CURRENT AND PROMISING PRACTICES FOR INCREASING VICTIMS' SERVICE USE AND REFERRALS

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INTRODUCTION

Background

A variety of programs and services currently exist for victims of crime or tragic circumstances in Ontario, Canada to help alleviate their psychological, physical, and financial pain. These include legal services, victim compensation programs and other financial supports, victim/witness assistance programs, counselling, rape crisis centres, domestic violence shelters and services, and so on (Ontario Ministry of the Attorney General, 2018). On a given day in Canada, victim service providers serve over 10,000 victims, the majority of whom are women and victims of violent offenses (many are female victims of domestic violence; Allen, 2014).

The Canadian provinces and territories are responsible for victim service provision and some have integrated, province-wide networks of victim service providers (Allen, 2014). One such network is Victim Crisis Assistance Ontario (VCAO; previously "Victim Crisis Assistance and Referral Service" [VCARS]). With over 60 sites currently across Ontario, VCAO offers direct services to victims including on-site crisis intervention (emotional and practical support) 24 hours a day, seven days a week, as well as safety planning; needs assessments; referrals to other supports and services; counselling; and assistance with transportation, crime-scene cleanup, and funeral expenses (Ontario Ministry of the Attorney General, 2018). VCAO is funded by the government and operated locally by not-for-profit community agencies. Many VCAO sites work in close cooperation with police and other emergency service providers and use trained volunteers to provide crisis intervention.

Victims may be best served within the immediate time (4 hours) after the incident (Executive Director of Victim Services Wellington, personal communication, January 2018). In 2011/2012, 48% of VCAO ("VCARS" at the time) providers reported that their main service delivery was at the scene of the incident (Allen, 2014). Because police and other emergency service providers are often the first official point of contact for victims after a crime or tragic event, they are important "gatekeepers in referring victims to victim support" (Winkel, Wohlfarth, & Blaauw, 2004, p. 118). Research in the U.S. has found that most victims of violent crime did not receive direct assistance from a victim service agency from 2000 to 2009 (Langton, 2011). However, when the crime was reported to police, victims were more than 3 times more likely to receive assistance from a victim service agency than when the crime was not reported (14% compared to

4%; Langton, 2011). This suggests either that police refer victims to service agencies or that more victims who contact the police also contact victim service agencies (or vice versa; Langton, 2011).

Moreover, as a result of a 1986 United Nations' declaration ("Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power"), victims' rights and needs became a key concern for policing agencies. Ontario (and other locations) introduced in its Victims' Bill of Rights the right to "have access to information concerning services and remedies available to victims" (Ontario Ministry of the Attorney General, 2015). Police in Ontario are also mandated to assist victims of crime (Ontario Ministry of Community Safety & Correctional Services, 2018). Together, these policies suggest that police have some responsibility in informing victims about available supports. Nevertheless, it is currently unclear how such victim-oriented policy commitments have impacted police services and if/how they meet the needs of victims in Ontario and elsewhere (e.g., Wilson & Segrave, 2011).

When police and other emergency service providers inform victims about VCAO, specifically, it is up to the victim to decide whether to take advantage of this service right away, as a follow-up service, or not at all. Thus, when VCAO is not used by victims who have come to the attention of emergency service providers, it is either because they declined, did not end up accessing the services, or because they did not understand or were not informed about the services.

Current Study

The Executive Director of Victim Services Wellington approached the Research Shop in late 2017, concerned that most victims who come into contact with emergency service providers in Guelph-Wellington were not using Victim Services Wellington (a VCAO site). Indeed, in Canada in 2014, only 31% of violent and non-violent crimes were reported to police and only 14% of victims of violent crimes contacted formal victim supports and services (and even fewer victims of non-violent crimes; Perreault, 2015). Thus, we aimed to better understand the current state of affairs with respect to victims' service use and referrals for VCAO. We also aimed to better understand the policies and practices that may help increase the number of people using and being offered support by VCAO. Specifically, our research goals were to examine:

1. If and how VCAO sites are currently being presented to victims by emergency service providers at the time of the incident.

2. What types of messages used by emergency service providers work best for referring victims to VCAO sites (i.e., increase referrals received by VCAO sites).

