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State-Provided Crime Victim Services Do Not Meet the Mental Health Needs of California's Disadvantaged Crime Victims

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1. Background

Victimization by violent crime is associated with high individual and societal costs. Crime victims are at high risk for post-traumatic stress disorder (PTSD), a potentially disabling and chronic condition associated with further health, occupational, and interpersonal impairment. Early intervention is important to help victims deal with the consequences of violent crime and to prevent long-term disability. Early treatment is particularly important for disadvantaged victims, who are more likely to develop PTSD and other disorders following victimization, yet are less likely to seek or receive mental health services than are populations with more social and economic resources.

To help victims recover, federal and state governments provide direct services as well as special compensation programs to cover the costs of medical and mental health treatment, lost wages, and other expenses. California operates the largest crime victim program in the country, but it has repeatedly been found to be deficient. Independent and legislative analysts have advocated re-examining and/or restructuring California's victim services.

1.1 Purpose of This Report

The policy question addressed in this report is not whether state programs for crime victims should continue, but what form they should take to maximize the numbers of victims served. This report:

- Synthesizes recommendations from prior evaluations of victim services.
- Reviews a randomized treatment trial that compares crime victims assigned either to usual care under a claims-based model or to a non-claims-based model of care provided by the Trauma Recovery Center (TRC) at San Francisco General Hospital/University of California, San Francisco (SFGH/UCSF).
- Presents the results of data analyses supplemental to the original trial to specifically examine victims' access to compensation benefits and to trauma-focused mental health, focusing on disadvantaged victims, who need the assistance most.
- Provides policymakers with information to better fund, structure, and deliver mental health services to California's disadvantaged victims.

1.2 Organizational Structure of California's Victim Services

California's services are supported by a mix of federal/state funds from restitution paid by criminal offenders. The administrative oversight and funding of more than $245 million annually is spread across numerous departments and agencies: 11 departments, 4 cabinet-level agencies, the Governor's Office, 2 other constitutional offices, and at least 16 other entities. The three primary agencies for victim services are the Victim Compensation and Government Claims Board, the Office of Emergency Services**,** and the Department of Health Services.

2. Recent Evaluations of Victim Services

A number of studies have evaluated victim services. National and state studies found California's victim services to be deficient at multiple levels of service organization and delivery. These deficiencies can be grouped into four categories:

- **Administrative Organization and Oversight:** Victim services lack coordination and leadership, resulting in costly service duplication and widespread inefficiencies, limiting the quality and quantity of available services.
- **Access to the Victim Services System:** Victims have poor access to the system: over three-quarters are unaware of their eligibility for services. Those who know that services are available encounter multiple difficulties applying for benefits.
- **Access to Victim Benefits:** Victims who enter the system and file benefit applications encounter numerous difficulties—at the policy level (eligibility requirements) and the procedural level (application evaluation and communication with victims).
- **Access to Mental Health Services:** Early treatment helps victims deal with the consequences of violence and prevents long-term disability. Victims who are deemed eligible can obtain traditional, office-based psychotherapy. For some, this may be sufficient. However, these services, which are often fragmented and office-based, may not meet the complex psychosocial needs of many crime victims.

3. The SFGH/UCSF Trauma Recovery Center

The Trauma Recovery Center (TRC), located near San Francisco General Hospital, was funded from July 2001 through June 2005 as a demonstration project to develop and test a more cost-effective model of mental health care than is currently offered through victim restitution funds. Funding came from the State Restitution Fund as enacted by two Assembly bills. The demonstration project was a randomized treatment trial to identify barriers to care and evaluate its clinical and cost-effectiveness against the usual model of victim services. The TRC model addresses key problems in the current system by providing comprehensive services—including assertive outreach, case management, and trauma-focused psychotherapy—designed to increase access to the victim services system, victim benefits, and mental health care.

4. TRC Study and Randomized Treatment Trial

The centerpiece of the model is the randomized trial that compares the TRC to usual care under the current victim services system. Participants were identified in the Emergency Department and inpatient medical units while they were being treated for crime-related injuries. The research sample comprises 655 acute-care victims of crime. Five hundred forty-two participated in the randomized trial; 338 were randomized to TRC services and 204 to usual care. An additional 113 sexual assault victims who received TRC services were not randomized but did participate in the study. All participants completed baseline interviews and were invited back at 4, 8, and 12 months for follow-up interviews.

The sample was largely male, and more than half were ethnic minorities. Over one-third were homeless, and almost two-thirds unemployed. The median monthly income for the sample was very low ($624), well below the poverty level for both individuals and families. Participants

reported an average of five types of prior trauma (e.g., assault, child abuse, natural disasters, accidents) and high levels of traumatic stress symptoms. Although 40% were employed at the time of the crime, this subset comprised impoverished individuals who had multiple psychosocial needs related to housing, medical services, and vocational assistance.

Initial analyses of the randomized trial data indicate that, compared to usual care, the TRC model was both clinically and cost-effective. Compared to usual care clients:

- TRC clients were four times more likely to file Victim Compensation Program applications.
- 56% more TRC clients returned to employment.
- Homelessness was reduced 41% more among TRC clients.
- 44% more TRC clients cooperated with the District Attorney's office.

5. Effects of the TRC Model on Access to the Victim Services System, Victim Benefits, and Mental Health Services

We used data from TRC trial participants to thoroughly examine whether the TRC model successfully addressed barriers to service that were repeatedly identified in evaluations of the current victim services system—specifically, access to the victim services system, victim benefits, and mental health services. These analyses, in combination with the results of prior national and state level evaluations of victim services, were used to formulate the following policy implications and recommendations for improving victim services in California.

6. Policy Implications and Recommendations

We conclude that California is failing to provide responsible, accountable, and accessible services for some of the state's most vulnerable citizens: victims of violent crime. While these conclusions are critical of the current system, they are being advanced in hope that Governor Schwarzenegger's statement that "justice cannot be served until victims are served" can become a California reality.

6.1 Administrative Organization and Oversight

Findings: The California system of victim services is fragmented, lacks cohesive leadership and oversight, has a top-heavy administrative structure, and has excessive overhead that reduces funds for victims. It is inefficient, with redundancy and duplication across numerous departments. This has led to duplication of services in some areas and lack of services in others. Services are generally poorly suited to meet the diverse needs of California crime victims.

Recommendation: Consolidate administration and oversight. As a number of prior evaluators suggest, victim services should be brought under a single agency, a newly formed Office of Victim Services. Consolidation would lead to greater coordination, less fragmentation and redundancy, and a positive fiscal impact due to improved efficiencies and a decrease in administrative overhead.

Recommendation: Restructure services to meet victims' needs. The State and Consumer Services Agency Report of 2003 offers a thoughtful and comprehensive plan for restructuring services to meet victims' needs. It should serve as a road map for needed structural change. The key recommendations are:

- Create a Victim Advisory Committee.
- Complete a statewide needs assessment.
- Develop an action plan to insure comprehensive statewide victims' rights and services.
- Identify programmatic best practices that can be replicated statewide.

6.2 Access to the Victim Service System

Findings: Crime victims do not obtain access to the victim services system because the majority (77%) do not know that services are available. Application procedures are so complex that many victims need professional assistance to complete and submit the extensive documentation. Prior evaluations consistently found low-income victims were disadvantaged in obtaining victim services. These findings were confirmed in the TRC randomized trial.

Recommendation: Inform victims about service availability. Use direct outreach in multiple settings to insure that victims understand available benefits. The TRC demonstrated that direct contact in acute-care hospital settings efficiently reaches victims injured in violent crimes. Outreach in different settings may identify other victims who are currently unaware of the services available to them.

Recommendation: Help victims apply for benefits and obtain case management. Provide assistance in completing and submitting applications for benefits. Provide comprehensive and effective clinical case management, similar to the TRC model, that takes into account language, literacy, homelessness, and PTSD's impact on functioning.

Recommendation: Provide assertive, targeted assistance to disadvantaged victims—those most in need of services but least likely to obtain them. The TRC demonstrated that outreach helped disadvantaged victims in a public-sector hospital setting. Outreach in other settings serving disadvantaged populations would probably reach additional crime victims.

6.3 Access to Victim Benefits

Findings: National and state evaluations found that documentation requirements for claims are burdensome and a barrier to care, applications aren't processed in timely fashion, and language and literacy barriers limit access. TRC data were similar and indicated that the most common denials of claims were related to police report problems. Victims may not report a crime due to embarrassment, shame, or fear of perpetrator retaliation. California Code states, "medical or mental health records may not be sufficient evidence that a qualifying crime occurred," implying that medical records may be considered and may not be sufficient evidence of a qualifying crime. However, cases that have only medical documentation but no police report are often denied eligibility. Additionally, victim compensation applications/brochures are only in English and Spanish. Correspondence is legalistic, complex, and often incomprehensible.

Recommendation: Evaluate and modify eligibility and documentation requirements. The Victim Compensation Program (VCP) should develop medical/mental health guidelines on what

constitutes sufficient evidence a crime has occurred, with claims reviewers trained on the revised guidelines. This will increase the likelihood that legitimate crime victims who are unable or unwilling to file police reports are deemed eligible for services.

Recommendation: Streamline claims processing. The VCP should be commended for its efforts to improve its processing procedures, but delays occur while waiting for information from other state agencies. The VCP should be given access to other state databases to verify applicants' claims.

Recommendation: Improve communication with victims and reduce linguistic and cultural barriers. Applications, brochures, and correspondence should be in languages common among California residents, or provision be made for victims to communicate with the VCP in languages other than English. Letters should be written at a lower literacy level to be readily understandable, less legalistic, and consumer-friendly.

6.4 Access to Mental Health Services

Findings: Untreated psychological trauma has significant economic impact, resulting in overutilization of costly medical services; loss of medical insurance, stable housing, and income; and failure to return to gainful employment. The TRC study documents the high level of crime victims' treatment needs. The current system primarily refers victims to office-based fee-for-service clinicians. This meets the needs of some victims of violent crimes, but tends not to meet the complex psychosocial needs of many, or even most, victims. The TRC model—providing comprehensive services, including outreach and case management, that are not currently reimbursable—is more effective than the current system. Our data suggest that the added outreach and case management services were essential to the model's success.

Recommendation: Improve access to mental health services. Assertive outreach is essential to link crime victims to mental health services. The TRC model's integrated outreach with case management and psychotherapy has proven highly successful in an urban area.

Recommendation: Expand the mental health services available through the victim services system. The VCP should expand beyond office-based psychotherapy to include the community outreach and case management services that are essential to crime victims' recovery. An integrated model, similar to the TRC, with a full range of mental health and social services, is likely to provide the most clinically and cost-effective care.

7. Fiscal and Policy Implications of Recommendations

Adoption of these recommendations will decrease overhead and improve efficiencies and accountability, with improved access and service quality for crime victims. Implemented strategically and adroitly, the recommendations can be achieved in a cost-effective manner. For example:

- Agency consolidation should lead to decreased overhead, increased accountability, and reduced service duplication and fiscal waste, with increased funds available for victims.
- Streamlining the claims process should result in administrative overhead cost-savings.
- The state needs to be proactive in maximizing federal funds. The creation of the Office of Victim Services will also create a cohesive, focused entity for seeking federal funds.

• Greater accountability will insure that federal dollars are maximized and that federal monies are not delayed due to poor fiscal oversight at the state level.

• State Restitution Fund revenues will be increased by a still greater effort to collect fines.

• Replication of the TRC model statewide may result in decreased costs, as it is more cost-effective than the current system of care.

