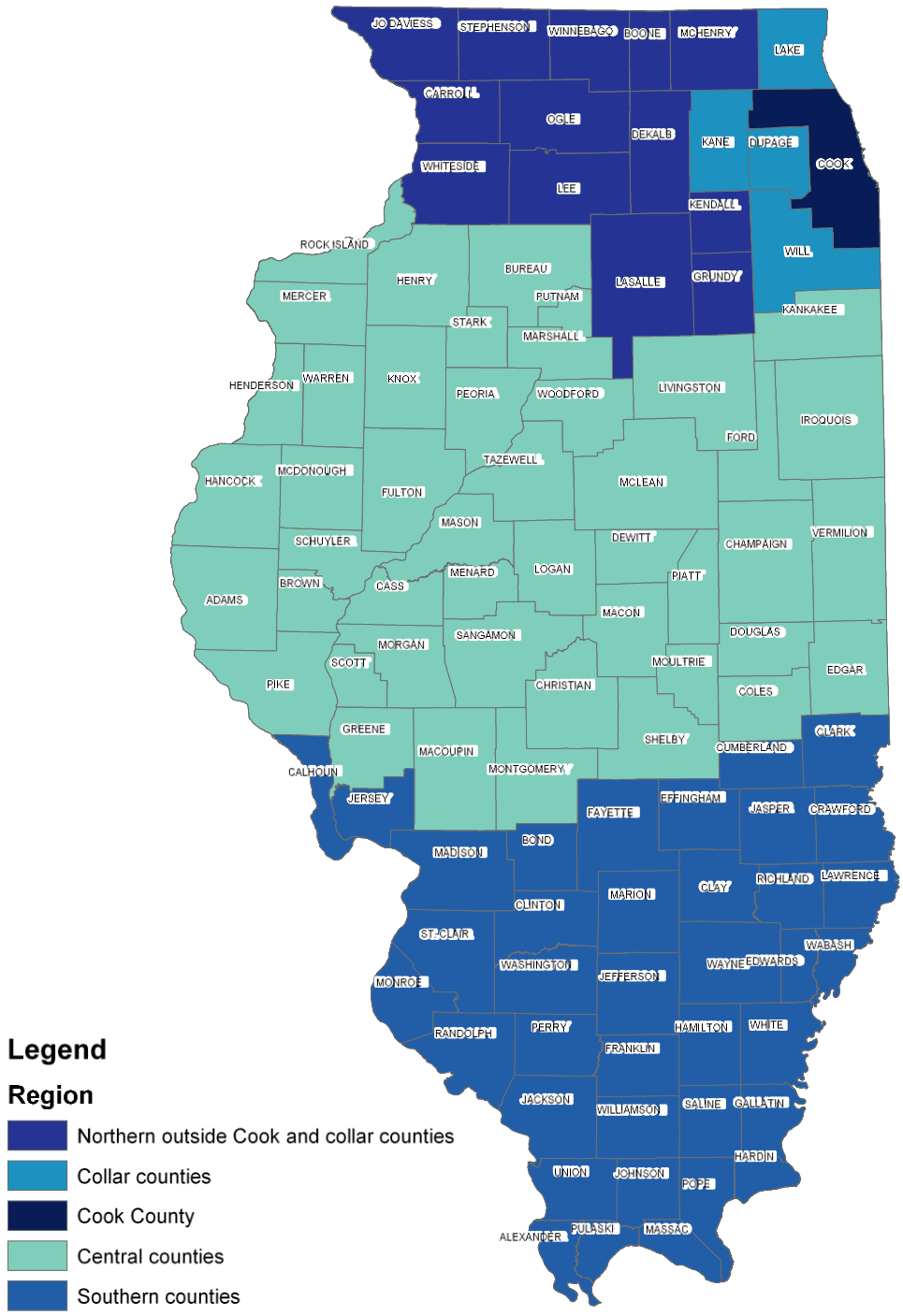
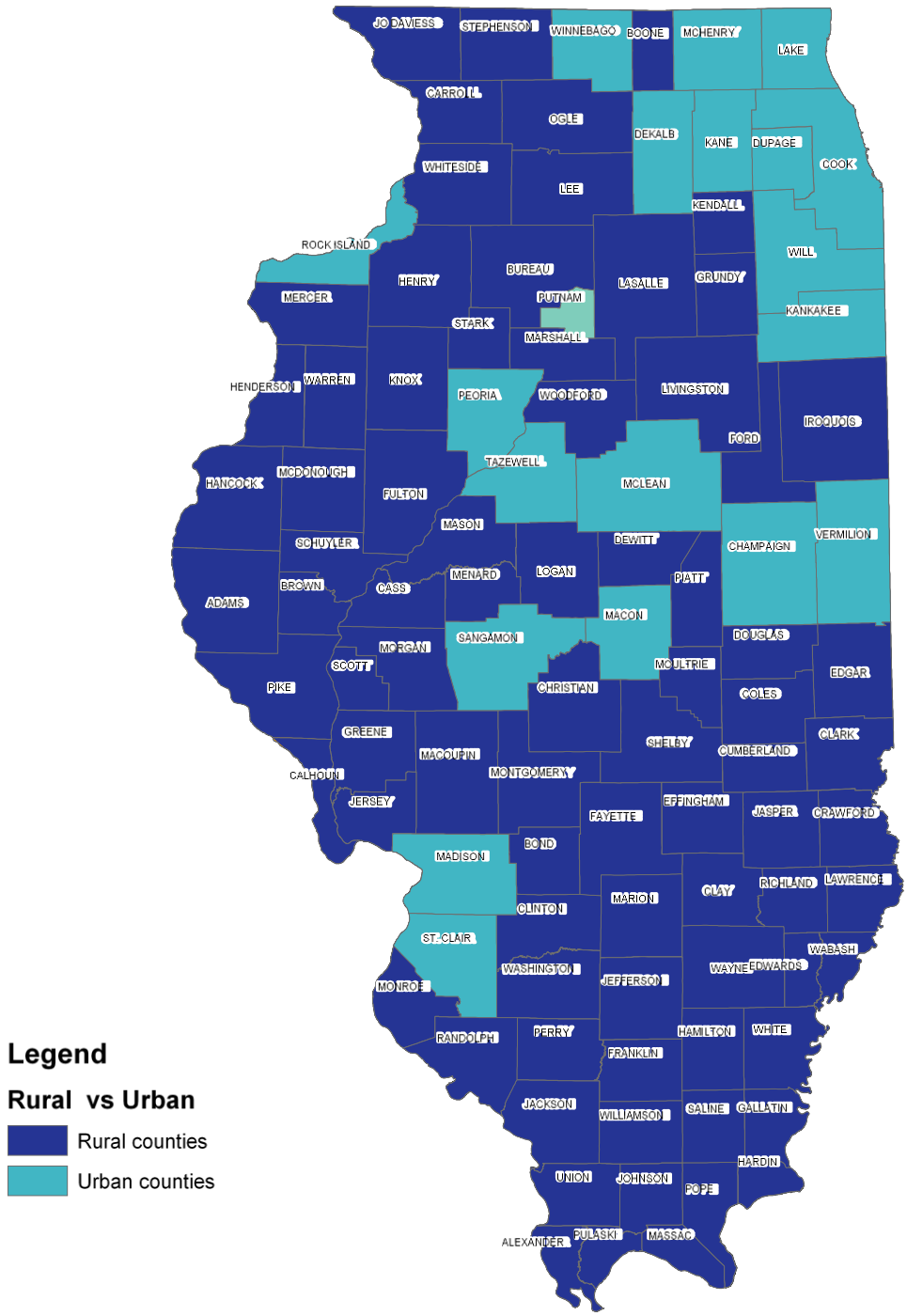
APPENDIX A
Map by Region



Map by Rural and Urban Counties



Legend

Rural vs Urban

Rural counties

Urban counties

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