3. What other policies and procedures used by VCAO sites and/or emergency service providers help encourage victims to use VCAO and/or increase referrals.

Before presenting the methods and results of our research, we review information currently available in the academic and grey literature on: (a) barriers to victims' service access, (b) barriers preventing referrals between services, and (c) potentially promising practices for increasing victims' service use and referrals.

LITERATURE REVIEW

Very few crime victims use formal victim services (Perreault, 2015; Sims, Yost, & Abbott, 2005). This may be a result of barriers that can prevent victims from accessing services on their own and emergency service providers from referring victims to available services.

Barriers to Victims' Service Access

Barriers identified in the literature that can prevent victims from accessing health and social services include:

- Limited availability of services, especially in rural areas (Booth & McLaughlin, 2000; Logan et al., 2004);
- Physical accessibility barriers, such as limited transportation, telephone access, or childcare, which may prevent victims from reaching services or attending appointments (Booth & McLaughlin, 2000; Gillis et al., 2006; Logan, 2004);
- Financial barriers; for example, some services may be less affordable for those with lower income or those who do not have health insurance (though this would not apply to free services like VCAO; Booth & McLaughlin, 2000);
- Limited or no knowledge about the availability of victim services or the range of services that programs can offer (Logan, 2004; Sims et al., 2005);
- Lack of perceived need; for example, victims feeling that they can rely on themselves or family/friends for needed support, or finding the service or resource irrelevant to their needs (Morton et al., 2014; Sims et al., 2005);

- Victims feeling overwhelmed with information and/or contacting a new service provider (Gillis et al., 2006; Morton et al., 2014);
- Limited privacy and confidentiality, especially in rural areas (Logan et al., 2006); and
- Negative interactions with service providers (Logan et al., 2006).

Negative interactions between victims and service providers appears to be one of the greatest barriers in preventing victims from accessing services. Research finds that any negative interaction with service providers at any level may severely affect a victim's persistence in seeking services (Campbell, 1998; Campbell et al., 1999; Campbell et al., 2001; Gondolf 2002; Logan et al., 2004; Ullman & Filipas, 2001). Positive responses by service providers are crucial to a victim's decision to access and/or use support services (Ahrens, Stansell & Jennings, 2010; Campbell, 2008; Halstead, Williams, & Gonzalez-Guarda, 2017; Moore, 2016; Morton et al., 2014; Orchowski, United, & Gidycz, 2013; Stermac, Horowitz, & Bance, 2017; Wooten & Mitchell, 2016).

Given the link between contacting the police and receiving assistance from a victim service agency (Langton, 2011), barriers to contacting the police may also prevent victim service use. Victims who do not report an incident to police often (Perreault, 2015):

- Felt that the incident was not important enough or believed the police would not consider it important enough;
- Felt the incident was a personal matter;
- Did not want to get the offender in trouble;
- Feared revenge; or
- Did not expect adequate results (e.g., due to a lack of crime evidence for meaningful police response, believed that the offender would not be adequately punished, received unsatisfactory service from the police in the past).

Gender may also be related to victims' service access. In Canada and the U.S., women who are victims of violence are more than twice as likely than men to contact or receive assistance from a formal victim service agency (Langton, 2011; Perreault, 2015). In addition to many of the same barriers noted above, representatives from victim support

and criminal justice agencies in Australia have described the following barriers that may uniquely prevent male victims of violence from accessing formal support services:

- Shame of the victimization and being perceived as "unmasculine";
- Not meeting service eligibility criteria;
- Real and perceived lack of services that are appropriate or meet men's needs;
- Victim service and criminal justice personnel failing to recognize male victims as requiring formal assistance; and
- Lack of male support workers (Bricknell, Boxall, & Andrevski, 2014).

Finally, victims of violent crime are more likely to use victim services than victims of non-violent crime (Allen, 2014; Sims et al., 2005). This may suggest that violent crime is more traumatizing and leads victims to seek services (Sims et al., 2005). Or, it may suggest that emergency service providers are more inclined to inform victims of violent crimes about available services (Sims et al., 2005).