• The governor and the legislature should require that 10-15% of the State Restitution Fund reserves ($127.4 million projected for FY 2007-8) fund the establishment of trauma recovery centers statewide, while mandating that 85-90% of the reserve be maintained.

• The legislature in coordination with the governor's office should convene public hearings as a catalyst for creating and implementing change in California's victim services system.

1. Background

Victimization by violent crime (including sexual assault, domestic violence, shooting, stabbing, and physical assault) is associated with high individual and societal costs in the form of mortality, medical and mental health treatment costs, reduced productivity, and impaired functioning (Breslau et al., 1998; Miller et al., 1996; Solomon and Davidson, 1997). Crime victims are also at high risk of developing post-traumatic stress disorder (PTSD) (Hembree and Foa, 2003), a potentially disabling and chronic condition associated with further health, occupational, and interpersonal impairment (Kessler, 2000; Wagner et al., 2000; Zayfert et al., 2002). Early intervention is important to help crime victims deal with the immediate consequences of violent crime and to prevent longer-term disability associated with PTSD (Gray and Litz, 2005).

Early treatment is particularly important for disadvantaged crime victims. Individuals who are poor, ethnic minority, or homeless are more likely than others to be victims of violent crime (Kilpatrick & Acierno, 2003; US Department of Justice, 2004) and more likely to develop PTSD and other serious psychological disorders following victimization. However, despite a higher need for mental health services, disadvantaged victims are less likely to seek or receive them than are populations with more social and economic resources (Kaukinen, 2004; Wells et al., 2001; Swartz et al., 1998).

To help crime victims recover physically, psychologically, and financially, federal and state governments have developed a system to provide direct services to victims and special compensation programs that cover the costs of medical and mental health treatment, lost wages, and other expenses. California's state government operates the largest state crime victims program in the country, with more than $245 million in annual funding (California State and Consumer Services Agency, 2003). The services offered by the state are both claims-based and non-claims-based.

1.1. Purpose of this Report

It is an established federal and state priority to increase access to mental health and social services for victims of crime. The policy question to be addressed in this report is not whether state programs for crime victims should continue, but what form they should take to maximize the numbers of victims who receive needed services. The following events demonstrate the relevance of this topic to current California health policy discussions:

- Over the past several years, victim services in California have been criticized for not meeting the needs of victims. A number of reports from independent and legislative analysts have advocated the reexamination and possible restructuring of California's state-level crime victimization services.

- The Trauma Recovery Center (TRC) at San Francisco General Hospital/University of California, San Francisco (SFGH/UCSF) was created in 2001 to develop and test a more cost-effective alternative model of care than the model of usual care offered through victim restitution funds. Developed in partnership with the State of California Victim Compensation and Government Claims Board (VCGCB), the TRC was funded from July 2001 through June 2005 by victim restitution funds as enacted by AB 1740 (Ducheny, Chapter 52, Statutes of 2000) and AB 2491 (Jackson, Chapter 1016, Statutes of 2000).

• Over the last year, several state legislators have expressed an interest in developing victim services systems similar to the TRC model in their own regions to provide comprehensive services to crime victims who are poorly served by the current system.

• In October 2005, the governor vetoed a bill to continue funding the TRC, stating that the VCGCB was designed to reimburse individuals rather than fund treatment programs. At the same time, the VCGCB currently carries a budget surplus of $116 million, projected to be $127 million in FY 07-08 (California Budget 2007-2008). Given historical patterns of compensation disbursement, it is not likely that such a large amount would be used directly for individual crime victim reimbursement.

Reexamining the effectiveness of California's crime victimization services and considering replication of the TRC are increasingly timely topics with relevance for a variety of policy stakeholders, including the VCGCB, state legislators, the Office of Emergency Services, the Department of Justice, and the Department of Health Services. This report:

• Reviews and synthesizes recommendations from prior national and state evaluations of victim services.

• Reviews the results of a randomized treatment trial that compares victims of crime randomly assigned to usual care under a claims-based model or assigned to a non-claims-based model of care provided by the UCSF/SFGH Trauma Recovery Center.

• Presents the results of data analyses supplemental to the original randomized trial data to specifically examine victims' access to victim compensation benefits and to trauma-focused mental health services, with a specific focus on disadvantaged victims who need the assistance most.

• Provides state policymakers with information needed to better fund, structure, and deliver mental health services to California crime victims most in need of help.

1.2. Organizational Structure of California's Victim Services

Programs focused on crime victims were first created in the 1960's. Initially, these programs addressed the financial impact of crime, and, in 1965, California took a leadership role in establishing the first claims-based Victim Compensation Program. In 1974, California again took the lead by developing one of the first Victim Witness Assistance Centers in the country (California Performance Review, 2004). California law requires the state's Victim Compensation Programs to reimburse victims for crime-related losses and to operate local offices to provide services to victims of violent crimes.

Both federal and state mechanisms provide funding for these programs. In 1984, Congress passed the Victim of Crime Act (VOCA), through which the Crime Victims Fund (CVF) was created. VOCA/CVF funds remain the largest source of federal monies for victim services (Newmark, 2006). Rather than using appropriated tax dollars, CVF is funded through fines, penalties, forfeited bail bonds, and other restitution fines levied against criminal offenders. More than $1.2 billion was deposited into the fund in 2004. However, a congressional cap has made only $671.3 million available for use. CVF funds are distributed on a state level to supplement the claims-based state Victim Compensation Programs, (approximately $186.1

million), the Victim Witness Assistance Centers (approximately $339 million), and other grant-based programs (approximately $31.5 million) (U.S. Department of Justice, 2005).

Victim services in California are thus funded by both federal VOCA grants as well as by state monies deposited into the California State Restitution Fund. The federal fund reimburses the state for 60% of the amount awarded to victims during the previous year. This 60% federal match provides an "incentive for states to reach out to more victims. As a state increases its annual payouts, the state then benefits from an increase in Federal allocation" (U.S. Department of Justice, Report to the Nation, 2003). The federal matching funds are divided among the departments and agencies described below.

The California State Restitution Fund, like the federal VOCA fund, receives monies collected through fines and penalties levied against those convicted of crimes and traffic offenses. In 1995, the state enacted legislation that mandated misdemeanor fines in every criminal case, resulting in the State Restitution Fund growing dramatically over the last 15 years – from $5 million in 1991-1992 to $57 million in 2003-2004 (California Performance Review, 2004).

The administrative oversight and funding of more than $245 million annually in victim services is spread across numerous state departments and agencies. These include 11 departments, 4 cabinet-level agencies, the Governor's Office, 2 other constitutional offices, and at least 16 other state entities (California State and Consumer Services Agency, 2003). A description of the three largest agencies providing oversight follows, along with their responsibilities:

1. **The Victim Compensation and Government Claims Board (VCGCB):** Reporting to the Governor's Office through the State and Consumer Services Agency, the VCGCB oversees 22 satellite offices throughout California. The Victim Compensation Program (VCP), operated by the VCGCB, is a claims-based program that helps victims cover the costs of medical and mental health treatment, lost wages, and other expenses by making claims to the state for reimbursable services. VCP claims are generally of two types: either the consumer pays out-of-pocket and seeks reimbursement from the state (e.g., funeral expense), or the service provider bills the VCP directly for the service (e.g., physician visit). Claims are individually evaluated, approved, or denied, with approvals subsequently paid. This system is distinguished from non-claims-based programs (e.g., a rape treatment center) where clients are eligible for services by virtue of the crime, and monies are generally block-granted for the provision of services.

   No General Fund monies are used to support the VCP. Funding comes from both the State Restitution Fund and federal funds. The VCP receives up to 47.5% of the federal matching funds received by the state. For over a decade, the State Restitution Fund has consistently maintained a large cash reserve. In Fiscal Year 04-05, it maintained a $66.2 million surplus, and in Fiscal Year 05-06, $106.3 million. Projections from the State and Consumer Affairs Agency estimate a surplus for Fiscal Year 06-07 of $116 million, and for Fiscal Year 07-08, $127.4 million.

   In Fiscal Year 04-05, the most recent date for which federal crime statistics are available, a total of 198,070 violent crimes were reported in California (U.S. Department of Justice,

Bureau of Statistics, 2006). During this same period, the VCGCB paid out approximately $58.8 million to 40,342 victims with approved applications for compensation (California Victim Compensation and Claims Board, 2005), or only 20% of victims reporting crimes.

Although the VCP has traditionally been a claims-based program, there is one notable exception. In 2001, the VCP entered into an inter-agency agreement with the University of California, San Francisco (UCSF) to create a four-year demonstration project—the Trauma Recovery Center (TRC)—to see if a different model of care would be more effective than the claims-based system. This program is discussed below in parts 3-5.

2. Office of Emergency Services (OES): This agency administers more than $100 million annually from commingled state and federal victim funds and oversees victim assistance centers in each of California's 58 counties. The OES also oversees grant funding to more than 500 local non-claims-based victim assistance programs, including rape crisis centers, domestic violence programs and shelters, and child and youth victim-related programs. The victim assistance centers receive at least 47.5% of federal CVF funds, which are allocated according to a base amount and to state populations. In addition, under federal guidelines, states are required to allocate at least 10% of federal monies received to fund programs in the following four priority categories: victims of sexual assault, domestic abuse, and child abuse, and victims of violent crimes who are from underserved groups, such as ethnic minority, low-income, or rural populations. These various functions and programs were all previously subsumed under the Office of Criminal Justice Planning (OCJP). However, OCJP was dismantled in January 2004, and these services were reorganized under the OES (Legislative Analyst's Office, 2004). This change is discussed further in sections 2.2.1 – 2.2.3.

3. The Department of Health Services (DHS): Located in the Health and Human Services Agency, this department oversees over $23 million annually for more than 100 domestic violence shelters and provides domestic violence education, training, and prevention programs.

In addition to these three major agencies, an additional eight state departments and 16 state agencies are involved in victim services. The eight additional departments are: the Department of Justice, Secretary of State, Department of Corporations, Department of Social Services, Department of Mental Health, Department of Corrections, California Youth Authority, and the Department of Housing and Community Department (California State and Consumer Services Agency, 2003).

2. Recent Evaluations of Victim Services

2.1. Evaluations of National Victim Services

2.1.1. Urban Institute Evaluation of State Victims of Crime Act Compensation and Assistance Programs (2003)

A National Institute of Justice-sponsored study conducted by the Urban Institute assessed the efficiency and effectiveness of victim compensation and victim assistance programs in meeting the needs of crime victims (Newmark et al. 2003). The study included California and five other states. Results clearly indicated that claims-based state victim compensation and assistance programs need to be better coordinated, and, if possible, consolidated into a single

agency. The study also found that the victim compensation claims process was at times cumbersome and burdensome to victims and should be streamlined. Of particular note, a survey of individuals receiving services in victim assistance programs found that only 45% of victims were aware that they were entitled to claims-based services and compensation, fewer than 15% surveyed received psychotherapy, and members of racial/ethnic minorities were more likely to have unmet needs.

The study recommended that programs for victims should provide more proactive outreach and should especially emphasize outreach to underserved populations, particularly racial/ethnic minorities, disabled victims, and special populations such as gay/lesbian victims.

2.1.2. National Institute of Justice Studies on Crime Victims' Needs (2006)

Alongside the aforementioned Urban Institute Evaluation, the National Institute of Justice sponsored a national study on crime victims' needs conducted by Safe Horizon (Newmark, 2006). The Safe Horizon study surveyed a total of 800 crime victims, and the Urban Institute Evaluation surveyed 594 crime victims. Both studies were somewhat limited. Members of racial/ethnic minority groups were not included in numbers proportionate to their representation among crime victims in general. Additionally, access barriers could not be fully examined because the Safe Horizon study included only victims who filed police reports, and the Urban Institute Evaluation surveyed only victims who were already receiving victim services.

