Victim Voice in Re-Envisioning Responses to Sexual and Physical Violence Nationally and Internationally

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Abstract:

Internationally and in the United States many victims of sexual assault and domestic violence are unserved, underserved, or ill-served, especially those from the most vulnerable populations. Programs developed in the United States are routinely exported to developing countries but often without success. Notably, the failures seen internationally resemble those in the United States and are related to structural and attitudinal–cultural factors. Many victims do not disclose, and if they do seek services, they often report that available options mismatch their objectives, present accessibility challenges, disempower their pursuit of justice, and fail to augment needed resources. A deeper understanding of obstacles to effective service provision is needed if the United States is to continue to be an international partner in victim response and violence prevention. This article builds on what is known about service delivery challenges in U.S. programs to envision a path forward that concomitantly accommodates anticipation of shrinking resources, by (a) reviewing illustrative services and feedback from victims about utilizing them; (b) examining structural inequalities and the intersections of personal and contextual features that both increase vulnerability to victimization and decrease accessibility and acceptability of services; (c) advocating for reintroduction of direct victim voice into response planning to enhance reach and relevance; and (d) reorienting delivery systems, community partnerships, and Coordinated Community Response teams. The authors suggest as the way forward pairing direct victim voice with open-minded listening to expressed priorities, especially in vulnerable populations, and designing services accordingly. Through a process that prioritizes adaptation to diverse needs and cultures, U.S models can increase desirability, equity, and thrift at home as well as enhance international relevance.

Keywords: international | policy | violence against women | sexual assault | domestic violence

Article:

This article focuses on governmental–community partnerships to respond to sexual and physical violence (SPV) victimization of women. The word *victim* is used to refer to those who have acts of SPV inflicted upon them, following Davies and Lyon's (2014) handbook on clinical and community responses. They preferred retention of victim because it conveys harm. The authors

suggested that, before U.S. programs are implemented in developing countries, they should be examined critically in their home setting for adequacy in meeting the expressed needs of victims, their success in outreach to underresourced and culturally diverse groups, and feasibility. This undertaking is particularly relevant presently, when funding levels are decreasing, demand for service is increasing, and long-term stability of victim services agencies and coalitions is threatened (National Network to End Domestic Violence, 2017a; Nonprofit Financial Fund, 2015). For example, 80% of domestic violence programs nationally reported that funding cuts were occurring from all sources, and 90% of states reported decreases in private donations (National Network to End Domestic Violence, 2017a). A 2015 survey based on 6,270 responses from nonprofit agencies across the U.S. concluded that 52% of them could not meet demand, and when turned away 71% of help-seekers went without services (National Nonprofit Financial Fund, 2015). If plans and services are unsustainable in the developed economy of their home setting, expectations of successful implementation internationally are unrealistic. The aim of this article is to envision a way forward in the United States that avoids retrenchment. It consists of (a) a review of illustrative services and feedback from victims about utilizing them; (b) an examination of structural inequalities and intersections of personal and contextual features that increase vulnerability to victimization and impact on service use; (c) advocacy for reintroduction of direct victim voice into service planning to enhance the match of offerings to needs; and (d) initial steps to reorient delivery systems, community partnerships, and Coordinated Community Response teams to address structural inequality and thereby increase breadth and reach of response to SPV. A U.S-based process that prioritizes adaptation to diverse needs and cultures could increase the desirability, equity, and thrift of SPV response at home as well as enhance international relevance. The composition of the psychology workforce well positions it to contribute to shaping national and international policy and practice (American Psychological Association, 2003; Carr et al., 2014).

International literature has documented many attempts to implement U.S.-program initiatives in developing countries (e.g., Petersen et al., 2016). For example, a protocol similar to U.S. Sexual Assault Nurse Examiners (SANE) screening, assessment, and examination programs including linkage to law enforcement and mental health services was implemented and evaluated in Afghanistan (Zupancic, Huber, & Gilmore, 2016). Two of three victims said other health problems were higher priority, 45% were offended by screening, and 57% were surprised that their victimization was subject to mandatory police report. The facilities lacked capacity such as few private exam rooms and referral options, and there were just 42 psychologists in the entire country. The methods conflicted with cultural beliefs that these problems were better treated by home remedies and religion. Finally, distance and cost were barriers because care was not free and 39% of the victims lived below the poverty line. The challenges to implementing this program in Afghanistan might have been better anticipated if the barriers that constitute access and service delivery in the U.S. had been identified and addressed. This concern is of paramount importance to the successful exportation of U.S.-based programs; thus, the remainder of this article focuses on the U.S. context. The diversity of the U.S. population and the proportion who live below poverty levels provide an ample laboratory for anticipating feasibility in underresourced countries but cultural input is required in each implementation both nationally and internationally. In the following sections, selected U.S. approaches to victim response are briefly reviewed along with the evaluation data on their successes both in reach and meeting their objectives.