Barriers Preventing Referrals between Services

Barriers identified in the literature that can prevent referrals between agencies include:

- Differences in agency philosophies, mandates, and agendas, which may limit or hinder collaboration;
- Lack of or poor communication, engagement, or commitment between agencies;
- Limits to confidentiality and information-sharing, which may limit trust or ability to collaborate;
- Lack of or inaccurate understanding of other agencies' roles; and
- Limited knowledge about the availability of other services (Hochstein & Thurman, 2006; Morton et al. 2014; Vinton & Wilke, 2014).

Service provider knowledge about the availability of other services and resources is crucial for proper referral and lack of this knowledge reduces victims' access to needed resources (Morton et al., 2014; Vinton & Wilke, 2014). Often, professionals are unaware of or are not knowledgeable about services and resources outside their own field of expertise (Hochstein & Thurman, 2006; Vinton & Wilke, 2014). For example, police

officers sometimes lack knowledge about the roles of other service providers and lack comfort in making referrals, and these are barriers to successful collaboration (Kirst et al., 2012; Morton et al., 2014; Rich & Seffrin, 2013).

Finally, while victims' rights and needs are increasingly a key concern for policing agencies, some argue that continued shift in police culture is needed (e.g., Wilson & Segrave, 2011). For example, Wilson and Segrave (2011) argue that policing continues to be perceived largely from a "crime-fighting law-enforcement paradigm" (p. 488). This must shift in order to promote improved police interactions with victims and "acceptance of victim service as an integrated aspect of the work of policing" (Wilson & Segrave, 2011., p. 489).

Promising Practices for Increasing Victims' Service Usage and Referrals

The above barriers suggest, for example, that:

- Victim services and emergency service providers should provide an empathetic and understanding response to victims;
- Emergency service providers should be knowledgeable, adequately trained, and regularly updated about victim services and other available supports in their communities (Kirst et al., 2012; Logan et al., 2004; Rich & Seffrin, 2013); and
- Institutional referral policies should be implemented in service agencies (Kirst et al., 2012).

In addition, integrated and/or collaborative agency response has time and again been recommended for victim service provision (Day et al., 2010; Hovell, Seid & Liles, 2006; Meyer, 2014; Morton et al., 2014; Robinson, 2006; Wilcox, 2010).

Integrated and Collaborative Agency Response

Integrated responses are designed to offer more streamlined referral processes between agencies, such as emergency services and victim support services (Meyer, 2014). Wilson and Segrave (2011) argue that police-based victim services that use a referral model whereby front-line police "connect with community-based and government services outside the police organization" (p. 486)—similar to VCAO's model—require policies and practices to support interagency collaboration and partnership.

Research suggests that an integrated response provides improved service delivery and outcomes for victims (Robinson, 2006; Wilcox, 2010). Integrated and collaborative response models facilitate interagency communication and referrals and often result in improved service access and delivery (Day et al., 2010; Hovell, Seid, & Liles, 2006; Meyer, 2014; Morton et al. 2014; Robinson 2006). For example, a number of studies have found that a coordinated community response to domestic violence—that includes comprehensive, community-based services for victims, rather than just criminal justice responses—helps to better protect victims (Bowman, 1992; Fleury et al., 1998; Gamache, Edleson, & Schock, 1988; Hovell, Seid, & Liles, 2006; Langan & Innes, 1986). Partly because police actions alone were deemed an insufficient response to domestic violence and other tragic/traumatic events, many communities have added victim crisis services to their police response (Hovell, Seid, & Liles, 2006; Martin, 1997). This has promoted a collaboration between criminal justice and social service agencies (Hovell, Seid, & Liles, 2006). In these cases, services for victims have been provided by either an outside community organization working in partnership with the police, or by specially trained police personnel (Hovell, Seid, & Liles 2006).

Most victim service providers in Canada have already established working relationships or partnerships with other agencies, programs, or service providers—most commonly with: other victim service agencies, policing and other emergency services, transition homes or shelters, and social services (Allen, 2014). However, these partnerships may be inconsistent and their impact on victims' service use and referrals remains unknown.