Despite these limitations, results from both studies provide useful insights into the needs of crime victims for help with emotional recovery, as well as with concrete, tangible needs. Victims required assistance with obtaining safe housing and financial entitlements, returning to work, and activities of daily living. Particularly striking was the finding that many victims do not obtain access to formal victim services programs. Only 4% of victims' needs were addressed by providers serving victims. In addition, only 23% of victims who received little or no outreach knew victim services were available to them, leaving 77% unaware of, or unable to gain access to, services. Victims with unaddressed needs were more likely to be members of racial and ethnic minorities. Of those victims who filed victim compensation applications, one-quarter reported problems with having their application processed in a timely fashion, and 73% were left with unreimbursed expenses.

The Safe Horizon report recommends streamlining the victim compensation claims process. It also recommends that programs serving crime victims do greater outreach, particularly to underserved populations.

2.2. Evaluations of California Victim Services

Between 2002 and 2006, there have been several comprehensive evaluations of victim services in California. The findings of these state-level evaluations are similar to the national-level evaluations in many respects. They criticized the state for serious problems with the current organizational structure of victim services, for a lack of coordination and leadership that has led to fragmentation in services, for duplication of services and other inefficiencies, and for fiscal mismanagement that has led to victims not being served. While the state has begun to address these issues, significant problems remain. A summary of these critiques follows.

2.2.1. Bureau of State Audits (California State Auditor, 2002)

This audit was conducted by the California State Auditor on the Office of Criminal

Justice Planning (OCJP) and on the domestic violence programs within DHS. The report concluded that the OCJP was not fulfilling its responsibility in administering state and federal grants for victim services, and that it lacked accountability and failed to ensure the quality of such services. Overlap and duplication of services between OCJP and DHS were also noted. Among its many recommendations, the report called for all domestic violence programs administered by these agencies to be consolidated into one agency.

2.2.2. Little Hoover Commission Report - Improving Public Safety (2003)

This report, focused primarily on the State of California's OCJP, similarly highlighted problems throughout the victim delivery system. It criticized the state for poorly coordinating and administering programs, for operating with a top-heavy administrative structure, and for providing fragmented oversight that has resulted in massive amounts of duplication across agencies, as well as fiscal waste and poor accountability. Additionally, funds were not distributed so that those with the greatest need received them. The report called for the dismantling of the OCJP and the distribution of its funds to other state departments.

2.2.3. Legislative Analyst's Office (LAO) Report (2003)

Given the OCJP's aforementioned problems, its poor history of performance, and its overlap with other state agencies, the Legislative Analyst's Office called for the dismantling of OCJP (LAO, 2003). With the dismantling of the agency in January 2004, $200 million in OCJP monies were transferred to the Public Safety and Victim Services Branch of the Office of Emergency Services (LAO, 2004).

2.2.4. California State and Consumer Services Agency Report: Strengthening Victim Services in California: A Proposal for Consolidation, Coordination, and Victim-Centered Leadership (2003)

In 2002, the California State Legislature enacted AB 2430 (Jackson, Statutes of 2002), which directed the California State and Consumer Services Agency to generate a report on crime services throughout the state. The legislation stated that the impetus for the report came from the recognition that "victims of violent crimes are a special needs population requiring timely coordinated responses to their physical and mental injuries," and that "current services for victims of violent crimes are fragmented and not easily accessed on a statewide basis." The resulting State and Consumer Services Agency report, published in 2003, provided a comprehensive review of victim services throughout California, including a review of organizational and funding structures for services. It called for a vast restructuring of victim services and made numerous other recommendations.

Like the other evaluations, the 2003 report documents serious weaknesses in the current organizational structure of victim services and criticizes the existing victim service delivery system for:

- An absence of statewide strategic planning for victim services.
- A lack of cohesive leadership, resulting in the duplication of services, as well as in ineffective partnerships and poor communication among different victim service agencies.

• A lack of coordination among government agencies leading to conflicting and duplicative policies.

• Inadequate planning for victim services, causing uncertainty in funding and changing program requirements from year to year.

• Poor communication among state advisory committees that serve as informal policy-making bodies.

• Failure to consult victims and service providers on significant policy issues.

• A top-heavy administrative structure with excessive overhead costs, resulting in fewer dollars available to victims.

• Poor grants management, including inadequate technical assistance to grantees and a failure to conduct thorough program evaluations.

The report concludes that most victims are unable to gain access to victim services in California. Barriers to access are greatest for vulnerable populations—those victims who are disabled, poor, homeless, from ethnic minorities, and non-English-speaking. The report further acknowledges that only a small number of victims file victim compensation applications, and an even smaller number receive mental health services, suggesting that there is a great need for outreach efforts.

The report's recommendations are to:

• Establish one state entity:

1) to oversee the three major state funding sources for victims (VCGCB, OCJP—now OES, and victim services programs in DHS), and

2) to consider consolidating the other 11 victim programs in other state agencies into one office—the Office of Victim Services.

• Designate a high-level administrator to coordinate all victim programs.

• Create a Victim Advisory Committee.

• Develop an action plan to insure comprehensive victim rights and services statewide.

• Identify programs that represent examples of best practices that can be replicated around the state.

• Develop new ways to deliver victim services, especially to increase access for vulnerable, low-income crime victims to mental health services and to the Victim Compensation Program.

• Develop more centers, such as the UCSF Trauma Recovery Center, to ensure that vulnerable populations, such as the poor and the homeless, are served.

• Complete a statewide needs assessment for victim services.

• Streamline the victim compensations claims process.

• Explore how to maximize federal funding that can be used to further supplement state funding.

• Increase revenues to the federal and state victim restitution funds by encouraging the courts to more diligently order restitution fines and more strictly enforce collection of these fines.

2.2.5. The California Performance Review Report (2004)

At the request of Governor Arnold Schwarzenegger, the California Performance Review (CPR) was conducted to examine the function of state government and to make recommendations on how to make state government more accountable, efficient, and cost effective (California Performance Review Report, 2004).

Consistent with other reports, the CPR report points out that the duplication of statewide victim services and the fragmented organizational structure interfere with efficiency, add to costs, hamper the ability of programs to take advantage of discretionary and federal grant funds, and create barriers to effective statewide strategic planning for victim services. Funding for victims is "spread across state government and victims of crime must navigate a system rife with conflicting and duplicative policies."

Specifically referring to the victim compensation claims process as administered by the VCGCB, the CPR report notes that as far back as 1983 the legislature recognized that the application process for victims "was difficult, complex and time consuming. Twenty years later the application has been simplified but the review process remains complex and time consuming." A large amount of documentation is needed to verify that an applicant's claim is valid. For example, documentation may be needed from some or all of the following groups: local police departments, hospitals, mental health care providers, physicians, employees, the Employment Development Department, the Department of Motor Vehicles, the Franchise Tax Board, the Department of Health Services, the Department of Social Services, and contract billing review services.

"Most of the requests for information are made concurrently by mail and require claims to sit awaiting responses. The response time varies from 1 week to 6 months. In the meantime, the victims wait. On rare occasions, victims' unpaid bills have gone to collection agencies while the victim waited for the State to finish its review and provide payment, thus causing victims further damage." The CPR report goes on to state that, as of May 2004, 8,000 claims awaited full processing, and 2,900 applications (36%) were over 30 days old.

In response to these concerns, the VCP is engaged in transforming their entire claims management system by automating and streamlining the claims process. However, the CPR notes that even with improvements in processes under VCP control, many delays are caused by the need to wait for other agencies to supply information verifying the validity of claims.

The CPR report recommends the creation of a single lead agency to decrease fragmentation and increase coordination of all victim services throughout the state. The division would consolidate the VCGCB, the victim services branch of the OES, and victim services within DHS, potentially resulting in a positive fiscal impact due to a decrease in administrative overhead and improved efficiencies. The report also recommends granting the VCP shared electronic access to other state databases—e.g., the Employment Development Department, the Franchise Tax Board, and the Department of Social Services—to make it easier for the VCP to verify pertinent information on an applicant's claim, such as information on unemployment or disability insurance, lost wages, or Medi-Cal assistance. Database access would decrease the

processing time for VCP applications, thereby improving the efficiency of the payment process.

Finally, the report recommends that the governor work with the legislature to require that "5-10% of Restitution Fund revenues for State Restitution fines and orders be allocated to Victim Witness Centers." It calls for this allocation to be made, while maintaining a "prudent reserve" in the State Restitution Fund.

2.2.6. Legislative Analyst's Office (LAO) Report (2006)

In February 2006, the Legislative Analyst's Office reviewed OES oversight of the funds and responsibilities that had been assumed when OCJP was dismantled in 2004. The LAO found that some of the same administrative problems were continuing under the oversight of OES. Specifically, accounting problems identified in OES's management of federal monies led the federal government to freeze some of its funding allocations. Also, the LAO found that OES proposals requesting additional funds to expand two programs were "lacking even the most basic information" and were poorly conceptualized and developed. The LAO recently recommended that the request for additional funding be denied (LAO, 2006).

2.3. Recent Developments in California Victim Services

2.3.1. Mental Health Services Act (Proposition 63): Funding for Adult Victims of Crime

In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA). Enactment of the MHSA expands mental health services and pays for it by taxing individuals who earn more than $1 million per year. The MHSA will eventually generate $800 million annually to support expanded mental health services. The new funding provides an opportunity to enhance mental health services for crime victims, particularly for disadvantaged victims. We reviewed the three-year plans for counties with populations of 200,000 or more in order to determine if any of these funds would indeed be used to support such services.

Allocation plans for 26 of the 27 counties were located via internet searches of each county's government website. (Information from Placer County was not available.) The review indicated that very few resources have been budgeted for crime victim services.

Of the 26 counties:

- Three counties listed crime victims either in general (San Francisco) or domestic violence victims in particular (El Dorado and Tulare) as a target group for proposed comprehensive mental health services, but no dedicated treatment slots were specifically allocated for crime victims.

- Two counties (Santa Clara and San Diego) proposed special programs for trauma and torture victims. In Santa Clara, the regional survivors of torture program for refugee populations had a proposed three-year budget of approximately $220,000. In San Diego, an outpatient mental health program (65 treatment slots) targeting refugees who are victims of trauma or torture had a proposed three-year budget of approximately $460,000.

- No county had proposed programs specifically for victims of domestic violence.

Based on this review of allocation plans for the most populous counties in California, we conclude that MHSA funding will not contribute substantially to the provision of trauma-focused mental health services for adult crime victims.

2.3.2. Improvements to Victim Services

In an attempt to address some of the problems in the current victim services system, the following changes have recently been implemented:

• **VCP Claims Management System improvements**: In recognizing that the claims process has been too time-consuming, in June 2006 the VCGCB revamped its Claims Management System by improving its electronic database. The VCGCB expects this new system will decrease the amount of time crime victims wait from the time an application is filed to the time a payment is issued. (Victim Compensation Connection, June 2006).

• **Creation of a Crime Victim's Advocate position**: In April, 2006 the governor created a California Crime Victim's Advocate (CVA) position. The CVA will function within the Governor's Office as California's lead advocate on state and federal policies that affect crime victims (Victim Compensation Connection, June 2006).