Victim Services in the United States

Many people assume that SPV services are longstanding, such as forensic examinations, trained criminal justice responders, shelters, trauma care, and community coordination. However, these services were not widely developed or substantially government-supported until the passage of the Violence Against Women Act of 1994 (VAWA; Aday, 2015; Violence Against Women Reauthorization Act of 2013). VAWA was enacted originally as part of the Violent Crime Control and Law Enforcement Act of 1994, with the goal of improving criminal justice responses to domestic violence, sexual assault, and stalking. VAWA focused on law enforcement efforts and required all funded programs to use a coordinated community response (CCR). This model directs the efforts of victim service providers toward enhancing the performance of law enforcement and prosecution. Prioritization of criminal justice was a substantial shift from the original direction of shelters and crisis services that focused on support of victims and increasing community awareness (Aday, 2015). The legislation received input from the National Task Force to End Sexual and Domestic Violence, which to this day continues to set priorities and help draft legislation (Legal Momentum, 2017).

A criminal justice system–centered response is not victim-centered, however. The primary purpose of the justice system is to assign blame and impose punishment on those determined to be guilty of crimes (e.g., Seidman & Pokorak, 2011). The evidence has shown that only a minority of victims seek and a fraction receive the full spectrum of criminal justice services. Using rape as an example, during the past 15 years in Australia, Canada, England and Wales, Scotland, and the United States, victimization surveys showed that an average of 14% of sexual violence victims reported the offense to the police. Of these, 30% of cases proceeded to prosecution, 20% were adjudicated in court, 12.5% resulted in convictions of any sexual offense, and just 6.5% were convicted of the original offense charged (Daly & Bouhours, 2010).

The evolution of service provision over the past three decades has resulted in a sophisticated, expansive, bureaucratized, and expensive response network with a central criminal justice focus (Aday, 2015). Over the years, the policies and practices of communities and organizations have shifted in response to funding mandates (Martin, 2005). Some VAWA-covered services are based and funded through victim service agencies. However, VAWA money creates more stability for justice initiatives compared to historical activities such as support, counseling, and advocacy and fosters more interaction with criminal justice personnel and less connection with other social, medical, mental health, and community entities (Aday, 2015). Access to victim support services housed within criminal justice facilities is much easier for those who are willing to formally report crimes. For a movement that began at the grassroots in the 1970s with victims themselves raising awareness and starting the first support groups, VAWA implementation has ended up pushing them away from the table and suppressed grassroots advocacy (Aday, 2015; Martin, 2005).

Despite language in the Violence Against Women Reauthorization Act of 2013 that prioritized improved responsiveness to specific cultural groups and those who may hesitate to access services because of sexual orientation, gender identity, and religion, biennial reports from grantees supported by VAWA-authorized funds have documented that a justice-focused response

model leaves many unserved (VAWA, Measuring Effectiveness Initiative, 2017). The data indicate that most recipients are White, urban, English-speaking women without disabilities who are not considered elderly. For those victims who seek services, an accumulated body of work over the past three decades reveals a range of VAWA-supported services that improve outcomes for some victims; however, positive outcomes are more numerous for domestic violence than for sexual assault. For example, a recent study showed that the state of Kentucky averted $85 million in costs through issuance of protection orders to improve victims' quality of life (Logan, Walker, Hoyt, & Faragher, 2009). Specialized domestic assault response teams and domestic violence courts process cases more efficiently, increase offender compliance, impose enhanced penalties, improve outcomes for victims, and achieve higher rates of conviction (Cattaneo, & Goodman, 2010). Evaluation data most often consist of outputs (numbers of people served, units of service delivered) or ratings of satisfaction with service. Lacking are longer term assessment of individual outcomes and community-level impact (Aday, 2015). With this caveat, VAWA is considered to have moderate evidence of effectiveness for Sexual Assault Response Teams (SARTs), often in combination with Sexual Assault Nurse Examiners (SANE) programs (Greeson & Campbell, 2013), victim compensation (Zweig, Newmark, Raja, & Denver, 2014), shelters (Sullivan, 2012), and rape crisis centers (Shaw & Campbell, 2011; also see the Office on Violence Against Women [OVW] reports: OVW, 2012, 2014, 2016).