The current study helps to fill a number of gaps in the literature by examining the current state of affairs with respect to victims' service use and referrals for VCAO, as well as policies and practices that may help increase the number of people using and being offered support by VCAO.

METHODS

Recruitment

Upon approval by the University of Guelph Research Ethics Board, our community partner (the Executive Director of Victim Services Wellington) contacted VCAO sites across Ontario using a list of 49 email addresses and online contact forms that we gathered from websites. This initial email explained the purpose of the study and requested that contacts participate in a voluntary online survey by a specified date.

Recruitment focused on Executive Directors from each site; however, other staff members were recruited when the Executive Director was unavailable. Our community partner also sent a reminder email to all contacts about one week prior to the deadline.

Online Survey

We used online surveys through Qualtrics. Participants who accessed the survey link provided in the recruitment and reminder emails were first directed to the consent form. Those who chose to participate clicked "I Agree" and the survey page followed. Those who did not wish to participate clicked "I do not wish to participate" and their browser was redirected to a thank-you page. Participants could withdraw at any time during the survey by clicking "withdraw from study" at the bottom of every page. Survey responses were anonymous.

Survey questions asked about participants' position, calls and referrals received, how emergency service providers make referrals to victims, training and education for emergency service providers, helpful practices for increasing referrals, and so on (see Appendix A for the complete list of survey questions). The research team created this plain language English survey with input from our community partner. Time required of participants was less than 10 minutes to read the recruitment and reminder emails and approximately 30 minutes to complete the survey. Participation was voluntary and we did not provide any incentives.

Participants

We received a total of 33 surveys. After deleting the surveys of participants who withdrew (n = 1) or did not respond to any questions past the consent form (n = 9), we were left with a final sample of 23 VCAO workers. Most participants (n = 19) were VCAO Executive Directors; the remaining 4 were managers or coordinators. We did not ask any demographics questions in order to maintain participants' confidentiality.

Data Analysis

We used quantitative and qualitative methods to analyze the survey responses. For the quantitative analyses, we divided the open-ended responses into categories and analyzed frequencies of how many participants reported each category. Most of these categories were mutually exclusive; that is, we only counted each participant in one

category and counts sum to the total number of participants who responded to each question.

For the qualitative analyses, we used NVivo (a qualitative analysis software) to organize the data into codes or themes. In some cases, these were the same categories used in the quantitative analyses of the corresponding question and, in other cases, they were different or were broken down into subthemes to provide additional supplement to the quantitative findings. Unlike the quantitative results, the qualitative results were not necessarily mutually exclusive; that is, some participants may have reported different (even opposing) ideas. We provide some direct participant quotes throughout the results section, with minor typos corrected.

RESULTS

Referral Sources

Most participants reported that they receive referrals to their VCAO site from multiple sources. The most common—reported by all 23 participants—was first responders, including police, fire services, and Emergency Medical Services (EMS). Participants also reported the following sources:

- Healthcare services including hospitals, private practices, addiction services, and community care access centres (reported by 13);
- Women's services including women's shelters, sexual assault centres, and other violence against women agencies (reported by 11);
- Self- or public referrals (reported by 11);
- Family and child services including (family) counselling, child and youth services, Children's Aid Society, and other social services (reported by eight);
- Schools or schoolboards (reported by three); and

- Other sources including community and social services such as employment, Ontario Works, Indigenous agencies, probation and Crown, Victim/Witness Assistance Program, and other victim services (reported by 16)[2].

Referral Methods

The two most commonly reported referral methods were email and telephone—both reported by nine of the 10 participants who responded to this part of the question. Other reported methods included walk-ins (reported by five), communications centre/dispatch (reported by two), fax (reported by two), a referral form dropped off in the office (reported by one), pager (reported by one), and an answering service for after-hours (reported by one). Of the 10 participants who responded to this part of the question, the majority reported multiple methods of contact, especially phone and email (thus, these categories are not mutually exclusive).

Follow-up versus Immediate Care Calls

More participants reported that they receive more calls for follow-up care (n = 12) than reported that they receive more calls for immediate care (n = 4). Two reported an equal distribution and five provided responses that were unclear or dependent on the referral source or definitions of immediate versus follow-up. For example, one participant reported that most calls from the police or hospital are for immediate care but that most calls from other referral sources are for follow-up care.

