Utah Victim Services Commission Study

Best Practices for Serving Victims & Survivors of Crime:

A Research Review

Final Report

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Contents

OVERVIEW

Crime victimization is associated with a range of negative impacts, which include psychological distress, reduced quality of life, impaired functioning, physical injuries, financial instability, and increased risk of future victimization (Bastomski & Duane, 2019; E. Navarro et al., 2024). As a result of victimization, individuals are at an elevated risk for developing post-traumatic stress disorder, depression, anxiety, substance abuse disorder, complicated grief, and suicidality (Amstadter et al., 2007; Freedy et al., 1994; Spilsbury et al., 2017). The likelihood that a crime victim will develop serious mental health concerns is influenced by crime characteristics (such as severity of injury, chronicity of abuse, and perceived life threat) and victim characteristics (history of mental illness, perceived social support; Amstadter et al., 2007). Many individuals who experience physical or sexual assault have a prior history of victimization, which can complicate recovery and require specialized interventions (Amstadter et al., 2007). For victims who report the crime to law enforcement, participation in the criminal justice system can result in negative outcomes that include nightmares, decreased social activities, loss of appetite, recurrence of phobias, and psychological distress (Campbell et al., 2005; Herbert & Bromfield, 2019; Koss et al., 2004).

Victim service programs provide support to assist individuals in recovering from the short- and long-term impacts of crime. Research indicates that victim service interventions can benefit victims of many types of crime (Nascimento et al., 2023), including intimate partner violence (Hackett et al., 2016; Karakurt et al., 2022), child abuse (Cohen et al., 2003), elder abuse (Ervin & Henderson, 2020; Satchell et al., 2023), identify theft (Irvin-Erickson & Ricks, 2019), sexual assault (Melton et al., 2020; Simske et al., 2022), homicide (Bastomski & Duane, 2019), and sex trafficking (Sibnath et al., 2011). The potential benefits of receiving victim services range from alleviating psychological distress, improving self-efficacy and social support, and improving safety to reducing future episodes of violence. However, research on the impact of services on victims' outcomes is mixed, with some studies showing no difference between those who receive services and those who do not (Sims et al., 2006). Such findings indicate that the quality and relevance of available services are important factors when considering efficacy.

In the United States (US), there are 3.7 victim service providers per 100,000 residents (Oudekerk et al., 2019). That number varies widely across states, however; Wyoming has 14.8 providers per 100,000 residents and New Jersey has 2.1 providers per 100,000 residents. In 2017, Utah had 3.9 victim service providers per 100,000 residents[1]. Nationally, the majority of service providers are non-profit or faith-based (45%), followed by government (43%). Prosecutor-based programs comprise 18% of victim service providers and law enforcement-based comprise 16%. Tribal victim service agencies provided the widest array of services (n=32), followed by non-profit or faith-based (n=29; Thompson et al., 2021).

[1] For a county-by-county assessment of victim service provider density in Utah and the United States, see https://bjs.ojp.gov/victim-service-providers-us-counties-2017

OFFICE OF VICTIMS OF CRIME

Model Standards for Serving Victims & Survivors of Crime[2]

According to the US Office for Victims of Crime, crime victims most ***frequently need*** and ***use*** the following services:

Crisis and Short-term Services

Victims often experience emotional distress in the aftermath of a crime. Crisis services, provided as soon as possible after a destabilizing event, are intended to restore stability, improve coping, address immediate safety concerns, and mitigate the long-term impact of the criminal event. Those services include:

- Safety planning, including safe and secure use of technology (e.g., information on electronic "footprints," spyware, anti-stalking tools)
- Advocacy or support
- Medical services
- Protective relocation, address confidentiality, or shelter
- Negotiations with creditors, landlords, and employers
- Assistance with funeral arrangements after a homicide
- Childcare
- General information on victimization
- Assistance with document replacement (e.g., birth certificate, identification card)
- Interpretation and translation services
- Assistance with property repair and return

Criminal and Civil Justice System Services

In the wake of a crime, victims need information about criminal justice processes to assist them in deciding whether to report the incident to law enforcement. Both community-based and system-based advocates provide information and referrals to help victims understand and participate in the criminal justice system. Those services include:

- Information on victims' rights
- Forensic examination
- Information on administrative or justice-related case proceedings
- Information about automated victim notification

[2] The OVC Guidelines are presented as an example here because they are relatively broad and apply to the widest array of crime types. The use of these guidelines is not intended to be exhaustive; many federal funding sources require the provision of specific services, by crime type, that are not listed here.