Most victims never report their victimization to any formal system (for review of disclosure and help seeking, see McCart, Smith, & Sawyer, 2010), so published evaluations do not reflect the experiences of SPV victims more broadly. Poor and minority women are more likely to be victimized but less likely to report and seek remedies than are European American women. If they disclose, many victims are more likely to turn to family and friends rather than to formal service providers (Bletzer & Koss, 2006; Starzynski, Ullman, & Vasquez, 2017). Few seek medical or legal assistance related to the victimization (McCart et al., 2010). Furthermore, studies done in larger cities and multisite studies have found that race, class, ethnicity, sexual orientation, and geographic and jurisdictional characteristics can also reduce program effectiveness (Townsend, Hunt, Kuck, & Baxter, 2006; Women of Color Network, 2006).

The evidence of program impact cannot reflect those victims who are unknown to any system. Their absence from the database raises questions such as the following: Were the services that existed those that were most needed by victims? Did they know about available resources? What obstacles were perceived in accessing them? Was there pressure from family or friends to remain silent? Did social support resources exist in the community that were not mobilized? In the next section, variables that may both elevate vulnerability to victimization and decrease the likelihood of using existing services and satisfaction with them are examined.

Structural Inequality and Intersections of Identity

The antiviolence movement strives to meet the needs of those whose identities place them at a disadvantage on a stratified social ladder. *Intersectionality,* although variously defined in the literature, considers the sociocultural basis of privilege and inequity (Crenshaw, 1991; Marecek, 2016). Individuals have multiple identities such as sex, age, race−ethnicity, national origin, religion, education, income, disability, and sexual and gender orientation. The intersections of identities are associated with the likelihood of victimization, its impact, and responses to it

(Coulter et al., 2017). Many intersections are associated with structural inequalities that stem from ingrained classism, racism, sexism, ableism, religious intolerance, homophobia, and other biases. Structural inequalities are transgenerational, compounding the effects of lower quality education, unemployment, incarceration, witnessing violence, exposure to stress, family instability, and adverse childhood experiences (Gans, 2011).

At the most basic level, structural inequalities, such as precarious economic resources, place options to report and seek help out of reach. Victims may have limited or no alternative housing options, lack funds for transportation or childcare, be unable to take time off from hourly employment, and have inadequate means to support their children without the abusive partner's contribution (Goodman, Banyard, Woulfe, Ash, & Mattern, 2016). Additionally, victims may lack knowledge of services due to poverty or lack of education or because an abuser denies access to telephones or transportation (Vinton & Wilke, 2014). In general, traumatic experiences result in a loss of resources (Hobfoll et al., 2007) and create a cascade of additional problems. Victims experience feelings of hopelessness, powerlessness, and isolation and may develop mental health problems, including posttraumatic stress disorder (PTSD; Goodman & Smyth, 2011). Emotional distress inhibits reporting and help seeking (Goodman & Smyth, 2011).

Victims may also feel that engaging with systems is not worth the consequences. Goals of the criminal justice and medical systems may be different from what victims would spontaneously express, including fear of losses such as reputation, income, the family home, employment, social relationships, and removal of their children by protection services (Pajak, Ahmad, Jenney, Fisher, & Chan, 2014). Even providers who describe their services as victim-centered may exert subtle coercion to accept services that match the agency's mission, such as leaving the abuser or reporting abuse to law enforcement, but mismatch victims' self-perceived needs (Davies & Lyon, 2014). Formal sources such as criminal justice−legal, medical, and clergy tend to be rated negatively by survivors (Ullman, 2010a, 2010b) or described as satisfactory immediately afterward, but subsequently, no victims except those with preexisting mental health diagnoses return after the initial visit (Starzynski et al., 2017). Victims who have negative disclosure and help-seeking experiences report that these encounters leave them feeling depressed, anxious, blamed, violated, and reluctant to seek further help (Campbell, 2005; Campbell, & Raja, 2005). They manifest increased social withdrawal, increased self-blame, and decreased sexual assertiveness (Relyea & Ullman, 2015; Ullman, 2014). Approximately 90% of victims who have postassault contact with formal systems (e.g., police, school officials) experience at least one highly distressing secondary victimization (Campbell, 2005, 2008). When assaults are reported to authorities against victims' wishes, it is psychologically distressing and decreases their likelihood of continued engagement with the legal system (Campbell, Greeson, Bybee, & Fehler-Cabral, 2012; Campbell, Greeson, Fehler-Cabral, & Kennedy, 2015). Being forced to report and engage with formal legal proceedings results in young women's being deeply upset and ultimately disengaged because of lack of choice (Campbell et al., 2012).