The 12 participants who reported that they receive more calls for follow-up care reported that they thought this might be because:

- The types of incidents that occur are often more appropriate as follow-up calls;
- Incident scenes are quick, chaotic, or unsafe (not enough time or reluctance by police officers to bring in VCAO);
- Police officers lack awareness or forget about VCAO, or offer an ineffective referral to the victim;

[2] The categories in the "Referral Sources" section are not mutually exclusive as participants often reported multiple referral sources. It is possible that some participants reported their most common referral sources while others reported all their referral sources.

- Victims decline "because they don't understand who [VCAO is] or what [VCAO] can do", because they do not realize the effects of trauma or needed assistance until later, or because they would rather wait to deal with more services because they are "exhausted" from dealing with emergency services on-scene;
- Victims already have the support they need at the time of the incident or "don't need immediate, on scene assistance" in most cases;
- Common referring agencies work regular office hours and send referrals "next day or up to 2 weeks later when they find out of the occurrence"; and/or
- Police officers "are excellent when it comes to determining whether or not we [VCAO] are needed immediately".

The 4 participants who reported that they receive more calls for immediate care reported that they thought this might be because:

- Their site has the capacity to provide immediate response;
- Their site has developed a positive working relationship or Memorandum of Understanding (including automatic referrals in immediate aftermath of crime/tragedy) with the referring service providers in their area; and/or
- Their site is "always trying to educate about the importance of victims receiving assistance at the time of the incident".

Importantly, some noted that they were satisfied with receiving more calls for follow-up care and not wanting this process to change. Some similarly recognized that there are many cases where VCAO might not be helpful right on scene and might be better utilized and accepted by victims hours or even days later.

Five participants reported that their site receives between 0 and 100 on-scene calls annually (lowest was 40); six reported between 101 and 200; five reported between 201 and 300; two between 301 and 400; 4 reported 500 or more (with 1 reporting more than 1,000); and one participant was unsure about how many on-scene calls their site receives annually.

In contrast, three participants reported that they receive between 0 and 100 follow-up care calls annually (lowest was 20-30); one reported that they receive between 101 and 200; one reported between 201 and 300; 15 reported above 500 (with 10 reporting more

than 1,000 and the highest reported being 3,500 calls); and three participants were unsure or did not respond.

Almost all participants (n = 22) reported that they receive the most referrals for immediate care from police (the remaining one participant reported "Municipal Service").

Emergency Service Providers' Referrals

Seventy percent of participants (n = 16) reported that emergency service providers (typically police) in their area have some form of mandate, directive, protocol, or Memorandum of Understanding to offer VCAO. Some reported that this directive applied to all victims of violence or tragic circumstances and some reported that it only applied to domestic violence. Some also reported that only some police services in their area had such a directive while others did not. One participant explained that, even if a victim declines the service initially, the protocol dictates that their VCAO site still receive the referral so that they may follow-up with the victim later. Another reported that their site has a purchase of service agreement with the police as well as a worker who works out of the police station and "has access to their database in order to make victim contacts". This participant reported that this system works well.

The remaining seven participants reported that emergency service providers in their area are not mandated to offer VCAO. One of these participants explained that, instead, their site had a working relationship with emergency service providers "that is beneficial to them to allow us [VCAO] to take on the emotional support and to seek funding to support with security functions".

Despite many reporting that emergency service providers in their area are mandated to offer VCAO, 65% of participants (n = 15) reported feeling that emergency services do not refer all the calls that should be made to their VCAO site. Some of these participants provided anecdotal evidence, including:

- Hearing of cases where people could have used VCAO but we were never notified;
- Hearing from self-referred victims that they were never offered VCAO at the time of the incident;
- Receiving referrals from social services for cases that were not referred by the investigating police;

- Never or rarely having received referrals from certain services such as Fire and EMS; and/or
- Having served a small proportion of the annual domestic violence calls that police received.