- Assistance with victim compensation applications and restitution
- Legal services, for issues related to immigration, family, employment, public benefits access, victims' rights enforcement, domestic violence/sexual assault, and housing
- Crime scene cleanup

Health and Behavioral Health Services

Crime victims, particularly victims of violent crime, are at an elevated risk of developing a range of clinical diagnoses, including depression, anxiety, post-traumatic stress disorder (PTSD), and substance abuse. Early intervention can accelerate recovery processes and prevent the development of long-term psychological disorders. Victim service agencies may provide these services directly, make referrals to community-based agencies and organizations, and remove barriers to accessing services. Those services include:

- Mental health services, counseling, and support groups
- Substance abuse services
- Social services
- Medical care that may include treatment for injuries, pregnancy prevention, and prophylaxis for sexually transmitted infections.

Stability Services

As a result of a crime, victims may experience substantial instability in areas such as housing, employment, social support, and community connection. This is especially true for individuals who were experiencing instability in these domains prior to the crime. Victim service agencies are often asked to provide services intended to help victims achieve long-term stability, including:

- Housing assistance
- Educational and literacy services
- Job training/placement and employment services
- Childcare
- Connection to faith communities and cultural groups

The specific services a crime victim needs will vary by crime type and individual circumstances. A study of Victims of Crime Act (VOCA) funded programs showed that victims average four different types of services after a crime. Victims of impaired driving, domestic violence, sexual assault, and crimes involving a weapon present with the widest range of needs (Newmark et al., 2003).

The ***OVC Model Standards for Victims and Survivors of Crime*** indicates that all victim services, regardless of victimization type, should strive to do the following:

- Provide **nonjudgmental social, informational, and practical support** to all crime victims and survivors
- **Promote safety, healing, justice, and rights** for victims and survivors

- **Ensure a voice for victims and survivors** through the implementation of victim-centered policies and practices
- **Promote access for victims and survivors** to a seamless web of multidisciplinary and comprehensive services to meet their needs in the short and long term
- Advocate for individual victims/survivors as well as for **social, institutional, and legal change**

IMPACT OF VICTIM SERVICES

To characterize the impact of services on victim outcomes, the following section is organized around three primary types of interventions: victim advocacy, clinical treatment, and coordinated responses.

Victim Advocacy

Advocacy-based interventions are one of the most common services available for victims of crime. Services are provided by trained individuals who may be paid employees or volunteers. Advocates are generally not licensed to provide mental health treatment. Advocacy-based services focus on crisis intervention, general support, psychoeducation, community referrals, and safety planning. Advocacy may also include information regarding criminal justice processes, events, and outcomes. Advocacy programs may be community-based or embedded in the criminal justice system, within law enforcement or prosecutors' offices. These services are typically provided at no cost to victims/survivors. Much of the research on advocacy-based interventions centers on those characterized as **empowerment-based**, which means services that focus on increasing victims' autonomy, sense of control, and ability to make their own decisions (Trabold et al., 2020).

Advocacy-based interventions are associated with short-term improvements on psychological symptoms such as depression and anxiety across a range of victimization types (Ervin & Henderson, 2020; Karakurt et al., 2022). While research on the impact of advocacy on re-victimization shows inconsistent results (Trabold et al., 2020), there is evidence that the combination of safety planning, psychosocial education, and social support can reduce the frequency and severity of violence among victims of domestic violence (Karakurt et al., 2022). Advocacy-based interventions are also associated with improvements in multiple measures of well-being, including self-esteem, self-efficacy, overall health, and quality of life (Trabold et al., 2020). Advocacy interventions that include both female victims of intimate partner violence and their children are associated with improvements in parent and child well-being and positive family relationships (Hackett et al., 2016). Group-based advocacy, such as social support groups, are associated with improvements in perceived social support and reductions in symptoms of grief and depression for victims experiencing a range of crimes, including impaired driving, elder abuse, homicide, and identity fraud (Adams, 2010; Bastomski & Duane, 2019; Ervin & Henderson, 2020; Irvin-Erickson & Ricks, 2019). Given the stigma, and subsequent social isolation, that many individuals experience in the wake of a crime, the primary focus of advocacy services should be to increase social support. Peer- and advocate-led groups can provide such support and are associated with improvements in feelings of personal growth (Satchell et al., 2023).