2.3.3. Loss of Funding for an Innovative Comprehensive Care Model for Victims of Crime

The Trauma Recovery Center (TRC) at SFGH/UCSF was created in 2001 as a demonstration project designed to develop and test a comprehensive service model for victims of crime that, if effective, could be disseminated throughout California to improve victim services statewide. The TRC model did prove cost-effective, and there has been widespread bipartisan support for the creation of similar programs in other counties. However, as detailed below, a gubernatorial veto and legislative delays have prevented the dissemination of this promising model.

The TRC demonstration project ended in June 2005. To preserve this successful program as a replicable model in California, the Public Safety Committee of the State Assembly introduced an urgency bill AB 1768. AB 1768 called for continued funding of the TRC for Fiscal Year 05-06 through restitution funds "in order to ensure the uninterrupted provision of vital services to victims of trauma." AB 1768 received wide bipartisan support and was approved in both houses by a two-thirds majority vote. However, the governor vetoed the bill in October 2005, stating:

"The Victim's Restitution Fund was established to assist all victims of crime by providing reimbursement for out of pocket expenses for costs related to the crime. I support protecting this fund so government can ensure victims do not face economic hardship after suffering at the hands of a criminal. Making a special appropriation out of this fund for a service provider, even for a program as successful as the Trauma Recovery Center at San Francisco, would endanger our ability to ensure these funds will be available to all victims throughout the State. In addition, by using funds in the manner contemplated by this bill will compromise Federal reimbursement funds to California because they are not being spent on direct victim reimbursement."

The governor's veto was based on incomplete and inaccurate information. The funding for the TRC, if approved, was $1.3 million, and, at the time of the veto, the State Restitution Fund had a surplus of $72.5 million, with an anticipated growth in the surplus reaching $78.8

million by Fiscal Year 07-08. As of this writing, the surplus has grown to $116 million and is projected to be $127 million in FY 07-08 (California Budget 2007-2008). Therefore, funding the TRC would not have endangered compensation for other victims.

On the contrary, there is evidence that the TRC model increased access to victim compensation and to other resources for victims who would be unlikely to utilize them on their own.

- The TRC demonstrated that it was more effective at increasing access to care (serving six times as many victims than usual care) than the current service system, and it did so in a more accountable and cost-effective manner.

- In addition, the TRC served seven times as many victims in need of mental health services as the entire panel of San Francisco fee-for-service providers. Data demonstrated that in the absence of the TRC, these victims would not have been given services because of the extensive access issues that exist under the current system of care (see section 2.4 below). Contrary to the governor's veto message, defunding the TRC has resulted in fewer victims having access to mental health care.

- The veto message is only partially accurate in stating that AB 1768 would compromise federal reimbursement because funds for the TRC are "not being spent on direct victim reimbursement."

    - The veto message is accurate insofar as the state cannot receive federal reimbursement for victims with denied applications, victims who did not file applications, or victims with approved applications who have received non-reimbursable services, such as outreach and case management services.

    - However, for TRC crime victims who have approved applications (representing 78% of the victims who filed applications), the state *can* bill and receive the 60% federal match for all allowable expenses, including lost wages, medical expenses, and mental health services.

    - In addition, it has been demonstrated that disadvantaged crime victims have a difficult time gaining access to the victim compensation system. Denying them assistance in the face of such a large surplus, because the state may not able to obtain federal matching funds for some services, represents an inherent bias in the current system of care. The goal of the state's victim services, *and the obligation of the state,* is to serve victims, not to achieve a full federal write-off or an ever-increasing surplus.

2.3.4. Additional Bills Related to the Trauma Recovery Center

In June 2006, Assembly Bill 50 was amended by Assemblyman Leno to introduce a measure similar to AB 1768 referenced above. The bill provided an additional year of funding for the SFGH/UCSF Trauma Recovery Center with the monies coming from the surplus in the State Restitution Fund. The bill was signed into law on September 30, 2006. In his signing message, Governor Schwarzenegger stated, "Given that the TRC has demonstrated its success by increasing the number of victims served while simultaneously decreasing the cost of services, I do not want to jeopardize its existence….I believe that every victim in every county in California

should have access to similar programs that increase the availability and success of victim services while reducing overall costs of administration…" The Governor's signing message goes on to direct the VCP and Department of Finance to, "…assess the cost of implementing similar programs on a statewide basis and to determine the availability and condition of any appropriate funding sources."

In January 2007, Senate Bill 153 (co-authored by Senators Migden and Runner) was introduced. This bill, if approved, would fund a variety of victim assistance services, including child advocacy centers in each county and up to five Trauma Recovery Centers that would provide comprehensive services to victims of crime. SB 153 would redirect all but 1% of the funds now sent from the State Penalty Fund (SPF) to the Driver's Training Penalty Assessment Fund (DTPAF). The DTPAF funds have been used to augment the General Fund. This redirection from 25.7% to 1% would result in a reallocation of General Fund monies. If approved, the expanded system of TRCs would be under the administrative oversight of the OES. SB 153 has been referred to the Senate Appropriations Committee.

In February 2007, Assembly Bill 1669 was introduced by Assemblyman Leno to ensure the uninterrupted provision of vital services to victims of trauma. The urgency bill provides for a year of continued funding for the SFGH/UCSF Trauma Recovery Center, with the monies coming from the surplus in the State Restitution Fund. AB 1669 has been referred to the Assembly Committee on Public Safety.

2.4. Summary of the Current Context of California Victim Services

California services for crime victims, like those throughout the United States, have repeatedly been found to be deficient at multiple levels of service organization and delivery. These deficiencies can be usefully grouped into four categories, which reflect different types of difficulties requiring different types of remedies:

- **Administrative Organization and Oversight:** Evaluations have consistently found the state-level organization of victim services to be problematic. Responsibility for victim services is spread across multiple state agencies, and both coordination and leadership are lacking. As a result, there is costly duplication of services and widespread inefficiencies that limit both the quality and quantity of services available to crime victims.

  Many evaluations and critiques have made well-reasoned and well-informed suggestions for consolidating and streamlining the organization and administration of victim services. While it is disappointing that the initial efforts at consolidation—dismantling OCJP and shifting its responsibilities to OES—did not lead to the anticipated improvements, detailed recommendations proposed by the State and Consumer Services Agency and by the California Performance Review offer additional options for improving administrative organization and oversight.

- **Access to the Victim Services System:** Crime victims, particularly disadvantaged victims with the highest need, have poor access to the service system. Many victims are unaware of their eligibility for services, and those who know that services are available encounter multiple difficulties applying for benefits. Access to services can be improved by streamlining the application process and offering outreach programs that inform victims about available benefits and assist them with the applications.

• **Access to Victim Benefits:** Victims who gain access to the victim services system and file applications for benefits encounter numerous difficulties in obtaining benefits. Difficulties occur both at the policy level, in relation to eligibility requirements, and at the procedural level, in relation to processes for evaluating applications and communicating with applicants.

Careful evaluation of current eligibility requirements in relation to victims' circumstances can inform clarification and modification of eligibility rules so that technical details do not keep eligible victims from receiving needed services. Systematic evaluation of the application and review process and associated documents can guide simplification of current procedures to enhance the accuracy and efficiency of the application process.

• **Access to Mental Health Services:** Criminal victimization puts victims at high risk of developing post-traumatic stress disorder (PTSD) and other potentially chronic and disabling psychiatric conditions. Early mental health treatment is important in helping crime victims deal with the immediate consequences of violent crime and in preventing long-term disability. Victims who are deemed eligible for victim services can gain access to traditional office-based fee-for-service psychotherapy. For some crime victims, this type of mental health service is sufficient to help them in their recovery. However, these frequently fragmented services may not meet the complex psychosocial needs of many crime victims.

Vulnerable populations, such as ethnic and cultural minorities, the homeless, the chronically mentally ill, the physically disabled, substance-abusing patients, immigrant and refugee groups, non-English speaking patients, and others living in poverty, typically have far too many complex psychosocial problems to avail themselves of office-based treatment. Linguistic and cultural factors pose additional barriers to care. In addition, trauma and violence, by their very nature, often drive victims into isolation and a reluctance to seek treatment. Ironically, a common symptom of PTSD is to avoid talking about the traumatic event, but healing and recovery require remembering and addressing the issues surrounding it.

Helping many crime victims, particularly those from vulnerable populations or those with severe, debilitating, trauma-related symptoms, requires a flexible treatment approach emphasizing community outreach, clinical case management, and coordinated and integrated psychosocial, medical, legal, and other human services. Coordination and collaboration across all of these complex systems is essential to reducing the consequences of violence and trauma in a cost-effective manner.

TRC data cannot address deficiencies in administrative organization and oversight, but they do yield useful insights into problems in the current victim services system that affect victims of violent crime, including barriers in access to care, and deficiencies in benefits and mental health services. TRC data can also be used to examine how modifications to the current service system can remedy these problems.

3. The SFGH/UCSF Trauma Recovery Center (TRC)

The Victim Compensation and Government Claims Board was directed by Government Code Section 13974.5-13974.7 to enter into an interagency agreement with the Regents of the University of California to establish the Trauma Recovery Center. The TRC was funded by the State Restitution Fund as enacted by Assembly Bill 1740 (Ducheny, Chapter 52, Statutes of 2000) and Assembly Bill 2491 (Jackson, Chapter 1016, Statutes of 2000).

The TRC was created to develop and test an alternative model of care that would be more cost-effective than the one currently offered through victim restitution funds. By addressing key problems that had been identified in the current victim services system, the new model was designed to help crime victims overcome the challenges of interpersonal violence and return to social and economic productivity. The TRC provides comprehensive services intended to increase access to the victim services system, to victim benefits, and to mental health care. Funded from 2001 through 2005 as a demonstration project, the TRC included a randomized treatment trial to help identify barriers to care and to evaluate both the clinical and cost-effectiveness of this new model compared to the usual model of victim services.

3.1. Existing Model of Services for Crime Victims and Rationale for Developing the TRC

California's Victim Compensation Program (VCP) is directed to provide responsive, timely, and coordinated help to victims of crime, which includes providing financial assistance to victims and reimbursement for mental and physical health services needed to treat injuries related to the crime.

Traditionally, the local victim services office (located in most counties) helps to identify crime victims and then assists them in applying for victim restitution funds. Victims are typically identified through police reports and the local District Attorney's office. The victim services office may send letters to victims and will sometimes make phone calls, but outreach is generally quite limited. Unless crime victims file a police report, they are in most cases not identified at all. This is particularly problematic because a significant number of victims do not report crimes to law enforcement out of embarrassment, shame, or fear of retaliation from perpetrators. A national study of rape victims found that only 16% report the crime to police (Tjaden and Thoennes, 2000). Moreover, individuals with mental and physical disabilities are less likely to file police reports, to be believed once a crime is reported, and to participate in the criminal justice process (Kilpatrick and Acerno, 2003). Therefore, a large number of legitimate crime victims may not have access to services.

Local victim services offices also conduct preliminary screenings of victims' eligibility for benefits and assist those who appear to meet eligibility criteria in submitting applications. Victims also receive referrals to mental health services that traditionally are provided by fee-for-service private practice clinicians who work almost exclusively in office-based settings in the community.

The existing service model limits access to the victim services system because only a subset of crime victims are informed about the availability of services, and only victims who clearly meet eligibility criteria are encouraged to apply. Access to mental health services is limited because traditional office-based services offered by fee-for-service providers may not meet the full range of victim needs.