Many of these participants provided potential explanations, including:

- Police officers lack awareness or forget about VCAO, or do not believe that victims need such services;
- Police officers lack the compassion to offer the support of VCAO or lack awareness of the "lasting effects of trauma or victimization";
- Inconsistency in referrals from police (only some officers and only some police services ever refer; referral left to the discretion of the officer);
- A "stain[ed]" relationship between their VCAO site and police services; and/or
- Lack of time and funding for VCAO to provide "sufficient public education".

Even when there was some form of mandate, directive, protocol, or Memorandum of Understanding, some participants reported that not all officers refer and that there are no repercussions for not referring or not explaining VCAO to a victim.

Only three reported feeling that emergency services do refer all (or most) of the calls that should be made to their site. Only one of these participants provided a potential explanation and suggested that it was because of a Memorandum of Understanding. One participant was unsure whether emergency services refer all of the calls that should be made to their site and four provided responses that were unclear or mixed (e.g., not receiving enough calls specifically for immediate care or specifically from some referral sources, noting that referral numbers have "tripled" in the last few years from "building a relationship with community partners and developing protocols to ensure no victim is missed").

Referral Messaging

Only two participants reported knowing clearly how or what emergency service providers say when referring a client to their VCAO site. One reported that emergency service providers ask if the victim would like VCAO to attend on-scene and, if the victim

declines, they let her or him know that VCAO will be following up with them within 72 hours. The other provided a script that emergency service providers (presumably) use. The script referred to Victim Services as a "community partner" and offered to have someone on scene immediately to go over available supports and services or to have someone follow-up in a few days. This participant noted that their business card is also always provided to the victim.

Sixty-one percent of participants (n = 14) were unsure of how or what emergency services providers say when referring a client to their VCAO site. However, several of these participants explained that they provided emergency service providers with training or information on what they should say, such as giving a general overview of how VCAO can be supportive, stressing confidentiality, or keeping the message simple. Some of these participants also noted that referral messages likely vary between individual officers and police service agencies and one suggested that officers in her/his area may offer VCAO but likely do not explain "who [they] are or how [they] can assist".

The remaining seven participants either did not respond to this question (n = 2) or misinterpreted the question to be about how or what emergency service providers say to their VCAO site when making a referral (n = 5).

Many participants (n = 10) reported that they thought that emergency service providers in their area do not use consistent messaging when offering/explaining the participant's services to victims. Three participants reported that they thought that emergency service providers do use consistent messaging; five reported that they were unsure; three provided responses that were unclear; and two did not respond.

Training & Education

All participants who responded to the question (n = 21) reported that emergency service providers in their area do receive or have received some form of training or education about VCAO. This includes providing training at meetings or VCAO providing block training, in-service training, shift briefing, yearly or bi-yearly training with platoons, training during domestic violence courses or firearm recertification days, supervisor or new recruit training, reminder emails, and/or information pamphlets. One participant also noted that their site works at the local Ontario Provincial Police (OPP) station twice a week and is able to provide refreshers to officers or answer officer questions. While most of these trainings applied to police, a few participants reported attending fire

department meetings, "lunch and learns" at a local hospital, and community committee meetings around homelessness, domestic violence, community safety, and others.

However, many reported that this training/education was limited and often ineffective. For example, some reported that: (a) training is only provided by officer staff; (b) their VCAO site does training only when they are invited; (c) their VCAO site is only given several minutes to train and most officers "don't pay attention"; and (d) VCAO training sometimes occurs in conjunction with training about all other services in the area and VCAO "[gets] lost in the mix".

Of the 21 participants who reported that emergency service providers in their area do receive or have received some form of training or education about VCAO (all who responded to the question), 62% (n = 13) reported that this has resulted in more referrals to their site. However, many of these participants reported that this increase is often temporary and that, after a period of time, referral numbers often "drop back down again". Seven participants reported that training/education has not resulted in more referrals and one was unsure.

