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Crime Victim Service Providers' Barriers to Service Provision: Comparisons across Service Providers

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Abstract: The current study examines victim service providers' barriers to service provision by analyzing five types of service providers. Two research questions are explored: (a) any differences in the reported barriers across the service providers and (b) any differences in staff capacity, caseload capacity, underserved or vulnerable victim populations, and victimization types across the service providers. The findings show the existence of significant patterns of distribution of victim service providers' barriers to assisting victims across the service providers. Nonprofit organizations reported a higher prevalence of the barrier of excess capacity. Government agencies reported a higher prevalence of the barrier where victims' situation or the crime type did not meet the requirements for receiving services. Medical organizations reported a higher prevalence of the barrier that the services they provided were inappropriate for the victims. It is also found that government agencies reported heavier caseloads handling more diverse types of criminal cases with fewer staff than all other providers analyzed in the current study. Furthermore, government agencies reported a higher prevalence of serving victims of adults 60 or older, males, and African Americans and a higher prevalence of handling cases of intimate partner violence, crimes against children, crimes against the elderly, violent crimes, and property crimes. In addition, nonprofit organizations served more non-English speaking victims, whereas campus organizations reported a higher prevalence of handling sexual assault cases. This study suggests strategic resource allocation planning and more research attention to government agencies' barriers and needs to victim service provision.

Keywords: Crime victim, victim service, service providers, barriers to service provision

Introduction

Crime victim services gained energy from the growth of victimology and victim activism in the 1970s when victim support groups and advocacy groups arose (Young & Stein, 2004). By the end of the 1970s, many states launched victim assistance programs, and at

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the national level, the National Center for Victims of Crime and the Office for Victims of Crime were established in 1985 and 1988, respectively. It is estimated that approximately 12,200 victim service providers operate in the United States, including governmental, private, healthcare, educational, and tribal organizations (Oudekerk *et al.*, 2019).

By and large, victim services fall under the following categories: (a) information and referrals, (b) legal and victims' right assistance, (c) financial and material assistance, (d) emotional support and safety, (e) medical and physical health assistance, and (f) other services (e.g., language and disability services) (Morgan & Thompson, 2021). The goal of offering these services and resources to crime victims is clear. It is to help victims secure safety, promote recovery, and navigate resources available in the criminal justice system. Victim services are critical to securing the safety of crime victims at an early stage and linking victims to accessible services and resources. For instance, early intervention from victim advocates can provide tailored services to victims of domestic violence and their children by considering the level of risk for subsequent violence and victims' needs and preferences (McCarry, Radford, & Baker, 2021). In addition, victim service providers are often in a prime position to provide victims with a smooth transition to various systems of legal assistance, such as preparing victims for court, providing court interpreters, or assisting in filing temporary restraining orders (Elliott *et al.*, 2013; Hart & Klein, 2013; Jerin *et al.*, 1995; Roberts, 2007). More importantly, the use of victim services can improve victims' self-efficacy and coping skills, and prevent subsequent victimization (Bennett *et al.*, 2004; Xie & Lynch, 2017).

Despite the expansion in service ranges and programs related to victim assistance and support, however, victim service providers have consistently faced a number of barriers to quality, appropriate, and timely service provision to crime victims. It becomes clear that there is a need for more research that examines victim service providers' barriers across multiple dimensions. The current research adds to the existing literature by analyzing different types of victim service providers to investigate any differences in victim service providers' barriers to serving crime victims.

Victim Service Providers' Barriers to Assisting Crime Victims

A body of research has explored victim service providers' opinions on experiences and challenges while assisting crime victims and have identified multiple barriers to victim support within their organizations or programs. Those reported barriers can have an impact on the quality of the services they provide to crime victims and may also have an impact on their perceptions of organizational efficacy.

Insufficient Funding

A lack of funding has been reported as a major challenge that prohibits many victim service providers from providing quality assistance to crime victims. A study of 25 rape

crisis centers found that 64% of the sample mentioned the lack of funding as an issue that obstructed quality services for survivors (Ullman & Townsend, 2007). Additionally, a study of 159 service providers working with human trafficking victims found that 72% of the sample reported that more funding was needed to perform quality service provision (Clawson *et al.*, 2003).