Cultural factors exacerbate access issues for members of marginalized communities. These include beliefs held in certain communities about violence, the unnaturalness of seeking help outside the family circle, unfamiliarity with available assistance, mistrust of formal agencies, and fear of deportation (White, Yuan, Cook, & Abbey, 2013). Survivors have reported dismissive, humiliating treatment in public offices while attempting to obtain various types of subsistence

(Laughon, 2007). Previous negative experiences can result in mistrust of mainstream institutions (Maier, 2013). Rape survivors have reported enduring invasive, traumatizing medical exams that had no bearing on their legal case (Nugent-Borakove et al., 2006). Cultural barriers may emanate from the service providers themselves. Survivors from marginalized communities have described racialized and prejudicial experiences in their encounters. For example, Zweig and colleagues (2014) reported that individuals identifying as non-English speakers, immigrants, or American Indians have difficulty accessing a sexual assault exam due to language barriers, lack of cultural competency among first responders, and lack of availability of trained Sexual Assault Nurse Examiners in their geographic area. Additionally, those with disabilities disclose experiencing a credibility gap—people do not believe them and think they are lying and or making up their report (Scheppele, 1992). "Racial loyalty" may also deter disclosure and encourage members of communities of color in which discrimination and disproportionate incarceration occur to confine their help seeking to informal networks (Bent-Goodley, 2001). The combination of antitransgender bias and persistent, structural racism is especially devastating for transgender African Americans (Grant, Mottet, Tanis, et al., 2011). Victims fear not only their attacker but also the possibility of being shamed or shaming the family. Oftentimes, especially for those in rural areas, social isolation negatively impacts reporting and help seeking, either due to being in the same small tight-knit community as the perpetrator or because of geographic distance from services (McCart et al., 2010).

Concerning those who disclose and seek services, data have recorded that they often say their available options mismatch their objectives, present accessibility challenges, disempower their pursuit of what justice means to them, and fail to offer concrete responses to basic needs. As mentioned previously, VAWA-funded programs center around justice, but pursuing a justice process that focuses on incarceration as its endpoint may not be high on a victim's agenda within in the context of food, shelter, childcare, employment, money concerns, and social isolation. Little is known about the services victims might have used but could not find, what justice is desired by victims, how services could have been made accessible, and what community supports existed to help but were not mobilized. Multiple literatures are converging with calls to bring back the focus on victim needs, but often this has taken the form of developing so-called victim-centered approaches. Closer examination of them reveals inattention to the evaluation literature on the toll many of services take on victims and are lacking direct input from unserved and underserved victims regarding unmet needs and potentially helpful initiatives (Davies & Lyon, 2014). Many centers have a standard menu that isn't comprehensive enough to address intersectionality. The outcome of the same service can vary for people at different intersections of identities. Some victims adopt what is viewed by service providers as uncooperative, oppositional, or angry behavior (Greeson & Campbell, 2011). Yet, behind the provocative behavior are victims trying to achieve the goals they seek, especially from the justice system. These victims' efforts are almost always unsuccessful, and the systems resist change.

Suboptimal consideration of structural inequality promotes paternalistic, top-down approaches that limit victims' voice. Experts too often think they know better what victims need than do victims themselves. Approaches based on the transformative possibilities of intersectionality have a social justice focus, challenge dominant knowledge paradigms, emphasize the role of interdisciplinarity, and reject one-size-fits-all solutions (Warner, Settles, & Shields, 2016). The failure to address intersectionality and structural inequalities jeopardizes the validity and

legitimacy of the antiviolence movement (Sokoloff & Dupont, 2005). These concerns point to interventions at the community rather than individual level.

Coordinated community responses (CCRs), as defined by VAWA, were mandated (Auchter & Moore, 2013). CCRs date to the 1980s and exist today to ensure coordination of various victim services with criminal justice responses. Unfortunately, successful CCRs are hard to achieve (Mancini, Nelson, Bowen, & Martin, 2006). Communities often lack a protocol for coordination between systems, limiting the ability of service providers to seamlessly work together within their individual scopes of responsibilities to address the needs of the survivors. Collaboration between agencies within communities may be hampered by organizational capacity issues, as well as an unwillingness of personnel to collaborate (Giacomazzi & Smithey, 2004). Systems often experience tensions between access to information and privacy as a safety issue, including confidentiality of personally identifiable information, sealed records, and closed courtrooms (Hulse, 2010). There may be excessive wait lists, bureaucracy, red tape, and a lack of fit between needs and services that resist amelioration through coordination (Pajak et al., 2014). Often CCRs do not have partners at the table that adequately reflect the community (Pennington-Zoellner, 2009).