3.2. The Trauma Recovery Center Model

The TRC treatment model was designed to reduce the multiple barriers to access evident in the current victim services system and to meet the special needs of crime victims by 1) directly providing mental health services; 2) coordinating care among medical and mental health care providers, law enforcement agencies, and other social services; and 3) offering a multidisciplinary staff of clinicians that includes psychiatrists, psychologists, social workers, and nurse practitioners. The TRC model utilizes a comprehensive, flexible approach integrating three modes of service: assertive outreach, clinical case management, and evidence-informed, trauma-focused therapies.

3.2.1. Assertive Outreach

Following a violent assault, most victims are too badly injured and/or too emotionally distressed to independently obtain the services they need or meaningfully participate in efforts to apprehend and prosecute the perpetrators. Assertive outreach is essential to identify crime victims, link them with needed services, and encourage their cooperation with law enforcement.

In most instances, the TRC's assertive outreach efforts begin while patients are receiving medical care at the Level 1 Trauma Center at San Francisco General Hospital (SFGH). The majority of physically injured crime victims in San Francisco, including victims of gunshots, stabbings, sexual assaults, and domestic violence, are treated in the SFGH Emergency Department and inpatient medical units. TRC staff contact these patients at bedside and subsequently help them file victim compensation applications. Staff may help victims in obtaining documentation needed to support their claims and in filing police reports. Additional TRC services are offered to all victims, including those who are unable or unwilling to file a police report. The TRC also accepts referrals from the San Francisco Community Health Network's 10 neighborhood public health clinics. Typically, these clinic patients are victimized between 31 days and three years before their referral to the TRC. Outreach efforts locate eligible victims who are not usually identified through the local victim services office, thus improving access to services. With TRC assistance and support, crime victims who might not otherwise cooperate with law enforcement often file police reports and follow up with legal proceedings, increasing cooperation with law enforcement.

3.2.2. Clinical Case Management

Following a crime, victims have many pressing needs: medical care for physical injuries, mental health care for emotional distress, safe housing, income support if unable to work, and assistance in dealing with complex legal proceedings. Crime-related injuries and emotional upset make it extremely difficult for victims to meet these needs on their own.

Clinical case management is a central component of TRC services. Initially, TRC clinicians help patients apply for victim compensation funds, thus improving access to benefits available for victims. Clinicians also coordinate medical follow-up appointments and meet immediate needs for safe housing and financial entitlements. Clinicians actively seek out patients in the community if they don't come to their appointments and make home visits if victims are not able to come to the TRC. After immediate needs are met, clinicians help patients with longer-term needs, which may include vocational rehabilitation, Section 8 housing, or other social

services. Once trauma-focused therapy is completed, the TRC links individuals who require ongoing services for chronic mental health problems to other mental health agencies and works to insure a smooth transition to continued care.

Throughout the course of treatment, TRC clinicians work collaboratively with the San Francisco Police Department, the District Attorney's office, and the local victim services office to insure that patients cooperate with law enforcement and follow-up with legal proceedings.

Evidence-Informed, Trauma-Focused Mental Health Services

The TRC increases victims' access to mental health services by offering a wide range of services that includes individual and group psychotherapy and medication management. An appropriate package of services is tailored to each patient's individual needs, whether those needs call for a full range of services or a more limited treatment plan. The primary treatment goal is the patient's functional recovery—including the ability to return to work or school and to manage the activities of daily living—and a renewed sense of safety in the world for both patient and family members.

3.3. Impact of the TRC Model

The positive impact of the TRC model has been documented in a number of ways. The results of the TRC randomized clinical trial are described in part 4 below, and the impact of the TRC model on access to the victim services system, victim benefits, and mental health care are described in part 5. Other evidence (Boccellari and Okin, 2005) follows:

- Assertive outreach resulted in the identification and treatment of over 800 victims per year.

- Integrated services increased the rate of sexual assault victims receiving mental health follow-up from 6% to 71%.

- TRC patients experienced improvements in health and functioning. At the end of treatment, 74% of TRC patients showed an improvement in mental health, and 51% demonstrated an improvement in physical health. Of those victims with substance-abuse problems, 52% either decreased their use or alcohol or stopped drinking altogether, and 55% either decreased their drug abuse or stopped their use altogether.

- Cost comparisons show that TRC services are both more comprehensive and significantly more cost-effective than the usual system of fee-for-service (FFS) care, in which mental health providers are reimbursed with victim restitution funds. Data compiled by the VCP on FFS mental health claims for the entire City and County of San Francisco were analyzed and then compared to TRC costs. This cost analysis clearly demonstrates that the TRC provides a wider range of services and is less expensive and more cost-effective: $66.81 per unit of TRC service compared to $72.23 per unit for FFS providers. In addition, the TRC served seven times as many crime victims as the entire panel of San Francisco FFS providers.

- In partnership with the San Francisco Police Department and various community-based agencies, the TRC has launched a major publicity campaign to educate the public about how to prevent drug-facilitated rapes.

• The TRC is one of two programs in California to be selected to pilot-test a rapid DNA testing procedure in cases of sexual assault that reduces analysis time from a minimum of six weeks to three days, allowing police to investigate suspects and crime scenes and the District Attorney's Office to bring charges more quickly.

• In recognition of the TRC's work with crime victims and law enforcement, the San Francisco District Attorney's Office and Office of Victim Services honored the TRC with its "Honoring Those Who Care" award.

• The TRC received a Certificate of Honor from the San Francisco Board of Supervisors for providing "Pioneering Care to Victims of Interpersonal Violence."

• The TRC also received the National Association of Public Hospitals' 2004 National Safety Net Award for Patient Services. The TRC is only one of two programs in the country to receive this prestigious national award.

3.4. Summary of Differences Between the Current Victim Services Model and the TRC Model

The current victim services model involves extremely modest outreach to a subset of crime victims, thereby limiting access to the victim services system. The TRC model increases access to the system by engaging in systematic, assertive outreach to all crime victims treated for injuries at SFGH.

The victim services model provides limited assistance in applying for benefits to victims who appear to *clearly* meet all eligibility criteria. In contrast, the TRC model increases access to benefits by providing extensive assistance to all victims, which includes helping them acquire the documentation required to satisfy eligibility rules.

The victim services model provides partial access to a limited range of mental health services by providing referrals to office-based, fee-for-service mental health care providers who typically provide traditional psychotherapy. The TRC model increases access to mental health care by providing a wider range of services—including outreach, case management, and coordination of care—that are offered in the home or community to meet individual client needs.

4. TRC Research Study and Randomized Treatment Trial

The centerpiece of the TRC's performance evaluation efforts is a research study and randomized treatment trial. The research study involved victims of recent interpersonal violence who were randomized to either TRC services or usual care, plus sexual assault victims, all of whom were offered TRC services. All participants were followed for one year to evaluate the effectiveness of TRC services.

4.1. Recruitment and Randomization

Patients were systematically identified through the SFGH Emergency Department and inpatient medical units while they were being treated for their crime-related injuries. Patients who met the criteria outlined in Table 1 were asked to take part in the research.

Table 1 **Inclusion and exclusion criteria for TRC research study**
Inclusion Criteria Age 18 or older San Francisco resident Victim of interpersonal violence receiving care in the SFGH Emergency Department or on an SFGH inpatient medical unit Willing to participate in research Exclusion Criteria Currently enrolled in mental health services Unable to give informed consent due to severe head injury, dementia, or acute medical or psychiatric illness

Hospital staff contacted the TRC when a victim of crime entered the hospital, and TRC research staff met with the patient to assess eligibility. Victims of domestic violence or other interpersonal violence (not including sexual assault) were asked to participate in the randomized research trial; victims of sexual assault, all of whom were eligible for TRC services under a pre-existing contract, were asked to participate in the research but were not randomized. Those who did not wish to take part received written information about the local Victim Compensation Program. Of those who consented to take part in the randomized trial, two-thirds were randomly assigned to TRC services, and one-third were randomly assigned to usual care. All research participants completed baseline research interviews and were invited back at 4, 8, and 12 months for follow-up interviews. Participants were reimbursed $20 for each research interview completed.

Recruitment began in August 2001 and ended in August 2004, with the last follow-up interviews completed in September 2005. Follow-up rates for research interviews were 77% at 4 months, 68% at 8 months, and 76% at the very important final 12-month interview. These follow-up rates are particularly high for research conducted in the public sector and are the product of extensive tracking and outreach efforts.

The complete research sample comprised victims of recent crime. Five hundred forty-two participated in the randomized trial, with 338 randomized to TRC services and 204 to usual care. An additional 113 victims of sexual assault who received TRC services were not eligible for randomization but did participate in the research study.

4.2. Participant Characteristics

The characteristics of the research participants are summarized in Table 2. Fifty-six percent of these crime victims were recruited from the emergency room (N=366), and 44% were recruited from inpatient medical units (N=289). Research interviews were conducted within 30 days of the crime, with the interview taking place within an average of seven days. As Table 2 shows, the sample was largely male, and more than half of the participants were members of ethnic minorities. Over one-third were homeless and almost two-thirds were unemployed. The sample had a very low monthly income, with a median of $624, well below the poverty level for

both individuals and families. Patients in the sample had a high incidence of previous trauma, having experienced, on average, five types of traumatic events (e.g., assault, child abuse, natural disasters, accidents, etc.) in their lives.

Table 2.
Demographic characteristics of research study participants

	Randomized Trial Participants (N=542)		**Sexual Assault Victims (all assigned to TRC services) (N=113)**	**Total (N=655)**
	TRC (N=338)	**Usual Care (N=204)**		
Mean Age	36 years (range 18-75)	38 years (range 18-63)	31 years (range 18-61)	36 years (range 18-75)
Gender				
Female	28% (N=93)	21% (N=42)	92% (N=104)	36% (N=239)
Male	73% (N=245)	79% (N=162)	8% (N=9)	64% (N=416)
Ethnicity*				
African American	50% (N=168)	55% (N=112)	19% (N=21)	46% (N=301)
White	23% (N=78)	17% (N=35)	43% (N=49)	25% (N=162)
Latino	13% (N=43)	11% (N=23)	14% (N=16)	13% (N=82)
Mixed Race	7% (N=25)	10% (N=20)	15% (N=17)	9% (N=62)
Other	7% (N=23)	7% (N=14)	9% (N=10)	7% (N=47)
% homeless	40% (N=135)	43% (N=87)	15% (N=17)	37% (N=239)
% unemployed	67% (N=225)	58% (N=119)	42% (N=48)	60% (N=392)
Median monthly income	$575	$600	$920	$624
Precipitant crime				
Physical Assault	45% (N=153)	45% (N=91)	0% (N=0)	37% (N=244)
Sexual Assault	0% (N=0)	0% (N=0)	100% (N=113)	17% (N=113)
Shooting	19% (N=64)	17% (N=34)	0% (N=0)	15% (N=98)
Stabbing	16% (N=53)	20% (N=41)	0% (N=0)	14% (N=94)
Domestic violence	15% (N=51)	16% (N=32)	0% (N=0)	13% (N=83)
Vehicular Assault	5% (N=17)	3% (N=6)	0% (N=0)	4% (N=23)

*Note. Due to rounding error, total percentages may not equal 100% in all categories. One participant assigned to the TRC declined to state ethnicity.

As shown in Table 3, these 655 patients reported high levels of traumatic stress symptoms at their baseline interviews. Almost half the sample, 46%, met criteria for diagnosis of Acute Stress Disorder (N=298). This may be an underestimate, given that the majority of patients were evaluated within days of their injury, and trauma-related symptoms typically continue to emerge or evolve over the course of time. This is a highly symptomatic group of crime victims,

with more than three-quarters reporting being hypervigilant and having intrusive memories of the crime. More than half reported having nightmares and flashbacks, i.e., re-experiencing the trauma as if it were actually occurring again.