Under the Federal Victims of Crime Act (VOCA) of 1984, federal funding is available to each state to support victims of a wide range of crimes. The VOCA funds support more than 6 million victims of all types of crimes annually through more than 6,000 direct victim service organizations (National Network to End Domestic Violence, [NNEDV], 2021). A critical issue with federal funding, however, is that it does not generate stable funds because it is replenished through fines levied on convicted federal criminals. If prosecutorial strategies change, the deposits change accordingly. In fact, the VOCA funds have annually declined since 2019 because of shrinking deposits (NNEDV, 2021). Although victim service providers receive multiple funds from federal, state, and local governments, they should rely on private donations if they fail to receive sufficient funding to run service programs (Yun *et al.*, 2009). A study of a sample of 69 victim service providers in Oregon found that 52.3% of the sample relied on private donations in addition to governmental funds (Elliott *et al.*, 2013). A related concern is that private donations are also not a stable financial source.

Insufficient funding is not a standalone issue; rather, it is coupled with other issues of service provision, such as expanding services, increasing staff capacity, and coordinating professional training and education. For example, many providers are unable to provide transportation services to victims in some areas due to insufficient funding (Vasquez & Houston-Kolnik, 2020). Without sufficient financial resources, victim service providers would stop or reduce services, which would prohibit the speedy service provision to victims who might be in imminent danger. It is also possible that such unstable funding could lead the providers to fear potential budget cuts and therefore take passive action in providing appropriate, timely, and quality services to crime victims.

Limited Availability of Services

One of the common barriers to service provision reported by victim service providers is the limited availability of services. Research suggests that many providers supporting victims of domestic violence and their children are not able to meet the demand for shelters (Clawson & Dutch, 2008; Greeson *et al.*, 2019; Poole *et al.*, 2008; Vasquez & Houston-Kolnik, 2020). Unfortunately, when beds are limited, victims with nowhere to go need to be turned away. It is not only securing shelters that is a top priority for many victim service providers. The need for a variety of services also exists. A study of 207 medical professionals and social workers screening domestic violence and sexual assault

cases found that 48% of the sample indicated the unavailability of 24-hour access to the social worker as a barrier to assisting victims of domestic violence and sexual assault cases (McGrath *et al.*, 1997). Additionally, recent research calls for offering more mental health care services to those who have been victimized and their family members (De La Rue *et al.*, 2023; Vasquez & Houston-Kolnik, 2020).

The limited availability of services can preclude particular victim populations from accessing or utilizing services. For instance, a lack of language services can prevent non-English speaking victims from receiving adequate assistance from victim service providers (Ullman & Townsend, 2007). Inaccessible public transportation in some victim service agencies, especially those operating in rural areas, makes it difficult for them to identify victims in desperate need (Hochstein & Thurman, 2006). In some cases, victims can be turned away because they do not qualify. For example, providers may be unable to assist single adults with certain services (e.g., housing) because they do not have children (Elliot *et al.*, 2013). Previous research also points out that many crime victims are not aware of the existence of services available to them. A study involving a sample of 144 crime victims found that only 3% of the sample used a victim service program, and 47% of the sample reported that no one notified them about the availability of any victim service programs in the first place (Sims *et al.*, 2005). More interestingly, Clawson and her colleagues (2003) found that 85% of the service providers' sample believed that victims were likely to have no access to services because they were not knowledgeable about available services.

Staff Capacity

Not all victim service providers are equipped with sufficient staff capacity to manage service calls and provide adequate services to victims of various crimes. Understaffing has been a longstanding issue since the 1990s. A study of victim witness advocates' perspectives on their service delivery found that advocates reported a great need for more personnel and support staff to relieve the large volume of paperwork (Jerin *et al.*, 1995). A more recent study conducted in Idaho found that one of the major reasons for the denial of services was staff shortages (King *et al.*, 2020). Additionally, many victim service providers have consistently demanded more professional on-the-job training and education (Clawson, 2003; Neff *et al.*, 2012; Spence-Diehl & Potocky-Tripodi, 2001). More training and education are critical for victim service professionals to help them better be prepared to advise crime victims about adequate resources as well as help-seeking strategies.