VAWA-authorized funds, as well as monies from other federal agencies (e.g., National Institute of Justice, Centers for Disease Control and Prevention) and private foundations, have become a major source of support for many organizations. Because these funds are typically awarded competitively, inequities result. VAWA legislation itself specifies the distribution of funds among systems. Uneven distribution is documented (Aday, 2015). It is unclear how priorities are set; however, more funds go toward justice-related activities than other services, and this observation is documented in dollar amounts by tracking federal records (Aday, 2015). For example, housing is the most common unmet need of victims, but VAWA funds for transitional housing were about 20% of those allocated for law enforcement (Pickert, 2013). Additionally, few communities, especially those outside larger urban areas, have DART, SART, and SANE programs, and those that do not geographically or demographically representative (Greeson & Campbell, 2013). Nearly all police departments serving 250,000 or more residents now operate a full-time specialized unit for domestic violence, and about half of them operate a full-time SPV victim assistance unit, but smaller communities do not (Reaves, 2017). There are some (inadequately funded) programs for special populations such as rural areas, the elderly, Native American tribes, and immigrants. However, these funds often go unawarded because eligible entities lack the experience and personnel to complete grant applications that are at a level of complexity geared to large institutions and private contractors. To continue building the case for reenvisioning the current response model, the following section defines and elaborates on the crucial role of victim voice.

Victim Voice

Victim voice is conceptualized as expressions of needs, priorities, and goals onto which the field could map existing emphasis and guide future resource allocation. A true reflection of victim voice involves hearing directly from victimized individuals who are demographically diverse and is also inclusive of the currently unheard voices of the majority of victims. These include those who choose not to disclose to law enforcement, seek medical care, visit a shelter or crisis center;

attend once and do not return; and would prefer not to share their views with others (Monroe et al., 2005; Starzynski et al., 2017). Given that *victim-driven, victim-centered,* and *victim-sensitive* have become common buzzwords, the authors were surprised by the lack of relevant material. What was found across multiple disciplines were eloquent testimonies to the impact of SPV in victims' own words. What is available filters victim voice through the perceptions of service providers (Kirkner, Lorenz, & Ullman, 2017, pp. 13–14). They typically listen carefully but nevertheless, given the design of the human brain, interpret what they hear through their own cognitive architecture (see Hilbert, 2012, for a review of over six decades of research on cognitive biases; also see Goel, 2017, for review of biases in medical decision-making and health disparities). Definitions of the terms referencing victim-centered practice vary. Consensus has emerged that "being survivor-centered means listening to victims and providing them meaningful choices" (Hanson, 2017, p. 1; also see Davies & Lyon, 2014; Goodman, Thomas, et al., 2016). Unfortunately, the term is also used when victims are in reality being pressured or treated differently depending on whether they agree to pursue a central agency mission (reviewed in Davies & Lyon, 2014). Based on concerns about the affordability, equity, and suitability of the current SPV-coordinated response model presented to this point, the following sections consider responses to move forward.

Reenvisioning to Avoid Retrenchment

Reaching a more equitable spectrum of people and locations is an achievable goal that rests on grounding in the scope of victim needs, developing bold and innovative modalities and service delivery mechanisms to meet those needs, and focusing on approaches that are more efficient for each dollar expended. The following sections suggest steps to these ends. Although it is beyond the scope of this article to elaborate, many of the suggestions discussed have been inspired by over two decades of work on models of coordination to deliver more effectively mental and medical health services to diverse communities. These models advocate for using a social ecological approach that puts the patient−client at the center. These include systems of care (Stewart, 2013), family justice centers (Gwinn & Strack, 2006), and integrated health care models that stress "a high degree of collaboration and communication among health professionals. . . . These integrated behavioral health practices around the country feature psychologists and physicians working together" (American Psychological Association, Center for Psychology and Health, 2017).