Table 3. Trauma symptoms reported at the baseline interview.

	Randomized Trial Participants (N=542)		Sexual Assault Victims (all assigned to TRC services) (N=113)	Total (N=655)
Symptom	**TRC (N=338)**	**Usual Care (N=204)**		
"On guard" (hyper vigilant)	82% (N=276)	84% (N=171)	91% (N=103)	84% (N=550)
Intrusive memories of the trauma	86% (N=292)	79% (N=161)	92% (N=104)	85% (N=557)
Difficulty concentrating	78% (N=263)	69% (N=140)	90% (N=102)	77% (N=505)
Easily startled	70% (N=237)	64% (N=131)	86% (N=97)	71% (N=465)
Insomnia	72% (N=243)	67% (N=136)	85% (N=96)	73% (N=475)
Avoiding things that remind them of the trauma	62% (N=209)	58% (N=118)	92% (N=104)	66% (N=431)
Flashbacks	50% (N=168)	48% (N=98)	56% (N=63)	50% (N=329)
Nightmares	52% (N=175)	40% (N=82)	73% (N=82)	52% (N=339)

Although 40% were employed at the time of the crime, this subset comprised impoverished individuals who had multiple psychosocial needs related to housing, medical services, and vocational assistance. When asked if they had "enough money" to cover expenses, 50% did not have money for medication (N=325), 48% did not have enough money for rent (N=310), and 29% did not have enough money for food (N=192). In terms of other psychosocial needs, 79% expressed interest in obtaining medical services (N=515), 79% in help finding safer housing (N=513), 70% in help finding a job (N=456), 74% in receiving mental health services (N=486), and 42% in receiving substance-abuse services (N=275).

4.3. Key Results of the TRC Randomized Treatment Trial

Analyses of the complete data from the TRC randomized treatment trial are in progress, but key findings from initial analyses follow. Compared to those receiving usual services:

- TRC clients were four times more likely to file Victim Compensation Program applications.
- 56% more TRC clients returned to employment.
- Homelessness was reduced 41% more among TRC clients.
- 44% more TRC clients cooperated with the District Attorney's office.

The results obtained to date strongly indicate that the TRC model is both clinically- and cost-effective compared to current victim services

5. Impact of the TRC Model on Access to the Victim Services System, Victim Benefits, and Mental Health Services

Barriers to access have been repeatedly identified in evaluations of the current victim services system. This section presents an in-depth examination of the TRC's success in reducing barriers to the victim services system, victim benefits, and mental health services. To conduct the evaluation, we used the following sources: 1) data collected in the TRC randomized treatment trial; 2) additional data on trial participants collected through a systematic review of clinical records; 3) data from the Victim Compensation Program on claims submitted by trial participants; and 4) qualitative data from a focus group with TRC clinicians about barriers to care for crime victims.

5.1. Access to the Victim Services System

Crime victims cannot obtain the benefits and services to which they are entitled if they are not aware that benefits exist nor able to apply for them. The TRC model was designed to improve access to victim services through assertive outreach to all victims of crime identified at SFGH and the provision of case management to all victims engaged in TRC services. A key aspect of the outreach efforts was to inform victims of the availability of VCP benefits, and an initial focus of case management efforts was to assist victims in applying for benefits.

5.1.1. Applications Filed

Claims data obtained from the VCP on randomized trial participants indicate that the TRC's outreach and case management efforts were highly successful in improving access to the victim services system. Of the 338 trial participants randomly assigned to TRC services, 56% (189) submitted applications for VCP benefits. In contrast, only 23% (47) of the 204 participants randomized to usual care submitted applications. The difference is statistically significant, both in terms of the percentage of applications (chi square=55.9, $p<.01$) and the likelihood of filing an application: TRC patients were more than four times as likely as usual care patients to file an application (odds ratio=4.2, $p<.01$).

5.1.2. Importance of Professional Assistance

Further analysis demonstrated the importance of the direct services provided by the TRC. This analysis included all 451 research study participants offered TRC services (338 randomized trial participants and 113 non-randomized victims of sexual assault). Of the 451 victims, 343 (76%) engaged in TRC services, while 108 (24%) did not. Sixty-nine percent (235) of those who engaged in services submitted applications for VCP benefits. However, only 17% (18) of those victims who were offered services but did not engage in them submitted applications. The difference in application rates between those who engaged in services and those who did not is statistically significant (chi square=89.6, $p<.01$). The provision of services is critical in improving access to the victim services system. Said differently, disadvantaged crime victims appear unlikely to gain access to the victim services system without professional assistance.

5.1.3. Disadvantaged Victims

To determine whether TRC services improved access specifically for disadvantaged victims, we used our randomized trial data 1) to examine the relationship between demographic and socioeconomic characteristics and the filing of an application, and 2) to examine whether receiving TRC services had any differential effect on application filing. The only demographic or

socioeconomic characteristic directly associated with filing an application for benefits was homelessness at study entry. Homeless participants were 76% less likely to file applications than were housed participants (odds ratio=.24, p<.01). TRC services did significantly increase the application rate among homeless participants: 50% of homeless participants randomly assigned to TRC services filed applications, compared to only 9% of homeless participants randomly assigned to usual care (chi square=39.8, p<.01). While income was not directly related to application filing, lower-income TRC participants (incomes below the sample median of $624 per month) were more likely than lower-income usual care participants to file applications: 54% (99) compared to 16% (16) (chi square=43.8, p<.01).

5.2. Access to Victim Benefits

Filing an application is only the first step in obtaining victim services benefits. The VCP must follow state law and regulations in determining eligibility, and if the victim does not meet these eligibility criteria, the VCP has no alternative but to deny the claim. One important eligibility requirement is the crime victim's cooperation with law enforcement, which includes, but is not limited to, reporting the crime, responding to requests in a timely manner, assisting with identifying and apprehending suspects, and testifying in criminal proceedings. Some of the reasons why claims are denied include:

- The crime victim was not willing to cooperate with law enforcement, or there was insufficient documentation that a crime was committed.
- The crime victim did not file the compensation application in a timely manner (i.e., within one year of the date of the crime or less than three years after the date of the crime) without a "good cause" reason submitted.
- The crime victim was on felony probation or parole, and therefore not eligible for reimbursement of victimization-related expenses while on parole/probation.
- At the time of victimization, the crime victim was engaged in illegal activity, and the illegal activity was found to be involved in the events leading to the crime.

As a unique feature of the randomized treatment trial, the VCP and TRC agreed that the TRC would submit applications to the VCP even for victims who did not meet state eligibility criteria in order to accurately determine the number of crime victims deemed ineligible and the reasons for their ineligibility. This information could help determine whether state law and regulations governing eligibility should be changed to improve victims' access to benefits.

5.2.1. Application Approval

As a first step in determining whether the TRC model improved access to victim benefits, we used the VCP claims data for the randomized trial sample to compare the application approval rates of participants assigned to TRC services with those assigned to usual care. The results are shown in Table 4.

Table 4. VCP Application Submission and Disposition in Randomized Participants						
	Total Randomized Trial Participants (N=542)	**TRC (N=338)**	**Usual Care (N=204)**	**Chi-square Statistic and Odds Ratio**		**p**
Filed VCP Claim	44% (N=236)	56% (N=189)	23% (N=47)	X^2=55.9	OR=4.2	0.0001
VCP Claim status						
Approved	81% (N=191)	78% (N=148)	92% (N=43)	X^2=4.2	OR=0.34	0.04
Denied	19% (N=45)	22% (N=41)	9% (N=4)			
VCP Claims approved/total sample	35% (N=191)	44% (N=148)	21% (N=43)	X^2=28.8	OR=2.92	0.0001

Of the 189 applications filed by participants randomized to TRC services, 78% (148) were approved and 22% (41) were denied. Of the 47 applications filed by participants randomized to usual care, 92% (43) were approved and 9% (4) were denied. The approval rate for TRC participants was significantly lower than the rate for usual care participants (chi square=4.2, p=.04). This difference is not surprising, since usual care participants who submitted applications for benefits generally submitted them through the local victim services office, which screens applicants for eligibility and only submits applications that are likely to be approved. By contrast, the TRC intentionally submitted applications for victims whether or not they met current eligibility criteria. The anticipated higher denial rate for TRC participants likely reflects barriers for some legitimate crime victims who do not qualify under the state's current eligibility criteria. Reasons for denial are examined in detail in section 5.2.3 below.

5.2.2. Application Processing Time

The time required to process applications and determine eligibility for benefits is a crucial factor influencing access to benefits, particularly access to compensation for medical bills, lost wages, and relocation expenses.

Up until June 2004, the State of California used the federal Office for Victims of Crime (OVC) definition of application processing time: "The processing period begins when the Compensation Program first receives an application and ends when a check is mailed on behalf of an eligible victim. Count all calendar days during the processing period, including days in which the program is awaiting information." In June 2004, the VCP changed its definition so that the "counting and processing of time begins when the VCP accepts an application as complete and ends on the date the staff recommends to award or deny a claim."

For the purpose of this analysis, we have used the federal OVC definition of processing time— beginning when the VCP first receives an application rather than when the application is complete—because it more accurately captures the wait time that the victim is subjected to (Executive Officer's Report to the Board, June 2004).

Table 5 shows that there was not a statistically significant difference between the processing times of applications from TRC participants and those from usual care participants

Table 5. Mean Processing Time of Applications								
	Total Randomized (N=236)		**TRC, non-SA (N=189)**		**Usual Care (N=47)**		**Statistic**	**p**
	M	SD	M	SD	M	SD		
Days from received application to hearing	109.3	101.3	120.8	98.9	62.8	98.6	F=0.40	0.53
Days by approval status								
Approved	87.1	97.1	100.2	95.6	42.3	35.3	F =48.3	0.0001
Denied	203.0	89.1	195.1	71.5	283.5	246.3		

(F=0.40, p=.53). The mean processing time was longer for TRC participants, but there was a high degree of variability in the processing times for both groups. The average processing time for TRC participant applications was 121 days (4 months). The average processing time for usual care participant applications was 63 days (2.1 months).

Looking at all applications, however, there was a highly significant difference in the processing times for approved applications relative to denied applications across treatment conditions (F=48.3, p<.01). Approved applications were processed in an average of 87 days (2.9 months), while denied applications took an average of 203 days (6.8 months). Thus, TRC services had no real impact on application processing time.

5.2.3. Application Denial

In order to more fully explore potential barriers to obtaining access to victim benefits, we reviewed the clinical records of the 253 crime victims who participated in the TRC research study and submitted VCP applications: 189 randomized trial participants assigned to TRC services and 64 non-randomized victims of sexual assault. The clinical records held a variety of information related to the crime that brought the victim to the TRC, including applications and other documentation submitted to the VCP. Randomized trial participants assigned to usual care could not be included in these analyses because comparable data were not available for individuals who did not receive TRC services.

Of the 253 submitted applications, 196 (77%) were approved, including 18 that were initially denied and then successfully appealed and 57 (23%) that were denied. Of the 57 denied claims, two were submitted without the assistance of the TRC, and therefore no application information is contained in the chart. The other 55 denied claims were submitted through the TRC, and information present in the charts was examined in detail.

Reasons for the VCP's denial of the 55 claims are summarized in Table 6.

Table 6. Reasons for denied claims (n=55)		
Reason	**N**	**%**
No crime occurred	36	66
Lack of cooperation with law enforcement	7	13
Was involved / or participated in a crime	6	11
Duplicate claim	4	7
Late claim	1	2
Lack of cooperation with the VCP	1	2

A more detailed discussion of potential barriers to access follows.