Rurality

The literature suggests that victim service providers located in rural areas report more barriers to service provision to crime victims compared to providers located in urban

areas. Rurality creates issues pertaining to geographic isolation and fewer resources available to victims (Elliott *et al.*, 2013). A recent study of 94 victim service providers found that agencies located in rural counties reported more needed services, such as counseling, language services, childcare, shelters, legal assistance, and emergency services (Gillespie *et al.*, 2021). Rurality is also linked with service inaccessibility. Although, in general, victim service providers consistently report the need for affordable and accessible transportation regardless of location, rural providers report more barriers from the lack of transportation and longer travel distance, which prohibit them from offering immediate response and services especially for victims who rely on public transportation (Hochstein & Thurman, 2006; King *et al.*, 2020). Another critical concern regarding rurality is staff capacity. Previous research reports that compared to urban providers, rural providers are likely to struggle with more staff shortages, limited resources, and fewer opportunities for ongoing professional training and education (Houston-Kolnik & Vasquez, 2020; King *et al.*, 2020; Yun *et al.*, 2009).

Victim Populations

Some notable studies have suggested that a lack of knowledge about the victim populations service providers serve may also prevent quality service. For instance, a study of victim service providers serving victims of human trafficking indicated that service providers' lack of knowledge of trafficking issues might hamper their ability to identify victims of human trafficking and provide adequate services (Clawson *et al.*, 2003). Another study of service providers' perspectives on barriers affecting the self-disclosure decision-making process among male survivors of child sexual abuse highlighted the importance of gaining knowledge for service providers about societal norms, gender roles, masculine identity, and emotions to better serve the particular population (Sivagurunathan *et al.*, 2019). Furthermore, serving immigrant populations requires particular attention to cultural aspects (Keller & Brennan, 2007; Kulwicki *et al.*, 2010; Lewis *et al.*, 2005). A study of cultural challenges to service delivery for Arab immigrant victims of domestic violence found that many providers had multiple challenges due to victims' disagreement with the use of services, lack of trust in confidentiality, and cultural norms that bring shame upon the victims (Kulwicki *et al.*, 2010).

Current Study

The current study builds on existing research by including an important variable of types of service providers in the analysis to investigate differences in victim service providers' barriers to serving crime victims. We aim to answer the following research questions:

1. Are there any differences across the providers in the reported barriers for why they are unable to serve victims?
2. Are there any differences across the providers in staff and caseload capacity, underserved or vulnerable victim populations, and victimization types?

The strength of this research comes from an in-depth analysis of victim service providers' barriers to service provision by focusing on the types of providers, which have not been exclusively explored. Findings can be used by key stakeholders in victim advocacy, criminal justice, and research roles.

Methods

Data

The current study uses the 2019 National Survey of Victim Service Providers (NSVSP) funded by the Bureau of Justice Statistics (BJS) and the Office for Victims of Crime (OVC). The data was collected from May to November 2019 with an eligible sample of 7,237 victim service providers. A list of victim service providers was compiled as part of the 2018 NSVSP conducted one year before the 2019 survey was conducted. The sample was selected based on a single-stage stratified sampling method in all states and population size was considered in 14 states with a larger population. Two data collection methods were jointly utilized. First, all eligible providers were invited to complete a web survey. Second, if they did not complete the web survey, trained interviewers reached out to them via telephone. The providers were asked about the types of services they provided to victims, demographic information about victims, staff capacity, the number of victims they provided direct services, and reasons for not being able to serve victims. The response rate was 57.7%, which produced a total sample of 3,269 victim service providers.

Variables

Five types of victim service providers are included in the analysis: (a) nonprofit organizations, (b) government agencies, (c) medical facilities, (d) campus organizations, and (e) tribal governments. Nonprofit organizations include any nonprofit victim support coalitions and faith-based entities. Government agencies are criminal justice agencies, such as law enforcement, prosecution, courts, corrections, and juvenile justice serving the general population. Medical facilities include hospitals, medical facilities, and emergency facilities. Campus organizations include law enforcement, campus securities, health service programs, and victim service coalitions specifically serving the campus community. Tribal governments are criminal justice agencies and nonprofit victim support coalitions specifically serving the tribal, Native American, and/or Alaskan Native population.

Barriers to service provision are measured with a survey question to indicate the primary reason victims seeking services could not be served by the providers. A total of 3,164 (96.8%) victim service providers answered that they had a barrier to assisting victims with response options: (a) program reached capacity, (b) services were inappropriate for the victim, (c) victims' situation or the crime type did not meet requirements for receiving services, (d) victims' service needs did not fall within the organization's or program's mission, (e) victims could not attend services (e.g., due to transportations, childcare needs, or some other needs), and (f) other reasons. Appendix A lists other reasons for being unable to serve victims.