Meet Victims Where They Are

Advocates, service providers, justice professionals, policymakers, and funders are challenged to reflect on the extent to which the services in their communities are not only *victim-centered* but also the extent to which they are inclusive and *victim-informed*. The goal is to move forward cohesively toward a system plan that reflects listening to victim voice, seeking input from multiple intersections of identities, striving to dismantle systematic biases, and connecting with community groups and the broader social justice movement. Those looking to solicit voices must be willing to do so in ways that are conscious of the power dynamics between service professionals and victims, institutional and systemic oppression affecting victims, and social stigma that still surrounds SPV victimization in general (i.e., see "Tenets of Multi-Cultural Counseling"; American Psychological Association, 2003). Victim-informed services go beyond

inviting victims to the conference table as specimens to be analyzed; rather, victims should be met in their own neighborhoods and familiar spaces. They require a commitment to cultural humility and radical listening. *Cultural humility* is an expansive process of self-reflection, breaking down of power dynamics, and committing to a mutual and ongoing learning experience (Foronda, Baptiste, Reinholdt, & Ousman, 2016). *Radical listening* is about overcoming personal biases to become truly attentive to the critical issues that speaker(s) are expressing (Agnello, 2016). Radical listening involves accepting answers without judgment when the input is uncomfortable and challenges preconceptions of victim needs, letting go of biases toward biases favoring existing interventions, and shifting the center of power back to victims.

Radical listening and cultural humility are integral to developing intersectional coordinated response options. Applying an intersectional perspective to reenvisioning victim services requires challenging status quo knowledge, working collaboratively across multiple disciplines, and always asking who benefits and who is harmed or left out by policies and practices. The answers to intersectional questions will always lie with the service users. Services will likely continue to change over time as victim characteristics, situations, and needs change. Intersectionality is a continual process, not an end goal. Valuing it prods service developers to continually come back to victim voice as the primary driver.

Soliciting victim voice is easier said than done. Holding listening sessions at providers' offices or at professionalized locations in the community is insufficient. An alternative is to shift to participatory methods to meet victims where they are (e.g., Ahrens, Isas, & Viveros, 2011). An essential step is to make connections with community entities such as ethnic affiliation groups, places of worship, and community centers. They undoubtedly have their own agenda and do not necessarily have SPV on their radar (Murray, Smith, Fowler, White, & Stamey, 2009). A first step is building common cause; the same structural inequalities that have been discussed in this article in the context of SPV underlie a multitude of other social ills. Bridges are built through dialoguing with women who aren't necessarily victims but can speak for others such as friends and sisters. Only after there is trust do the voices of victims begin to emerge from the group. Bridge building has a secondary benefit of raising awareness of SPV as an issue within the community and begins conversations in homes (Bletzer & Koss, 2006). Readers will recognize that these steps are characteristic of community-based participatory (CBP) approaches to intervention development and delivery. CBP can increase community engagement, decrease disparities in service access, and lead to more sustainable community services (Wallerstein & Duran, 2006). In CBP everyone works together on all aspects of development, from information gathering to envisioning programming based on the information collected (Israel, Eng, Schulz, & Parker, 2012). The focus is on identifying community strengths and building upon them to create meaningful resources, rather than restricting focus to acute deficits (Yuan et al., 2016).

Professionals in the SPV field may find that concomitant with reenvisioning services is the opportunity to alter indicators of impact, including identifying victims' views of success. There is growing interest in expanding the concept of success beyond "bean counting" (i.e., number of victims served, number of training sessions offered, and number of arrests and prosecutions; Aday, 2015). A levels of analysis approach that defines what short- and longer term success might look like for communities, organizations, and service providers, as well as for victims and offenders, should be considered. Multilevel approaches, which have driven applied psychology

and health promotion for over 40 years (e.g., Belsky, 1980; Bronfenbrenner, 1977), take into account the complex interplay of multiple actors and systems. Evaluation questions might include the following: What was the balance of extrapolated victim voice and actual victim participation in victim-informed service development? When services achieve positive outcomes, what processes predict them? A related question is the extent to which success at the system level translates into better outcomes for victims.

Maximize Reach

Survey data from domestic violence programs report that 66% of agencies have had to reduce services (National Network to End Domestic Violence, 2017a). The difference in the number of individuals who would benefit from services versus those who actually receive them is often described as a treatment gap. Kazdin (2017) quantified the mental health treatment gap and detailed novel models that utilize innovative modalities to extend psychosocial interventions into nontraditional settings. Among his primary principles are task shifting, efficient and innovative delivery modalities, and cross-sector and nontraditional community partnerships. The same principles can be applied to SPV victim services.