Advocacy is a multi-faceted intervention that includes a range of heterogeneous components across programs; consequently, few studies isolate the impact of specific activities. However, there is research to suggest that victims of intimate partner violence benefit from post-shelter interventions that are empowerment-based, ecologically focused, and high dosage (Trabold et al., 2020). Psychoeducation alone is associated with increased knowledge but not reduced symptoms of psychological distress (Satchell et al., 2023). Short-term interventions, often associated with crisis response, are typically insufficient to produce long-term impacts on well-being (Eckhardt et al., 2013; Rivas et al., 2015; Sims et al., 2006); however, they are an important mechanism for problem-solving, safety, and connecting to other resources.

When considering program structure, non-profit agencies are more successful than system-based programs at meeting a wide range of victim needs (Newmark et al., 2003). Service providers are sometimes unable to meet the full range of a victim's needs; however, when resources limit the number of clients that can be seen or the number of services provided. Victim service programs, which are often grant-funded, experience high rates of staff turnover due to fiscal instability in both leadership and entry-level positions. This turnover can negatively impact staff confidence in providing services as well as capacity for organizational planning and development (Townsend et al., 2017). In cases where victims have unmet needs, those are most commonly in the areas of financial assistance, service referrals, and criminal justice advocacy. Victims identify a primary unmet need is for victim service programs to "strengthen the justice system's response to offenders, primarily in the form of more severe punishment" (p. 202). Victims who received services from a system-based advocate express greater satisfaction with the criminal justice process than those who do not.

Crime Victim Compensation Programs

Since 1965, crime victim compensation programs have used state and federal funds to make payments to victims for crime-related costs. Most commonly, those funds are used to compensate victims for medical costs, lost wages, and funeral expenses. The funds have also been used to cover the costs of mental health treatment and sexual assault forensic exams. The receipt of such financial support, which can offset the financial impacts of victimization, is a substantial mechanism for minimizing the psychological consequences of crime (Alvidrez et al., 2008). However, relatively few crime victims (6% of victims of violent crimes in 2023) apply for crime victim compensation (Hall & Hamblett, 2025). Victims of human trafficking, adult sexual assault, elder abuse, child physical abuse, and stalking are less likely to apply for compensation than victims of other types of crimes (E. Navarro et al., 2024). State program administrators identified the following barriers to applying for compensation funds: lack of awareness of the program, psychological distress, and distrust of authority. Recipients of crime victim compensation funds have also identified barriers to accessing funds in the form of complicated reimbursement processes, lengthy response times, extensive paperwork, and requirements around cooperating with law enforcement (Hall & Hamblett, 2025)[3]. Comprehensive advocacy provided immediately after the criminal incident increases the rate of filed crime victim compensation claims (Dekker et al., 2024).

Crime-specific Victim Advocacy: Homicide Survivors

Depending on the type, and circumstances, of the incident, crime victims may require specific services, which not all service systems have the capacity to provide (Bastomski & Duane, 2019). For example, system-based victim advocates may not have training on the unique needs of homicide survivors (Bastomski & Duane, 2019). Victim service providers who work with homicide survivors report the need for training on media interactions (Spilsbury et al., 2017). Those services include assistance making decisions about when and how to respond

[3] For a state-by-state comparison of crime victim compensation programs see: https://www.americanprogress.org/article/hope-after-harm-an-evaluation-of-state-victim-compensation-statutes/

to media requests and processing the emotional impact of media coverage, including when the reporting is inaccurate. Homicide survivors may need assistance with death notification, funeral arrangements, and facilitating crime scene clean-up (Spilsbury et al., 2017). The victims' residence may also be a crime scene, which creates needs related to shelter, transportation, basic needs, and obtaining necessary documents.

Homicide survivors may also have a complicated relationship with system-based advocates. In cases where survivors are also crime suspects, they may not trust criminal justice stakeholders, including system-based advocates (Bastomski & Duane, 2019). In some cases, homicide survivors receive fewer services from system-based victim advocates when their goals for the case do not align with those of the prosecutor (Ervin & Henderson, 2020). Depending on service provider density, there may not be a community-based advocate who can provide support if the survivor does not receive adequate care from system-based advocates (Spilsbury et al., 2017).