Three additional variables are used to further investigate if there are any differences in staff and caseload capacity, underserved or vulnerable victim populations, and victimization types across the providers. Staff capacity includes the number of full-time paid staff and the number of active interns or volunteers. The caseload capacity is measured with the number of direct services they provided during the past 6 months. Direct services mean direct assistance including referrals, counseling, notices of court proceedings, legal assistance, shelter, medical response, and other services that fit the victims' needs. Underserved or vulnerable victim populations include children under age 13, adolescents from 13 to 17, adults 60 or over, male victims, African Americans, Hispanic/Latinos, Asian/Hawaiian/Pacific Islanders, and non-English speakers. Victimization types involve intimate partner violence, human trafficking, sex crimes, crimes against children, crimes against the elderly, violent crimes including homicide, robbery, and assault, and property crimes including burglary, motor vehicle theft, and financial fraud or exploitation.

Analysis Strategies

Descriptive statistics were used to outline the distributions and characteristics of the victim service providers, barriers to service provision, staff and caseload capacity, underserved or vulnerable victim populations, and victimization types. Chi-square tests were performed to explore the differences across the victim service providers with three categorical variables for barriers to service provision, underserved or vulnerable victim populations, and victimization types. An ANOVA (Analysis of Variance) test was performed with staff capacity and caseload capacity.

Results

Table 1 provides an overview of the distributions and characteristics of victim service providers and the victim populations that they served. Nearly half of the providers were nonprofit organizations (49.8%), followed by government agencies (40.3%). Medical facilities, campus organizations, and tribal governments remain at around 3% of all

providers. Of all providers, 21% reported that they were unable to serve victims because the victim's situation did not meet the requirements, followed by a reason that the victim's service needs did not fall within the mission of their organization or program (19.0%) and a reason that the program reached its capacity (16.7%). In addition, 21.2% reported that they had other specific reasons that did not fall under the given response options. Appendix A lists responses in the "other" category.

Across the victim service providers, the average number of full-time paid staff was 13.6 and the average number of interns or volunteers was 17. It is important to highlight that the providers relied more on interns and volunteers than full-time paid staff. The average number of contacts received from victims was 1,322. Although whether the providers tracked victims' demographic information varied, approximately, 60% of the providers offered some useful information. Of 1,958 providers that tracked victims' age, 24.1% reported that they served children under age 13, 25.3% reported that they served adolescents from 13 to 17, and 21% reported that they served adults 60 or over. Of 2,036 providers that tracked victims' gender, 17.3% reported that they served male victims. Of 2,012 providers that tracked victims' race and/or ethnicity, 25.1% reported that they served African Americans, 24.3% reported that they served Hispanic/Latinos, 18.2% reported that they served Asian/Hawaiian/Pacific Islanders, and 16.7% reported that they served American Indian/Alaska Natives. Of 2,106 providers that tracked victims' English proficiency, 25.3% reported that they served victims with limited English proficiency. A total of 2,151 providers tracked the types of services that victims received in their organizations or programs. Among those providers, 29.4% reported that they offered services to victims of intimate partner violence, followed by victims of crimes against children (27.2%) and victims of violent crimes (26.6%).

The primary goal of this study is to compare any differences in barriers to service provision across different types of victim service providers. As mentioned earlier, the providers in this study were asked to report why they were unable to offer services to crime victims. Table 2 presents the analyses of prevalence, including percentages of the five service providers in the barrier categories, and the chi-square tests for significant differences. First, 29.3% of nonprofit organizations reported a greater prevalence of the barrier that they were unable to serve victims because they reached capacity than other providers, whereas government agencies (2.7%) reported the lowest prevalence. Second, 17% of medical organizations reported that they were unable to provide services to certain victims because the services they provided were inappropriate for the victims. Third, 31.5% of government agencies reported a greater prevalence of the barrier that they had to turn victims away because victims' situations did not meet the requirements, where medical facilities (12.4%) reported the lowest prevalence in the category. Fourth, 28.6% campus organizations reported that they had other reasons