Duplicate claims: Although "duplicate claim" was cited as reason for denial only four times, the chart review indicated that all four seemed to stem from clerical errors at the VCP resulting in the assignment of two different claim numbers for a single claim.

Problems with police reports: Seventy-nine percent of all denials fell into two categories: "No crime occurred" and "Lack of cooperation with law enforcement." Review of available documents revealed that the majority of these denials stemmed from problems with the filing of police reports or with the reports' content.

While state regulations do not require a police report to be filed, VCP evaluations rely very heavily on them. The lack of a police report may be considered evidence of a failure to cooperate with law enforcement or may suggest that "no crime occurred." In over half (53% or 29) of the 55 denied claims, a police report had not been filed. In one instance, the police did not generate a report, and in another, documentation about the status of the report was absent. Reasons victims did not file police reports are summarized in Table 7 for the 27 victims for whom documentation was available.

Table 7. Reasons victims did not file a police report (N=27)

Reason	
Fear of retaliation	30% (N=8)
Too symptomatic/distressed	26% (N=7)
Didn't see point	15% (N=4)
Fear of negative police response	11% (N=3)
Did not want police involved in situation	11% (N=3)
Unknown	7% (N=2)

Examination of the clinical records indicated that victims who declined to file police reports often had legitimate reasons for not doing so. The most common reason was fear of retaliation by the perpetrator. This reason was cited by 30% of victims who did not file a police report and was particularly common among victims of domestic violence and neighborhood/gang violence. Symptoms of post-traumatic distress—being too frightened or psychologically or cognitively disorganized—also prevented victims from filing. Symptoms accounted for 26% of the instances in which no report was filed. In 15% of the cases, victims believed that there was no point in filing a police report because, for example, they did not see the perpetrator and could therefore not provide information that would lead to an arrest. Other reasons for not filing a police report included being afraid of the police or believing that the police would not believe them (11%), or not wanting the police to be involved (11%).

For 47% (N=26) of the 55 denied applications, a police report was filed. In eight of these cases, a copy of the report was present in the chart and was reviewed. The chart review indicated that in seven of the eight cases, the police report contained inconclusive, contradictory, or unclear information regarding whether a crime had occurred. The eighth police report clearly indicated that a crime had occurred.

During the TRC research study, the VCP did not accept alternative documentation in lieu of police reports, which remain the sole basis for determining that a crime occurred. Therefore, the TRC neither made systematic efforts to collect additional documentation, nor routinely submitted available documentation to the VCP. However, in five instances where applications were denied and police reports had not been filed, the chart review revealed that SFGH medical reports, legal documents related to sexual assault or domestic violence reporting, or other documents contained evidence that a crime had occurred. It is likely that additional documentation could have been obtained in more cases had systematic efforts been made.

Examples of problems in filing police reports: Qualitative data from a focus group of TRC clinicians provides specific examples of difficulties that individual victims encountered in filing police reports. Such examples shed light on situations where the reason given for denying an application is "lack of cooperation with law enforcement" or "no crime occurred."

Police were called but did not file a report. Several TRC patients stated that they attempted to file a police report, but the police would not make the report, believing the victim's report suspect or the evidence insufficient. For example, a 35-year-old gay man reported that he had been sexually assaulted by an acquaintance. In his effort to flee, he jumped through a second-story glass window, sustaining minor injuries in his fall. Neighbors called 911, but when the police arrived, they refused to file a police report. Instead, they filed an Unusual Occurrence report classifying the incident as an "accident." The police implied that a man couldn't be sexually assaulted and viewed it as a "domestic tiff."

Police determination of "lack of cooperation" seems inappropriate. In some cases where police had been unable to locate the victim, they reported the victim's lack of cooperation. In another case, a victim was described as uncooperative because he refused to participate in a wire tap out of fear of retaliation.

Police report casts inappropriate doubt on a victim's report of a crime. In one instance, a homeless man delayed reporting an assault by a stranger out of fear and distress; when he reported the incident to the police, they expressed disbelief because the patient had a previous history of committing domestic violence.

In another example, a monolingual Spanish-speaking woman reported being sexually assaulted by a physician during a physical exam. The police report indicated that her report was not credible. However, two other women later came forward with sexual assault complaints about the same physician.

5.2.4. Additional procedural barriers

The chart review combined with cumulative clinical experience at the TRC revealed procedural problems that limit victims' access to benefits.

- The VCP application is available only in English and Spanish.
- Letters sent to crime victims regarding the status of their VCP claims are written at a high literacy (at least eighth grade) level. Crime victims served in the public sector often have a literacy level of less than sixth grade. Frequently victims are unable to comply with requests for additional documentation because they cannot interpret the letters they receive. Letters are often written using legal jargon that even clinicians sometimes have difficulty understanding.

• Because letters regarding claims are written only in English, monolingual or limited English-speaking victims face additional linguistic barriers to obtaining entitlements.

• Some letters are written in a condescending manner that blames the crime victim for the crime. For example, a VCP claimant had been drinking at the time he was assaulted by a stranger on the street. The denial letter sent to the claimant states: "The claimant was involved in an activity which clearly put himself into a situation where the victimization was a reasonably expected result, and which a prudent individual would have avoided completely."

• Emergency awards may take up to 30 days to process and sometimes take even longer. Crime victims served in the public sector often need money urgently for food, shelter, and the support of their families.

• The state reimburses victims for lost wages. However, in some cases, the crime victim is a caregiver for children or an elderly parent. Because of the victim's crime-related disability, another family member may need to take time off from work to care for the victim or to assume childcare or eldercare responsibilities. Lost wages for these family members are not covered.

• The amount of documentation required to substantiate a claim can be overwhelming to the distraught crime victim. Streamlining documentation or decreasing the duplication of paperwork would help. For example, when applying for compensation for lost wages, victims fill out separate and distinct lengthy forms for both the State of California Employment Development Department and the VCP. It would greatly simplify the application process if both agencies accepted the same form.

• Currently crime victims can be reimbursed for moving expenses related to their safety. This works well for victims who can pay the first and last month's rent on their own and then wait to be reimbursed by the VCP. However, victims who lack adequate funds have difficulty renting new quarters. Most landlords require a deposit before signing a lease or rental agreement, but the VCP requires a signed lease before issuing reimbursement, creating an obstacle to victims who need relocation-expense reimbursements.

• Occasionally, after an application is approved, there is a delay in reimbursing crime victims for out-of-pocket expenses. Such delays contribute to victims' distress because unpaid bills are sent to collection agencies that then harass victims with intrusive and threatening letters and calls.

5.3. Access to Mental Health Services

An important goal of the TRC randomized trial was to evaluate whether the TRC model improved access to mental health services relative to the current service system. Indeed, the TRC was successful. Seventy-four percent (249) of participants randomized to the TRC entered mental health treatment, compared to only 30% (62) of participants randomized to usual care (chi square = 97.4, $p < 0.01$). Thus, crime victims randomized to TRC services were more than *six times* as likely to enter treatment as were usual care victims (odds ratio=6.4).

Additionally, a chart review of the services received by TRC clients supports the premise that traditional office-based mental health services reimbursed by the current victim services

system may not meet the needs of disadvantaged crime victims. A total of 291 individuals (including those randomized to TRC and non-randomized victims of sexual assault) entered TRC treatment. Nearly all of them (99%) required some case management services, with an average of 5.6 case management contacts per victim. This indicates that nearly all disadvantaged victims who obtain services require assistance meeting basic needs. However, case management services are generally not reimbursable expenses under VCP guidelines.

6. Summary

Interpersonal violence is known to have devastating and enduring psychological and physical effects on individuals, their families, and the communities in which they live. This report provides an overview of California's crime victim services. California operates the largest state crime victims program in the country, and it has traditionally taken a leadership role in providing services to victims. This reputation is being tarnished. Several reports from independent and legislative analysts, as well as from state agencies, have clearly demonstrated that the state's system of victim services is fragmented, lacking in cohesive leadership and oversight, and not readily accessible. The system is broken. It has a top-heavy administrative structure with excessive overhead that reduces funds that should be available to victims. It is inefficient, with redundancy and duplication of services across a large number of different departments. The victim compensation claims process is overly cumbersome, complex, and time-consuming. The quality of services offered by victim services programs has not been adequately evaluated, and a lack of accountability hampers the state's effectiveness in delivering services.

Governor Schwarzenegger and the California Performance Review have mandated that state government be both accountable and cost-effective, recommending that only programs meeting this standard be funded. Yet victim services in California continue to be plagued by problems. Troubling disparities are also evident, with underserved populations such as the poor, ethnic minorities, the disabled, and the homeless poorly served by the prevailing system of care.

Over the last several years, state victim service agencies and the State Legislature have taken steps toward improving victim services. For example:

- The State Legislature enacted AB 2430, which resulted in the State and Consumer Service Agencies 2003 Report on Crime Services throughout California. This comprehensive report provided extensive recommendations on how the state should restructure crime services. Unfortunately, this roadmap for change has been largely ignored.

- The beleaguered Office of Criminal Justice Planning was dismantled and its funds transferred to the Office of Emergency Services. Although this change helped to decrease some redundancy in victim services, the OES continues to struggle with its inherited fiscal management problems and has not been able to maximize federal grant monies.

- The legislature enacted AB 1740 and AB 2491, which established the first Trauma Recovery Center for the State of California. Although the TRC has demonstrated that it is both more clinically- and cost-effective than traditional victim services, and continued funding was approved by a two-thirds majority vote in both houses, the governor vetoed the program's continued funding. The governor's California Performance Review has

also made a number of recommendations for restructuring victim services, but the majority of these recommendations have not been implemented.

• The Victim Compensation and Government Claims Board has made great strides in revamping its claims management system and has recently implemented the new system to make the claims process more efficient. However, even with a streamlined process, the VCGCB must adhere to overly stringent government regulations and guidelines, which are biased against victims who may be unable or unwilling to file a police report.

• The governor recently created a California Victim's Advocate position to serve as the lead advocate on state and federal policy that affect crime victims. While this is a step in the right direction, it falls woefully short of the consistently recommended total restructuring of victim services.

Although these recent efforts are positive, they are only the initial steps required if California's victim services are to fulfill their important mission.

7. Policy Implications and Recommendations

Based on a review of reports by independent and legislative analysts and the results from a randomized treatment trial, our report concludes that the State of California is failing at providing responsible, accountable, and accessible services for some of California's most vulnerable citizens: victims of violent crime. All the critiques and data analyses deliver the same clear and consistent message: services for crime victims need to be restructured. While critical of the current system of care, this conclusion is advanced with the hope that Governor Schwarzenegger's statement that "justice cannot be served until victims are served" does not remain mere words, but rather can become California's reality.

7.1 Administrative Organization and Oversight

7.1.1. Consolidate Administration and Oversight

Findings: As noted, the California system of victim services is fragmented and lacks cohesive leadership and oversight. Its top-heavy administrative structure and excessive overhead reduce funds that should be available to victims. It is inefficient, with redundancy and duplication across a large number of state departments.

Recommendation: Restructure and consolidate the administration of California victim services. As a number of prior evaluators suggest, all victim services should be consolidated under a single state agency (the Office of Victim Services). This office would coordinate and oversee the VCGCB, the Public Safety and Victim Services Branch within OES, and victim services within DHS, as well as incorporate other victim programs found in more than 11 other agencies. This restructuring would also unite claims-based and non-claims-based programs under the same organizational umbrella. Consolidation would lead to greater coordination, less fragmentation and redundancy, and a positive fiscal impact due to a decrease in administrative overhead and improved efficiencies.