While grief support groups have demonstrated effectiveness in reducing the psychological impact of crime across many types of victimization, limited research demonstrates efficacy with homicide survivors (Bastomski & Duane, 2019). This may stem from the general nature of grief support groups, which are often open enrollment, meaning they are attended by individuals with a disparate range of traumatic experiences. However, a specialized intervention, designed for homicide co-victims, is associated with reductions in symptoms of post-traumatic stress disorder and depression (Bastomski & Duane, 2019). This program is comprised of two 10-session closed groups, the first of which focuses on education about media interactions, the criminal justice system, and developing peer support networks. The second, called Restorative Retelling, was provided several months after the homicide and focused on stress management and restorative memory sharing. The Restorative Retelling intervention has been successfully implemented with both adult and child homicide co-victims.

CLINICAL INTERVENTIONS

Clinical interventions are provided by trained and licensed providers, most commonly mental health professionals. They include a range of therapeutic modalities and target symptoms associated with a mental health diagnosis, such as depression, anxiety, or post-traumatic stress disorder. Clinical interventions may be available within advocacy organizations; victims/survivors may also seek out this type of service through public and private mental health providers. Clinical interventions may be covered by health insurance or through crime victim compensation programs.

Clinical interventions based on cognitive frameworks show the most promise for reducing short-term symptoms of depression, anxiety, and post-traumatic stress disorder among victims of violent crime, including intimate partner violence, sexual assault, elder abuse, trafficking, child abuse, and mass violence (Eckhardt et al., 2013; Hackett et al., 2016; Satchell et al., 2023). For victims of violence, including intimate partner violence, the impact of CBT interventions is enhanced when combined with other approaches, both clinical and non-clinical. Those include advocacy, empowerment, and exposure therapy (Amstadter et al., 2007; Karakurt et al., 2022). For victims of child abuse, including sexual and physical abuse, CBT interventions are associated with lower rates of depression, trauma, and behavioral issues; when provided to the non-offending parent, CBT interventions resulted in lower rates of parental distress and family conflict (Cohen et al., 2003).

When considering treatment modalities, research supports the effectiveness of both individual- and group-based clinical interventions as well as in-person, remote, and virtual-reality platforms. There is also evidence that psychotherapy, eye movement desensitization, narrative therapy, and complicated grief therapy can improve psychological symptoms in persons who have experienced violent crime. Clinical interventions are also effective for improving psychological well-being among victims of intimate partner violence, including improvements in self-esteem, self-efficacy, and perceived quality of life (Trabold et al., 2020).

Clinical Interventions: Improving Access to Treatment for Victims of Violent Crime

The Trauma Recovery Center (TRC) model is a public health intervention that provides case management to victims of violent crime to improve access to mental health treatment. TRC can be hospital- or community-based and its core elements include assertive outreach, clinical case management, and evidence-based mental health treatment (Dekker et al., 2024; Simske et al., 2022). Assertive outreach puts the onus on the care team to engage victims in care, acknowledging the fact that the impacts of violent crime may, themselves, present barriers for accessing services. Clinical case management provides a single point of contact, so that victims do not have to negotiate multiple care systems, and assistance in meeting basic needs that facilitates individuals' capacity to engage in treatment and recovery. Mental health interventions endorsed by this model include motivational interviewing, cognitive behavioral therapy, and exposure therapy. The TRC model is associated with increased access to mental health treatment, increased filing of victim compensation claims, reduced recidivism in terms of violent victimization, and reduced symptoms of depression, anxiety, and post-traumatic stress disorder (Dekker et al., 2024). Of note, those impacts were only evident when the victim received the intended nine sessions of therapy; impacts were not evident for victims who received two or fewer services or who only received advocacy but not mental health treatment. These results suggest that comprehensive advocacy is a primary vehicle through which victims

can access clinical services; however, advocacy, as a standalone response, is not always sufficient for improving clinical outcomes.

Clinical Interventions: Post-traumatic Stress Disorder Among Victims of Violent Crime