Task shifting

Task shifting involves using less highly trained personnel to support victims. Avoiding workforce reduction by task shifting hinges on a willingness to redefine roles; for example, moving from a face-to-face direct provider to other modalities to deliver information and support. Roles that are essential to task shifting include recruiters, trainers, supervisors, coaches, resource creators, and builders of community partnerships. Petersen et al. (2016) identified the promise of programs that train nonspecialists to screen and provide support for those with mental health, neurological, and substance abuse problems. Community health workers (CHWs), or *promotoras de salud,* have been a valuable linkage between Latinx communities and health care systems (Ingram et al., 2012). CHWs conduct prevention and health education activities in community settings; for example, CHWs have been successfully trained to identify signs of hearing loss, provide referrals for screening, and conduct support groups for people with hearing loss and their families living along the U.S.-Mexican border (Sánchez et al., 2017). CHWs could be trained to screen for SPV, make referrals, and lead support groups. Many colleges and universities have introduced practicum requirements to increase student involvement in the community. Students would add to the volunteer workforce for victim services (Sullivan & Bybee, 1999). Additionally, involving thriving victims, retired people, and lively individuals who are not able to work full-time would provide a pool of mentors who, through their nurturance and community investment, help victims avoid isolation and emotionally bond to healthy people. Valuable by-products of task shifting are that it is an avenue to diversifying providers to better match those with whom victims report they feel comfortable confiding in, recruiting from multiple communities to reduce geographic obstacles, and involving individuals who approach recovery through interventions consistent with victims' belief systems and language.

Efficient and innovative delivery modalities

In working with victims to reimagine services and service provision platforms, it is important to consider changing population characteristics. SPV services have faced declining resources for a number of years and have tended to hunker down with a set of programs that were developed for those born in the Baby Boom (1946−1964) and Generation X (1965–1981) periods. Models of service delivery used today are characteristic of the 1970s−1990s (e.g., an individual calls a provider, makes an appointment, and goes to a physical location for services). Expectations of services and service access will change with the behavioral patterns of newer generations of service users. Generation Y ("Millennials," born 1982–1999), and soon Generation Z ("GenZ," born 2000 and after) constitute the peak risk age for SPV. It goes without saying that these generations are highly engaged with technology and that services that can be provided through digital media may be ideal for them (Cardoso, Sorenson, Webb, & Landers, 2016). For example, millennials text far more frequently than they make phone calls. It has previously been documented that the present SPV response is based in large part on the expectation that victims will come to see providers at their physical offices. This approach fails to reach the majority of victims and will likely be unattractive to new generations. The National Suicide Prevention Hotline recently created the option for individuals to access assistance via text in lieu of talking on the phone. Trained community volunteers could be assigned smartphones to use for informational and rape crisis support text messaging. Support groups can be created on social media platforms, where strong privacy settings can be enabled to prevent nongroup members from viewing the group membership list or even from being able to search for the group itself.

Utilizing technology for information needs and service delivery is not a panacea, but it broadens options for victims and can increase capacity for providers. Banyard and Potter (2017) reviewed a range of studies that have evaluated demonstration programs utilizing social media and leveraging new technology. In previous generations, community awareness and education have been approached through public service announcements on TV. A significant proportion of millennial TV viewing is now on smartphones. Content appears on webpages saturated with advertising. Informational campaigns could potentially find new homes on commercial webpages if the SPV field pushed the public service model with social media corporations. The technology to develop images (.jpg) and short animations (.gif) has become increasingly accessible; creation of original media materials no longer requires expensive use of outside contractors. Public awareness campaigns still have currency, as evidenced by data that victims have been shown to benefit from greater understanding of society-wide oppression (McGirr & Sullivan, 2017). Informational placements on commercial websites can be sought through the methods that brought corporate support to domestic violence awareness in the past. Depending on placement, messages reach a wide audience and can be deployed strategically to reach potential supporters of victims; men who become allies against SPV; perpetrators; and most important, victims who are seeking no other form of service.

Cities and townships can also support victim resources for recovery through municipal design features. Municipal planning that brings people together builds community bonds, increases safety, and improves quality of life. Cities were originally designed around men's work and commuting habits, relegating women, the disabled, and the elderly to the home (Hayden, 2002). Urban planning efforts with city councils and public advisory boards could bring SPV into the deliberations. Victims who are in shelters and transitional living often rely on public transportation systems to access childcare, job interviews, parenting classes, TANF/WIC offices,

and doctor appointments. Limited bus routes and stops on darkened street corners increase transit time and decrease safety. Apartment or housing complexes that are being revitalized can include design features that encourage not only "neighborhood watch" for property crime but also communal watching of children—a helping hand for victims who are juggling many things at once. Time is among the many resources underserved people lack. Entities that manage public spaces can facilitate bringing women together around activities that they would do anyway, such as playing with children, helping with homework, and using public laundry facilities.