7.1.2. Restructure Services to Meet Victims' Needs

Findings: Administrative fragmentation has led to duplication of services for some

groups of crime victims and lack of services for others. Services are generally poorly suited to meet the diverse needs of California crime victims.

Recommendations: The State and Consumer Services Agency Report of 2003 offers a thoughtful and comprehensive critique of California's victim services and a plan for restructuring services to meet victims' needs. The recommendations remain valid, and the report should serve as a road map for the execution and implementation of needed structural changes. The key recommendations are:

- Create a Victim Advisory Committee.
- Complete a statewide needs assessment for victim services.
- Develop an action plan to insure comprehensive victims' rights and services in all parts of the state.
- Identify programs that represent examples of best practices that can be replicated statewide.

7.2 Access to the Victim Services System

7.2.1. Inform Victims About Service Availability

Findings: In many instances crime victims do not obtain access to the victim services system because they do not know that services are available. A recent national study found that only 23% of victims knew victim services were available to them. In California, the 40,342 victim compensation applications approved in Fiscal Year 04-05 represented only 20% of the 198,070 violent crimes committed in the state that year (U.S. Department of Justice, Bureau of Justice Statistics, 2006). In San Francisco, only victims who file police reports are referred to the local victim services office. In the TRC randomized trial, victims receiving TRC services were over four times more likely to file applications for victim compensation benefits than victims receiving usual care.

Recommendation: Use direct outreach in multiple settings to insure that victims of crime understand that benefits are available to them. The TRC trial demonstrated that direct contact with victims in acute-care hospital settings efficiently reaches victims injured in violent crimes. Outreach in other settings may identify additional victims who are unaware of the services available to them.

7.2.2. Assist Victims in Applying for Benefits

Findings: Current procedures for applying for victim compensation are complex, and many victims need professional assistance to complete applications. Among research participants assigned to TRC services, 69% of those who engaged in services submitted applications, compared to only 17% of those who did not engage in services.

Recommendation: Provide ongoing assistance to victims in completing and submitting applications for victim compensation benefits. Assistance provided as part of the comprehensive TRC model proved effective, and similar assistance with the application process could be provided in other types of settings.

7.2.3. Provide Targeted Assistance to Disadvantaged Victims

Findings: Prior evaluations consistently found that disadvantaged victims encounter particular difficulties in gaining access to the victim services system. In the TRC randomized trial, 50% of homeless individuals assigned to TRC services filed applications, compared to only 9% of those assigned to usual care. Similarly, among victims with below-median incomes, 56% of those assigned to TRC services filed applications, compared to only 16% of those assigned to usual care.

Recommendation: Provide targeted, assertive outreach to disadvantaged victims, who are most in need of services but least likely to be able to obtain them. The TRC trial demonstrated that outreach helps disadvantaged victims in a public-sector hospital setting. Outreach in other health and social service settings serving the homeless, members of immigrant groups, the disabled, and other disadvantaged populations would probably reach additional crime victims.

7.3 Access to Victim Benefits

7.3.1. Evaluate and Modify Eligibility and Documentation Requirements

Findings: The state has a dual mission to ensure that victims' needs are met, while also preventing the misuse of public funds. However, both national and state evaluations have found that the amount of documentation a victim needs to substantiate a claim is so unduly extensive and burdensome that it constitutes a barrier to care. Among crime victims who received TRC assistance in filing victim compensation applications, the most common reasons that claims were denied were related to problems with police reports. In over half of the instances in which claims were denied, the victim had not filed a police report, often with good reason. In about one-third of the cases in which victims had not filed a police report the victims feared retaliation from the perpetrator. In more than another quarter of the cases, the victims were unable to file reports because they were suffering from symptoms of post-traumatic distress. In other cases, police reports were filed but contained inconclusive or contradictory information about whether a crime had occurred.

Recommendations: The VCP should re-evaluate current eligibility requirements and consider other types of documentation in determining whether a qualifying crime has occurred rather than relying solely on police reports. In particular, current rules for considering medical documentation should be carefully reconsidered. Medical information provided by licensed health care providers and clearly documenting crime-related injuries should be allowed in lieu of police reports. Currently, California Code of Regulations Title 2, Section 653.5 (d) states, "medical or mental health records may not be sufficient evidence that a qualifying crime occurred." This implies that information in medical records may be considered and may (or may not) be determined to be sufficient evidence of a qualifying crime. However, in practice, cases with medical documentation but without a police report are often denied eligibility.

We further recommend that the VCP develop guidelines for licensed health-care providers as to the documentation needed to provide sufficient evidence that a crime has occurred. Additional training for claims reviewers on what is considered acceptable and sufficient documentation is also warranted. Together, the guidelines and training will increase the likelihood that legitimate crime victims who are unable or unwilling to file police reports may still become eligible for victim compensation reimbursement.

Specialized training of law enforcement officers is also warranted to ensure greater sensitivity to crime victims when collecting information about crimes. This is especially true in relation to culturally diverse and marginalized groups of patients, including patients who are ethnic and racially diverse; refugee and immigrant; gay, lesbian and transgendered; homeless; chronically mentally ill, cognitively impaired, or developmentally delayed.

7.3.2. Streamline Claims Processing

Findings: National data suggest that 25% of victims have difficulty in having their applications processed in a timely fashion, and 73% of victims with approved applications are left with unreimbursed expenses (Newmark, 2006). In the TRC randomized trial, approved applications were processed in 2.9 months, on average, while denied applications took almost four months longer, or 6.8 months, to process. The additional waiting period to determine whether individual bills will be paid is extremely difficult for victims who are already experiencing high levels of emotional distress and financial stress.

Recommendation: The VCP should be commended for implementing a new electronic database that promises to decrease the amount of time a victim has to wait between filing an application and having a payment issued. However, while this system will lead to improvements in the claims process under the VCP's control, many delays occur because the VCP has to wait for information from other agencies to verify claims. The process would be more efficient if the VCP could have direct access to other state databases to verify applicants' claims (California Performance Report, 2004).

7.3.3. Improve Communication with Victims and Reduce Linguistic and Cultural Barriers

Findings: Language and literacy barriers limit access to victim services. The victim compensation application and related brochures are currently available only in English and Spanish, and the correspondence that victims receive from the VCP is only in English. Even for English-speaking victims, the letters are extremely legalistic, complex, and difficult to comprehend. Eligible victims may inadvertently fail to complete the application process because they do not understand the correspondence received from the VCP.

Recommendation: The victim compensation applications and related brochures should be made available in other languages common among California residents. Individual letters to victims should be written at a lower literacy level, less legalistic, more clearly organized, and more consumer-friendly. Efforts should be made to translate letters into languages other than English or provide other means for victims to communicate with the VCP in different languages.

7.4. Access to Mental Health Services

7.4.1. Improve Access to Mental Health Services

Findings: Cumulative evidence documents that without some form of effective mental health care about half of victims of violent crime develop psychological or social difficulties. Furthermore, disadvantaged people, including those who are poor, homeless, of an ethnic minority, or disabled, are at increased risk for criminal victimization and for developing disabling PTSD after victimization. Thus, it is particularly important for disadvantaged crime victims to have access to appropriate mental health care through the victim services system. Data

from the TRC study document the high level of mental health treatment needs among disadvantaged crime victims. The majority of the participants in the TRC research study experienced significant symptoms of post-traumatic distress and other psychiatric disorders.

Recommendation: Assertive outreach is essential to link victims of crime to mental health services that they need. The TRC model emphasized assertive outreach to victims, beginning during or soon after their initial acute medical treatment for crime-related injuries. In the randomized trial, active outreach resulted in 74% of the victims assigned to TRC services entering treatment compared to only 30% of those assigned to usual care. Many victims are too distressed to pursue referrals to mental health care providers, and others are too unfamiliar with mental health services to see them as a helpful resource worth pursuing. The TRC model, which integrates outreach with case management and psychotherapy into a comprehensive model of care, has proven highly successful in an urban area. Other outreach models may prove equally useful in rural areas where a centralized comprehensive program is not practical.

7.4.2. Expand the Range of Mental Health Services Available Through the Victim Services System

Findings: It is a state and federal priority to provide victims of crime with responsive, timely, and coordinated assistance that includes mental health services. However, the current service system provides referrals only to private, office-based, fee-for-service (FFS) mental health practitioners, who tend to provide traditional psychotherapeutic interventions. These services meet the needs of some crime victims, but tend not to meet the complex psychosocial needs of many, even most, victims of crime, who also have concrete, tangible needs for help with, for example, finding safe housing, obtaining financial entitlements, returning to work, and activities of daily living.

The TRC model was specifically designed in collaboration with the VCP to provide comprehensive services that address a wide range of mental health and psychosocial needs. Like the FFS mental health services currently reimbursed by the VCP, the TRC model includes trauma-focused psychotherapy. However, the TRC model also offers extensive community outreach and clinical case management, services that disadvantaged crime victims need but that are not currently reimbursable. The TRC model is more effective than the usual system of care in improving cooperation with law enforcement, reducing homelessness, facilitating return to work, and improving the quality of life among victims of interpersonal violence. Data suggest that the added outreach and case management services were essential to the model's success, with assertive community outreach proving to be a powerful intervention to engage victims in needed services. Victims had numerous case management needs, and 99% of research participants who engaged in TRC services required some case management assistance.

Recommendation: The VCP should expand its coverage of mental health services beyond office-based psychotherapy to include the community outreach and case management services that are essential to the recovery of victims of violent crime. Whenever possible, an integrated service model, similar to the TRC model, that provides the full range of mental health and social services is likely to prove most clinically- and cost-effective.

8. Fiscal and Policy Implications of Recommendations

Adoption of the forgoing recommendations will decrease administrative overhead, improve efficiencies, lead to a more accountable system, and improve access to care and quality of services for crime victims. If implemented strategically and adroitly, all of the improvements can be achieved in a cost- effective manner. For example:

- Consolidating all victim services under a single agency should lead to decreased administrative overhead, increased accountability, reduced duplication of services, less fiscal waste, and increased funds available to serve victims.
- Streamlining the victim compensation claims process should also result in a decrease in administrative overhead and cost.
- The state should be more proactive in maximizing federal funds. The creation of the Office of Victims Services will also create a more cohesive and focused entity for seeking out federal funds.
    - The state should increase its efforts to pursue more discretionary federal grants.
    - The state should advocate that federal efforts be increased to enhance the collection of federal fines and penalties.
    - The state should advocate that the Congressional cap for VOCA funds be increased so that a greater percentage of those funds are distributed to the state.
    - The state should advocate that the federal government provide funding that allows greater flexibility to create more innovative programs.
- Greater accountability in state victim services will insure that federal dollars are maximized and that federal monies are not frozen because of poor fiscal oversight at the state level.
- Revenues to the State Restitution Fund will be increased by encouraging the courts to more diligently order restitution fines and more strictly enforce their collection.
- The TRC model should be replicated statewide as a cost-effective system of care that requires less administrative overhead than is inherent in a claims-based system requiring multiple levels of claims verification, claims review, and a billing and reimbursement system.
- The governor should work with the legislature to require that 10-15% of the State Restitution Fund reserves (now totaling $127.4 million) be allocated to fund statewide TRCs. This allocation would be made while also mandating that an 85-90% reserve be maintained in the State Restitution Fund.
- Public hearings on California's victim services system need to be convened by the State Legislature in coordination with the Governor's Office, as a catalyst for creating and implementing change.

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