Table 1: Descriptive Statistics for Variables Included in the Analyses

Characteristics	*Frequency*	*Mean*	*%*
Victim service providers			
Nonprofit organizations	1,628		49.8
Government agencies	1,318		40.3
Medical facilities	116		3.5
Campus organizations	107		3.3
Tribal governments	100		3.1
Primary reason for not being able to serve victims			
Program reached capacity	528		16.7
Services were inappropriate for victim	352		11.1
Victim's situation did not meet the requirements	665		21.0
Victim's service needs did not fall within the mission	600		19.0
Victim could not attend services	349		11.0
Other	670		21.2
Organizational capacity			
Number of full-time paid staff		13.6	
Number of interns or volunteers		17.0	
Number of calls received from victims		1,322	
Vulnerable or under-representative victims			
Children under 13	471		24.1
Adolescences from 13 to 17	496		25.3
Adults 60 or over	425		21.0
Male	590		17.3
African American	505		25.1
Hispanic/Latino	488		24.3
Asian/Hawaiian/Pacific Islander	366		18.2
American Indian/Alaska Native	336		16.7
Non-English Speaking	533		25.3
Victimization types			
Intimate partner violence	632		29.4
Human trafficking	434		20.2
Sexual crime	545		25.3
Crime against children	597		27.8
Crime against elderly	440		20.5
Violent crime	572		26.6
Property crime	539		25.1

for not being able to serve victims, whereas nonprofit organization (14.8%) reported the lowest prevalence. Lastly, the remaining two barriers – victims did not fall under the organization's mission and victims could not attend the services – did not show statistically significant differences across the providers.

Table 2: Barriers to Service Provision

	Nonpro.	Gov.	Medical	Campus	Tribal	$\chi^2(p)$
	%	%	%	%	%	
Reached capacity	**29.3**	2.7	9.8	8.6	7.4	**374.63*****
Services inappropriate	12.6	8.7	**17.0**	11.4	11.7	**15.30****
Situation did not meet	12.9	**31.5**	12.4	17.1	30.9	**156.62*****
Service needs did not fall	18.5	19.3	17.9	26.7	16.0	5.05
Victim could not attend	11.9	10.0	16.1	7.6	7.4	8.04
Other	14.8	27.9	25.9	**28.6**	26.6	79.67***

χ^2 = chi-square, *** $p < .001$; ** $p < .01$; * p -value < .05.

In addition to the differences in victim service providers' barriers by the types of providers, any differences in staff and caseload capacity, underserved or vulnerable populations, and victimization types were explored. Table 3 presents the analyses of means and the ANOVA tests for significant differences. Nonprofit organizations had the largest number of full-time paid staff (mean=17.1), followed by government agencies (mean=10.8) and medical facilities (mean=8.1). Regarding the number of interns and volunteers, nonprofit organizations had the largest number of interns and volunteers (mean=30.4), followed by campus organizations (mean=6.7) and medical facilities (mean=4.4). When it comes to caseload capacity, government agencies had the largest number of direct services (mean =2,219.3), followed by nonprofit organizations (mean=1,025.5) and medical facilities (mean=710.7).

Table 3: Staff and Caseload Capacity during the Past 6 Month

	Nonpro.	*Gov.*	*Medical*	*Campus*	*Tribal*	*F(p)*
	$\bar{x}$	$\bar{x}$	$\bar{x}$	$\bar{x}$	$\bar{x}$	
# of full-time paid staff	**17.1**	10.8	8.1	8.4	5.0	**5.70*****
# of interns or volunteers	**30.4**	3.0	4.4	6.7	.6	**43.65*****
# of direct services	1,025.5	**2,219.3**	710.7	222.5	106.1	7.813***

$\bar{x}$ = mean, *** $p < .001$; ** $p < .01$; * p -value < .05.

Table 4 shows significant variations across the providers in the victim populations of adults aged 60 years or over, males, African Americans, American Indians/Alaskans, and individuals with limited English proficiency. First, 26.7% government agencies reported that they served adult victims adults aged 60 years or over, whereas campus organization (6.7%) reported the lowest). In addition, 35.7% of government agencies reported the highest prevalence of victim populations of males, whereas medical facilities (22.1%) reported the lowest. Government agencies also reported the highest prevalence of victim populations of African Americans (30.2%), whereas tribal

governments (10.9%) reported the lowest. Not surprisingly, 40% of tribal governments reported that the victim populations they served were American Indians/Alaskans. Finally, 26.9% of nonprofit organizations reported that the victims they served were non-English speakers. No statistical differences were found for the populations of children, adolescents, Hispanics/Latinos, and Asian/Hawaiian/Pacific islanders.