Victims of violent crime are at an elevated risk of developing post-traumatic stress disorder, relative to exposure to other types of traumatic events (Amstadter et al., 2007). Clinical interventions are most likely to promote healing when they are structured, multimodal, and provided soon after the event (within four weeks; Simske et al., 2022). Brief cognitive-behavior protocols (B-CBT) demonstrate efficacy in accelerating healing among victims of violent crime, including sexual assault. B-CBT combines cognitive behavior therapy, stress management skills, exposure therapy, and psychoeducation (Foa et al., 1995). Exposure therapy is intended to extinguish an individual's response to traumatic cues, which could include anything that triggers memories of the incident. Repeated exposure to cues, achieved by describing and imagining the traumatic event, decreases victims' anxiety over time. Cognitive therapy seeks to remodel an individual's post-incident appraisals of the world, other people, and themselves, which may cause distress. Crime victims may particularly struggle with thinking that the world, and other people, are a source of danger. Cognitive therapy assists individuals to identify and alter maladaptive thinking, which is particularly important for victims who experience stigma, or feel blamed, for the criminal incident. Psychoeducation for victims of violent crime focuses on managing ongoing concerns around fear and safety, understanding common responses to trauma, and coping with the impact on interpersonal relationships. Stress management skills are effective for assisting victims in coping with the physical symptoms of crime-related distress and include breathing and relaxation techniques.

COORDINATED RESPONSE MODELS

Coordinated response models bring together interdisciplinary partners to respond to crime and crime victims. These models increase collaboration between first responders in order to improve criminal justice outcomes, criminal justice system processing, impact of the criminal justice system on victims, and overall victim well-being (Herbert & Bromfield, 2019; Johnson & Stylianou, 2022; A. E. Navarro et al., 2013). Coordinated response models may focus on crime committed against specific victim populations—such as child abuse or elder abuse—and also specific types of crime, such as sexual assault, intimate partner violence, and financial exploitation. Coordinated community response models typically bring together professionals across a range of disciplines who meet regularly to discuss and improve the criminal justice and social service system response to crime. This type of collaboration typically does not involve staffing specific cases; instead, participants review the system response to crime to identify problems and areas for improvement. Some models, noted below, do include case staffing elements. Coordinate response models can improve detection and response in elder abuse and are associated with reductions in future abuse (Ervin & Henderson, 2020) and community rates of domestic violence (Montanez et al., 2023). Law enforcement officers perceive that working with victim advocates in violent crime cases results in stronger criminal justice outcomes and improved victim experiences (Content & Fallik, 2025). However, given the wide variation in how coordinated response models are structured, researchers have not yet identified a core set of components that consistently predict positive impacts (Johnson & Stylianou, 2022).

Multi-Disciplinary Teams

Multi-disciplinary teams (MDTs) are a form of coordinated response that brings partners together to staff and respond to individual cases. The primary elements of MDTs are: they are comprised of representatives from at least three disciplines; they operate through shared decision-making and equal power among participants; and they develop shared responses protocols and processes for all partners (Ervin & Henderson, 2020; Herbert & Bromfield, 2019). Children's Advocacy Centers (CAC) are a commonly used model for responding to child physical and sexual abuse. CACs often co-locate the response to child abuse in a physical space and bring together specialized law enforcement, child protection case workers, and health care workers to investigate cases and ensure coordinated services are provided to children and families. Studies show these models are associated with improved case outcomes, in terms of increased rates of investigation, substantiation, charging, and conviction; those impacts are greater for processes earlier in the criminal justice system. MDTs also improve case processing outcomes by reducing the number of interviews a victim undergoes and increasing joint investigation between law enforcement and child protection services. Research also shows that MDTs can increase the number and types of services that families receive and increase caregiver satisfaction with the investigative process.

While the impact of MDTs on case and victim outcomes is mixed, across studies and crime type, such models have the potential to improve outcomes in the following domains (Herbert & Bromfield, 2019; Johnson & Stylianou, 2022; A. E. Navarro et al., 2013):

- Reduction in risk of future victimization and community crime rates
- Improvements in victims' overall prognoses

- Increases in victims' receipt of services (referrals, uptake, and variety of referrals)
- Reduction in the number of systems victims must navigate
- Increases in caregiver satisfaction with the criminal justice process
- Increases in satisfaction with investigative and care processes among CCR team members and referring agencies
- Reduction in the duplication of investigative steps
- Increases in the number of charges, prosecutions, and conservatorships/ substantiations

Collaborative Response to Crime: Sexual Assault Nurse Examiner (SANE) Programs

Sexual Assault Nurse Examiner (SANE) programs consist of nurses who are specially trained to provide post-assault medical care, emotional support, and forensic evidence collection to survivors of rape and sexual assault (Campbell et al., 2005). SANE programs are intended to increase prosecution rates for these crimes by improving the quality of evidence collected. Simultaneously, SANE programs seek to provide trauma-informed medical treatment and emotional support to address harms stemming from the initial assault and subsequent participation in the criminal justice process. While SANE programs vary in terms of structure, they are also intended to improve care coordination and are typically embedded in community-based sexual assault response teams that include, at a minimum, law enforcement, victim advocates, and SANE practitioners.