Victim Barriers

Participants reported the following reasons that victims decline VCAO, in their experience:

- Shame or embarrassment, as well as privacy concerns, especially in small towns where victims may know VCAO workers;
- Not wanting to bring someone into the home after a traumatic event;
- Not identifying as a victim or not wanting to be labeled as a victim;
- Being overwhelmed by the traumatic event, by the array of services that they are already in contact with (e.g., police statements, hospital visits), or by other extenuating circumstances (e.g., children crying, children with caretaker);
- Difficulty processing information being provided by emergency service providers in the immediate aftermath of a traumatic event;
- Not realizing (immediately) the impact of a traumatic event or that they need support or direction, or feeling that they already have enough support;

- Lack of awareness about VCAO and how they can be of assistance, or poor explanation about VCAO by emergency service providers (unclear, inconsistent, brief, described as volunteers rather than professionals); and/or
- Lack of awareness that they can reach out to VCAO days or weeks after a traumatic event.

Promising Practices

Participants offered many suggestions or promising practices for increasing victims' VCAO use and referrals. We divide these into the following 4 categories: (a) Emergency Services' Referral Messaging, (b) Referral/Usage Process, (c) Training and Education, and (d) Relationship Building.

Emergency Services' Referral Messaging

Participants provided several potentially promising practices for how emergency service providers in their area should or already do offer/explain their services to victims. Specifically, they reported that police officers should (or already do that works well):

- Keep the message simple—for example, "telling [the victim] that someone will be in touch and leaving it at that";
- Take the time and care to provide concrete information about what VCAO can offer and how they might benefit the victim;
- Personally and genuinely (not just out of obligation) recommend VCAO to victims based on their past work or experience;
- Use the language "professionals", "colleagues", and/or "partnership [with police services]" rather than "volunteers" to describe VCAO and their workers;
- Avoid using the language "victim" or even "Victim Services" because many people do not identify with the label "victim" after a traumatic event; and/or
- Use positive language and framing.

Referral & Use Process

Participants provided the following suggestions or potentially promising practices related to service use or the referral process that should be used or already are being used that work well:

- Instituting an automatic or mandatory referral process (for some, if not all, types of incidents) whereby officers:
    - Automatically inform all victims about VCAO, recommend its usage, and/or seek victim consent for VCAO to follow up (some believed that officers should be able to refer without victim consent);
    - Automatically call VCAO to the scene so that they can offer services/assistance to the victim directly; and/or
    - Automatically forward the victim's information to VCAO for follow-up and inform the victim that VCAO will be following up.
- Government removing the officer's discretion in offering victim services in the Victim's Bill of Rights.
- Police agencies providing VCAO access to their database or to a run-list so that VCAO may offer victims their services directly rather than relying on police to "sell" their services.
- Having someone (e.g., police officer) check whether or not referrals were made on a daily basis.
- Holding police accountable for their investigations and victim assistance and/or providing more incentive and recognition.
- Creating a simple card that police can offer and explain to victims before they part ways (though one participant described this technique as "hit and miss").
- VCAO explaining to victims that they are in partnership with police and that police wanted them to call the victim to check-in.
- Using an email referral system with police so that VCAO can receive basic information and follow up with the victim.

- VCAO and police being able to share information without confidentiality barriers, "much like "[Victim/Witness Assistance Program] can do".

Training & Education

Participants provided the following suggestions or potentially promising practices related to training and education that should be used or already are being used that work well:

- Continuing or increasing appropriate training for all community agencies and especially emergency service providers (such as weekly shift briefings and using Coach Officers to train and educate new officers); and/or
- Continuing or increasing public outreach and education about VCAO, including individual sites running radio commercials or having an active Facebook page, and province-wide media campaigns.

Relationship Building

Finally, participants provided the following suggestions or potentially promising practices related to relationship building that should be used or already are being used that work well:

- Building a strong and trusting relationship with police and other services by maintaining regular communication, inviting representatives from service agencies to VCAO volunteer or board meetings, and developing advocates within those service agencies;
- VCAO being active in the community and with other agencies or committees in order to increase their visibility;
- VCAO having "joint ventures" with the police, especially around public awareness initiatives;
- VCAO having a physical presence in police agency buildings/stations (face-to-face contact with officers helps to keep officers informed and ensure referrals are made); and/or
- Developing support from and a relationship with Senior Administration at police agencies to increase officer buy-in.