Table 4: Underserved or Vulnerable Victim Populations

	Nonpro.	*Gov.*	*Medical*	*Campus*	*Tribal*	$\chi^2(p)$
	%	*%*	*%*	*%*	*%*	
Children under 13	24.1	26.7	20.5	13.3	12.2	9.00
Adolescences 13 to 17	25.5	27.3	20.5	17.8	16.3	5.49
Adults 60 +	21.3	**26.7**	8.4	6.7	18.4	**22.23*****
Male	26.7	**35.7**	22.1	32.7	27.5	**17.24****
African American	23.9	**30.2**	20.0	27.7	10.9	**15.32****
Hispanic/Latino	23.5	27.7	22.4	21.3	16.4	5.97
Asian/Hawaiian/Pacific	17.5	20.9	18.8	21.3	7.3	7.66
American Indian/Alaska	14.7	18.9	20.0	14.8	**40.0**	**27.77*****
Non-English Speaking	**26.9**	25.0	22.2	18.2	1.8	19.75***

χ^2 = chi-square, *** $p < .001$; ** $p < .01$; * p -value < .05.

Table 5 presents significant differences across the victim service providers in all victimization types, except human trafficking. It is found that government agencies reported a greater prevalence of service requests for intimate partner violence (37.6%), crimes against children (34.6%), crimes against the elderly (31.7%), violent crimes (36.8%), and property crimes (44.5%) than any other service providers analyses in this study. In addition, 33.3% campus organizations reported that their service requests were related to sex crimes.

Table 5: Victimization Types

	Nonpro.	*Gov.*	*Medical*	*Campus*	*Tribal*	$\chi^2(p)$
	%	*%*	*%*	*%*	*%*	
Intimate partner violence	25.3	**37.6**	27.8	34.8	30.0	**32.13*****
Human trafficking	20.8	20.1	24.4	13.0	10.0	7.35
Sex crime	21.6	33.0	21.1	**33.3**	25.0	**31.94*****
Crime against children	25.1	**34.6**	26.7	21.7	23.3	**20.83*****
Crime against the elderly	16.5	**31.7**	12.2	7.2	18.3	**72.08*****
Violent crime	21.9	**36.8**	31.1	24.6	18.3	**51.07*****
Property crime	17.3	**44.5**	16.7	15.9	15.0	176.75***

χ^2 = chi-square, *** $p < .001$; ** $p < .01$; * p -value < .05.

Discussion

The overall purpose of this study was to extend the research on crime victim services to examine differences in barriers to service provision by types of victim service providers. This study also extends the research by including staff and caseload capacity, underserved or vulnerable victim populations, and victimization types in the analysis. Research Question 1 examined whether there were any differences in victim service providers' barriers to service provision across the providers. It was found that nonprofit organizations reported a higher proportion of the barrier of excess capacity. This finding mirrors previous studies that indicate that nonprofit providers emphasize the need to rebuild their organizational capacity (Donaldson, 2007; Houston-Kolnik & Vasquez, 2020). Nonprofit providers offer a variety of social and health services such as domestic violence shelters, rape crisis centers, counseling, and resource mobilization. Securing these services will positively impact the quality of services and the quantity of service recipients. Moreover, it was found that medical organizations reported a higher proportion of the barrier that the services they provided were inappropriate for the victims. It might be a situation in which victims might seek services for mental health concerns or counseling that the medical facility would not provide. It was also found that government agencies reported a higher proportion of the barrier where victims' situation or the crime type did not meet the requirements for receiving services. This might be a case where the incident lacked evidence sufficient to proceed with a criminal charge or the incident was not necessarily a criminal case. Additionally, it was found that campus organizations reported a higher proportion of having reasons other than those analyzed in this study. Despite a decent amount of literature on victim service providers' barriers to service provision, much remains unknown.

Research Question 2 examined if there were any differences across the providers in staff and caseload capacity, underserved or vulnerable victim population, and victimization types. It was found that nonprofit organizations had the largest number of full-time paid staff, interns, and volunteers compared to other service providers included in the analysis. This finding debunks a general perception regarding staff shortages in nonprofit organizations in the interest of assisting crime victims. In fact, nonprofit organizations are equipped with the largest staff capacity compared to government agencies, medical facilities, campus organizations, and tribal governments. However, this does not indicate that nonprofit organizations are equipped with sufficient staff capacity nor that the staffing issue is not a barrier to their service provision. In addition, this research found that government agencies provided the largest quantity of direct services to victims compared to other service providers. This is an anticipated finding because criminal justice agencies handle all criminal matters, and they serve the general public. Little research has explored barriers of government agencies to assist victims of

crime. Little research has focused on criminal justice agencies' barriers to collaborating with victim advocates (Gaines & Wells, 2017; Rich & Seffrin, 2013). More research attention is needed to improve our understanding of what government agencies' barriers are and how they address the needs of crime victims.