Cross-sector and nontraditional community partnerships: Refocus CCRs

The original conception of CCRs that placed the criminal justice system as the hub of the wheel has already been described (e.g., Shepard, 1999), as has the small proportion of victims who benefit from these services (Daly & Bouhours, 2010). The focus cannot be centralized on justice responses when victims have additional needs that they may see as equally or more pressing. Similar to trends in other systems of care, coordination of partners more equally and conceptualization of interventions to include community and societal levels could refocus CCRs (Petersen et al., 2016). For example, a comprehensive response could include a more victim-informed mission that engages social justice agencies, clinics, housing, and other organizations to meet victims' needs. Safe Housing Partnerships (National Network to End Domestic Violence, 2017b) offers an example of coordination of resources to address housing for victims who are left homeless because of SPV. Working across sectors can reduce the burden on single domains and respond to extensive needs that cannot be met by a single social service agency. Colocation of service agencies in the same building or complex increases accessibility and reduces the time that victims may spend traveling between locations, especially if they rely on public transportation (Gwinn & Strack, 2006). Consolidation of individual agencies is another option that has been rejected in the past but may bear reexamination.

An enhanced CCR model can connect resources that increase and strengthen victims' natural support systems. Many victim services, such as psychotherapy, do not extend beyond the acute care period. The focus is typically on addressing immediate deficits in the victim's life. Assets-based approaches are both underutilized and less costly (Hamby, 2013). They involve actively mobilizing social support from family, friends, and neighbors, as well as existing community institutions such as religious organizations; employers; and informal, self-sustaining support groups (Schultz et al., 2016; Shorey, Tirone, & Stuart, 2014). Traditional victim services often identify personal supports as part of safety planning exercises; however, those individuals may not know that they have been thus recognized. Some models, such as Family Group Conferencing, have been shown to increase social capital for families with domestic violence and/or child welfare issues (De Jong, Schout, Pennell, & Abma, 2015).

Using what has been learned from listening directly to victims, there may also be an opportunity to expand and enhance justice system techniques and options within a redesigned CCR model. Efforts to improve victims' experiences with criminal justice date to the earliest days of the movement. Promising new directions to strengthen response services include the development, implementation, and research of trauma-informed investigation and prosecution techniques (Preston, 2016) and the expansion of justice options to include nonadversarial choices. Restorative justice is a promising victim-focused avenue for SPV cases as an alternative to

offender outcome−focused strategies (diversion, plea agreements, and/or specialty courts and dockets), which have mixed or negative reviews from victims (Lopez & Koss, 2017). Restorative justice has been safely piloted through a community-prosecutor partnership with high rates of victim satisfaction and without increased severity of PTSD symptoms compared to the expected symptomatology trajectory for sexually victimized persons (Koss, 2014).

Conclusions

All indicators point to less financial support for SPV, threatening the sustainability of the response model that was created and nurtured when VAWA funding was growing. Not only is this model prohibitively expensive in many locales but evaluations indicate that services are distributed inequitably and raise many obstacles to their use by those most in need. National coalitions are documenting an ever-growing demand that is leading to reductions in service delivery from levels that were already suboptimal. Reduced resources do not inevitably lead to doing less, but they will if service models remain unchanged. Avoiding retrenchment will require evolution from the top-down agenda that has been in effect since the 1990s. Calls for recentering victim voice in policy and practices are becoming more widespread. Creating space for victim voice means that those who currently set the agenda must come to the table with an open mind, enable and elevate other voices, and share power. If asked for input, victims would likely allocate funding quite differently from the status quo. Using what is learned from them guides a refocusing of CCRs more in line with models of integrated or wraparound care. Principles that have emerged from multicultural counseling, mental health treatment gap, and wraparound models of service offer specific suggestions for promising directions within SPV, including task shifting, new forms of service, and cost-effective delivery. U.S models can increase desirability, equity, and thrift at home by utilizing methods based in cultural humility, radical listening to victims' voices, and community-based practice. Current threats to existing practice present an opportunity to reenvision and revitalize responses to SPV nationally and to lead to greater success when implementing U.S. models internationally.

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