Importantly, some participants recognized that efforts to increase referrals must be met with increased funding for VCAO sites so that they could respond to increased calls, especially if police referrals were mandatory for all victims.

CONCLUSIONS

There appears to be a disconnect between policy and practice. In Ontario, police are mandated to assist crime victims, but it is unclear if and how police are addressing these needs for support. Our literature review and survey results suggest that each of the following can have an impact on the number of people using and being offered support by VCAO:

- The message that emergency service providers use to refer victims to services;
- The characteristics of the messenger;
- The method used to deliver the message; and
- The relationships between emergency service providers and victim services.

According to our participants, emergency service providers should use simple and positive language about the benefits of VCAO with genuine endorsement based on past working experience. Moreover, VCAO should:

- Provide continual training for all community partners and emergency service providers;
- Implement public outreach strategies;
- Develop integrated and collaborative partnerships with emergency service providers; and
- Solicit support from senior administration to maximize buy-in from officers.

Such changes are not without challenges. For example, differences in service philosophies or mandates can impact collaboration, preventing inter-agency referrals. Moreover, building relationships and increasing training and public outreach efforts may require increased funding and resource allocation.

Some participants also discussed the need for mandatory VCAO referrals. At present, the RCMP's victim assistance policy and referral process allows for proactive referrals in

specific situations (e.g., when a victim is unable to provide informed consent and there are reasonable grounds to believe that they require support; RCMP, 2016). It is possible that additional training is needed to clarify if and when RCMP and other emergency service provers should proactively refer.

Limitations & Future Directions

Our findings should be considered in light of several research limitations. First, many participants misinterpreted question 10 in the survey ("When an emergency service provider does make a referral to your site, do you know how, or what they say?"). In future iterations of the survey, this question should use language similar to question 11, such as: "When an emergency service provider in your area offers/explains your services to victims, do you know how, or what they say?".

Second, we are missing the perspectives of other stakeholders, such as emergency service providers, frontline VCAO volunteers, and victims themselves. It is possible that these groups might have different recommendations, barriers, and thoughts. Because our survey was anonymous, we also cannot be sure if our sample was representative of all VCAO sites. We may be missing the perspectives of rural or other under-serviced sites.

Finally, the above recommendations to increase victims' VCAO use and referrals are based mainly on our participants' personal experiences and wishes for the future and may not be empirically-based. Future research should examine whether such strategies do increase victims' VCAO use and referrals. Despite these limitations, we believe that this research offers important potentially promising practices and speaks to the need for more consistent and improved referral strategies by emergency services.

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APPENDIX A: ONLINE SURVEY QUESTIONS

Instructions:

Please answer all questions **with as much detail as possible**. If you do not know the answer to a question, please indicate this. We ask that you try not to provide any responses on the survey that might directly or indirectly identify you or your site (for example, naming your Victim Services site/location, or any other emergency service sites).

1. What is your position at your Victim Services site?
2. How and from which service providers do you receive referrals for your Victim Services site?
3. Do you receive more calls for follow-up care or immediate care?
4. If you receive more calls for one of these, why do you think this might be?
5. How many on-scene calls does your site receive in a year?
6. How many follow-up care calls does your site receive in a year?
7. From which emergency service(s) does your site receive the most referrals for immediate care?
8. Do you feel that emergency services refer all the calls that should be made to your site? Please explain.
9. Are emergency service providers in your area mandated to offer Victim Services? Please explain.
10. When an emergency service provider does make a referral to your site, do you know how, or what they say?
11. In your experience, is there a way that emergency service providers in your area offer/explain your services to victims that works best?
12. Do emergency service providers in your area use consistent messaging when offering/explaining your services to victims?

13. Do emergency service providers in your area receive any training or education about Victim Services? Please describe.

14. If so, has any of this training resulted in more referrals to your site? Please describe.

15. In your experience, why do victims decline Victim Services?

16. Is there anything you think would be helpful to encourage victims to use your services, especially immediate care?

17. Has your agency done anything that you have found to be helpful at increasing the referrals your site receives (especially for immediate care)? Please describe.

18. Is there anything else you would like to add that might help to increase the number of immediate-care calls that Victim Services receive?