When it comes to underserved or vulnerable victim populations, there were significant cross-agency variations in five categories including adults aged 60 or over, males, African Americans, American Indian/Alaskans, and victims with limited English proficiency. Government agencies served adults aged 60 or over, males, and African American victims more than all other providers. Tribal governments served more American Indian/Alaskan victims than all other providers. Nonprofit organizations served more victims who had limited English proficiency than all other providers. These are important findings in regard to resource allocation planning. Response and recovery efforts for crime victims require timely intervention, support, and coordination with various types of service providers such as law enforcement, medical assistance, childcare, or counseling in order to help victims and their families. Thus, it is critical to find an optimal framework to allocate resources to the populations requesting assistance from each organization to maximize their competency in service provision.

Furthermore, six categories of victimization types showed significant cross-agency variations. Government agencies handled more cases of intimate partner violence, crimes against children, crimes against the elderly, violent crimes, and property crimes. Campus organizations handed more cases of sex crime compared to other service providers. This is an anticipated finding as government agencies handle all criminal matters. And it is critical to point out that victims of various types of crimes contact government agencies more likely to receive services and secure their safety. It is highly recommended that researchers in the future evaluate the current service availability and effectiveness of the services that government agencies provide and assess their needs. Perhaps they may have particular needs and preferences to better serve the particular population they frequently interact with or training to help staff better serve diverse populations.

Conclusions

Assistance and support from victim service providers are integral to victims' recovery. The primary purpose of the current research was to explore variations in barriers to assisting crime victims across different types of victim service providers. Overall, this study identified a number of important aspects of victim service providers' barriers to service provision in regard to types of service providers. In particular, government agencies reported heavier caseloads handling more diverse types of criminal cases with fewer staff capacity than other providers included in the analysis. As a primary reason

for being unable to serve victims, they reported that it was because victims' situation or crime type did not meet the requirements, so they needed to turn the victims away. Nonprofit organizations, on the other hand, reported lighter caseloads with more staff capacity compared to government agencies. However, it is critical to pay particular attention to their voice that they had to turn some victims away because they reached the capacity to continue to provide effective services to victims. Certainly, immediate efforts are needed to build and strengthen the capacity of nonprofit organizations that serve diverse victim populations.

Our findings must be considered within the context of the limitations of the research. While our analysis has focused on variations across different types of service providers, there are many other challenges that prohibit providers from serving victims of different crimes. For example, location and rurality were not explored in our analysis. In addition, there must be an in-depth analysis of the "other category" to explore if there are any differences in patterns of qualitatively reported barriers in the category. However, the present research contributes to an understanding of variations in the reported barriers to service provision by analyzing types of victim service providers with a large, national sample. With a nationally representative sample, this research provided an overview of victim service providers' barriers to service provision as well as caseload, staff capacity, underserved or vulnerable population, and victimization types that were handled within the organizations and programs.

Victim service providers may have more unknown complexity in their capacity to provide quality services to crime victims. Thus, more research should be conducted to further our understanding of victim services and their barriers to service provision. Future research should explore any differences in service outcomes and effectiveness between victim service providers. A research question is to assess whether victim service providers with more resources can better empower victims, increase victims' satisfaction with the service, and reduce subsequent victimization, compared to providers with fewer resources. In addition, government agencies, such as victim service divisions in law enforcement or prosecution, tend to be excluded from literature on victim service provision. More research attention is needed to improve our understanding of what government agencies' barriers are and how they address the needs of crime victims.

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Appendix A: List of Other Reasons for Being Unable to Serve Crime Victims