Qualitative studies indicate that SANE programs are associated with improvements in psychological well-being, including feelings of safety, anxiety, and overall quality of life for victims of sexual assault (Solola et al., 1983). Participants identified that SANE nurses' willingness to listen to their concerns was very helpful in negotiating the crisis. Ericksen and colleagues (2002) found that victims felt safe, respected, empowered, supported, and informed during interactions with SANE nurses. Victims appreciated being given choices about how they participated in the forensic exam and subsequent criminal justice proceedings. A comparative study found that victims examined by SANE program staff have greater access to necessary medical treatment such as pregnancy testing, emergency contraception, testing for sexually transmitted infections, and toxicology screening (Ciancone et al., 2000; Crandall & Helitzer, 2003). SANE programs are associated with improved evidence collection and more charges filed. Communities with SANE programs also identified improved coordination between medical and legal professionals, including regular communication, standardized response protocols, and interagency case review (Campbell et al., 2005). Improvements in the relationship between advocacy-based and SANE programs were less clear, with some advocates feeling excluded by the SANEs. These results suggest that resources should be directed toward both providing services and improving collaboration between responding partners in order to improve victims' experience.

Co-located Services

In some instances, coordinated response models are comprised of co-located agencies that provide a range of services to victims, such as the Family Justice Center model (Simmons et al., 2016). Such models improve outcomes for victims by creating seamless referral processes

and overcoming interagency barriers to collaboration and information sharing (Giacomazzi et al., 2008). When considering the co-location of services, within a single agency, the Sexual Assault Demonstration Initiative (SADI) Report found that dual-purpose domestic violence and sexual assault programs did not always provide the same tailored support services as standalone sexual assault programs (Townsend et al., 2017). In many agencies, sexual assault services were 'absorbed' into the domestic violence programming, which tended to focus on tangible needs, such as shelter, childcare, basic needs, and transportation. In contrast, sexual assault victims expressed the need for specialized and long-term services that addressed symptoms of trauma, including emotional support and skills for coping with triggering events. Dual programs can ensure they are providing adequate skills to all survivors by developing program manuals, training protocols, outreach campaigns, and data collection processes that allow the program to evaluate and monitor services over time.

CONCLUSION

The research reviewed here indicates that the services provided to crime victims can substantially improve outcomes related to overall well-being, daily functioning, physical and mental health, and future victimization. However, given mixed findings across studies, care should be taken when implementing victim services to ensure those programs align with best practices and have the ongoing capacity to monitor client needs and program fidelity. Victim services are most likely to have positive impacts when:

1) The availability of services is adequate for a given population, as determined by census, crime incidence, and victim service provider data. To achieve this, service providers must have the resources and organizational capacity to conduct ongoing assessments of community and victim needs (or access to this information as collected by another agency).

2) The full range of core services, as defined by OVC, is available within a specified framework (e.g., driving distance or time to access assistance). This includes ensuring adequate community services, so that providers can make seamless referrals to accessible treatment. Accessibility of services may be improved with the use of technology and virtual platforms.

3) Victims have access to specialized interventions as indicated by the circumstances of their victimization. This includes ensuring that victim service agencies have sufficient resources to train and staff programs so that services are timely, multi-modal, of sufficient dosage, and delivered with fidelity.

4) Victim service providers have the capacity to assertively recruit victims into services in close temporal proximity to the event. Early access to services can mitigate the harm of victimization and prevent re-victimization.

Eligibility criteria can be a useful mechanism to ensure that limited funds are used as intended. They can also create barriers for programs when funding for staff positions is split across multiple funding streams with strict criteria, because this may limit the types of services an advocate can provide to some victims. Funders and policymakers should seek a balance between dedicated funding, which focuses on a single type of victimization, with flexibility that allows programs to meet a broad range of victim needs, which may stem from multiple types of victimization. This could include braiding multiple funding streams together —both dedicated and unrestricted—into a single allocation that focuses on ensuring core services are broadly available to all victims across the state

5) Community- and system-based partners have the resources and organizational encouragement to collaborate with each other to improve system functioning and victim outcomes. This could include resources to fund: participation in and operation of coordinated response teams; interdisciplinary training; data collection and monitoring; and system-level strategic planning.

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