Insufficient financial resources
• Due to 60% funding cuts in the trafficking victim assistance program. • Lack of funding for travel up front to court. • Lack of funding to relocate victims/witnesses. • Our organization does not have emergency funds.
Lack of available services
• Client seeking therapy services and services were wait listed. • Lack of available services and resources to meet the victims' needs. • Limited services for victims of mass fraud and cyber intrusion crimes. • Need was beyond the programs scope. • Not enough Pediatric SANEs available on staff to meet the need. • We have served everyone has reached out to us - but we have been operational for only 2 months. • The waitlist for counseling services in our community has been 3-4 months.
Criteria unmet
• All victims of violent crime receive services only if we have a police report. • All victims seeking services can be served only if the incident is a sexual assault, dating/ domestic violence, and/or stalking. • Need a specific referral from Law Enforcement or Department of Human Service to serve victims. • They do not meet criteria for emergency shelter due to their cases are unrelated to their domestic violence history. • Clients did not meet criteria of program, such as, age (Adult Protective Services), or income guidelines (benefits). • Did not meet grant criteria (e.g., Victims' income is over the criteria). • Victim did not meet eligibility requirements of age or level of disability. • Did not meet age requirement (under 18 for a new case). • Must be a victim of juvenile crime only. • Suicide is considered non-criminal in our organization. • The only issue we have ran into is people not following up or calling us for other crises like suicidal ideation. • Victim was abuser and survivor (grant guidelines prohibit serving abusers).
Staffing issues
• Lack staff to meet with survivors and organize educational efforts. • All staff are on-call only. Approximately 1% of 24-hour coverage was not covered with forensic nursing staff. • did not have forensic nurse available at time of sexual assault or abuse victim arrival to the emergency department. • patient advocate not available at time of sexual assault or abuse patient arrive to the emergency department. • With only 2 full time employees one or both of us are in court and not available to assist with emergency walk-ins or referrals for civil protection order assistance. • We are volunteer based - we currently do not have enough volunteers to match up with our 160 families waiting. • We are limited by how many available advocates we have as to how many children we can serve. • We do not have enough court-appointed special advocate (CASA) volunteers to meet our child victim's needs.

Appendix A. Continued

Staff training
• Lack of training of new staff. • The social workers coerced the family to go to the providers that the social workers wanted. • Legal question that the organization staff cannot give advised to victim. • Staff was not even aware of any victims being turned away.
Mental health/substance abuse/medical/safety issues
• Severity of mental health issues requiring those needs be met prior to being able to shelter or educate victim. • Due to severe mental health needs that were beyond the scope of safe house standards for stability and safety. • We see a lot of people dealing with mental health, drug abuse and homelessness. If they receive our services, they don't stay long. • Substance use barriers impacted engagement. • Residents requires medical care beyond the capacity of the shelter staff. • Residents is a danger to herself or others. • Returning resident has jeopardized the safety of other residents and/or staff.
Housing, shelter, food, and transportation
• Agency doesn't have a shelter. • All of the shelters were overcrowded and refused our victims. • In housing, program reached capacity. • It may be personal barriers such as childcare or transportation issues. • Lack of affordable, accessible housing, lack of transportation infrastructure. • We do have food boxes for those who need emergency food.
Rurality
• Some rape victims are hesitated to come forward in a small rural community. • Rural areas draw a huge impact for traveling out of town. • We did not always have the type of services they need as we are a very rural small community. • We are the only victim service provider in our rural area, poverty stricken work or other reasons would often reunify with perpetrator, largely due to impoverished community, addiction, chronic homelessness, or no housing available.
Issues with criminal justice procedures
• Crime did not occur in our jurisdiction. • Crime was not committed or insufficient evidence to proceed with charges. • Criminal charges were not filed. • Case still under investigation/victims unidentified. • Lack of attorneys willing to take pro-bono cases. • Suspect never identified. • Courts did not appoint us to the case.
Decline by family/caregiver
• Caregivers of child victims were not cooperative with the investigation. • Family declined service for minor patient. • Lack of motivation to receive services by family/caretaker. • Parent declined or stopped bringing victim for services.

Appendix A. Continued.

Victim refusal
• Victims often become uncooperative. • Victims chose to not respond to our phone calls. • Client would come in to do an in-take but would not return. • The children/victims refused to participate with court-appointed special advocate CASA. • Victims' lack of knowledge of our programs • Victims request for the charges to be 'dropped' (e.g., domestic violence). • Fear of the defendant or reconciled with defendant. • Victim was afraid to come forward. • Victims did not show up to court hearing. • We had several no shows for forensic interviews but have no idea why they didn't come. • Timeliness of request for forensic medical exam post-assault. • They would refuse due to previous negative history primarily with state agency/CPS or law enforcement.
Language barrier
• At times in the past there have been language barriers, but we now have someone who works in our office that is bilingual. • Insufficient number of bilingual Spanish speaking counselors. • Languages available on staff/phone interpretation is utilized but not preferred by victims/survivors.