Remote and Hybrid Work in Crime Victim Services: A Scoping Review

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Abstract. Using the PRISMA framework for scoping reviews, we identified 27 studies on remote and hybrid work in the victim services sector that met our inclusion criteria. Studies were examined regarding (1) the data and methods used to examine remote and hybrid work in victim service agencies; and (2) provider-level and client-level outcomes. Findings show most studies are exploratory in nature, rely on qualitative data from professionals only (i.e., not service users), and suffer from methodological limitations (e.g., reliance on small, convenience samples). Further, most studies focus on the transition to remote service delivery during the COVID-19 pandemic and on domestic violence/sexual assault agencies. Findings show that common provider-level challenges include technological barriers, concerns about the security of online services, and the development of rapport with clients virtually; while strengths include personal-professional flexibility, the development of new collaborations, and work productivity/efficiency. Client-level challenges include technology access, digital literacy, and confidentiality and safety concerns, while strengths include increased access to services, reduced cost, and increased anonymity of virtual services. Results suggest that we need additional, rigorous evaluation research to understand how processes and outcomes differ between remote and in-person services. Expanding research to a wider range of types of crime victim service providers and crime victims are also important next steps.

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1. Introduction

Crime victims have a wide range of needs that can vary across victimization types and individuals. Victims may have legal needs such as requests for victim compensation (e.g., monies for funeral expenses for a homicide victim), notification of criminal case progression, court accompaniment, and no contact orders, as well as non-legal needs including medical, housing, and/or psychological support. Victim service providers (VSPs) help facilitate meeting these needs directly or through a "warm hand off" (e.g., a specific referral to another provider) (Richards, 2016). Historically, most VSPs worked with victims face-to-face in a physical setting (Pfitzner & McGowan, 2023). Over the past few decades, however, technological advances in communication such as videoconferencing, mobile chat, and electronic forms and applications (aka apps) have resulted in a wide range of options for remote and hybrid work (Flores, 2019), including for VSPs. Further, the use of "telehealth" or "telemedicine" (where electronic technology is used to provide health services to a patient) has also grown, resulting in an increased level of comfort in discussing sensitive/confidential topics remotely (Villalobos et al., 2023). Electronic services and service provision was further spurred by the COVID-19 pandemic which forced wide expansion of remote and hybrid work (RHW) modalities within the private and government sectors (Aksoy et al., 2022), including within the criminal

justice system (Ivković & Maskaly, 2022). As such, many criminal justice and victim service agencies pivoted to fully remote service offerings and continue to offer remote services to clients (and remote or hybrid work options for employees). While virtual services may increase accessibility for clients and improve efficiency and work-life balance for professionals, they come with challenges regarding technology access and safety (Arunprasad et al., 2022). Prior scoping reviews have examined studies of technology-based solutions (eHealth) for psychosocial support among sexual assault (SA) (Bach et al., 2024), intimate partner violence (IPV)(Anderson et al., 2021; El Morr & Layal, 2020; Linde et al., 2020), and violence against women (Eisenhut et al., 2020) survivors. However, it is unclear what is known about the challenges and opportunities for crime victims, regardless of victimization type, seeking services remotely *or* the impact of RHW on victim service professionals. As such the current scoping review aims to answer the following questions: (1) What data and methods are used to examine RHW in victim service agencies? (2) What is known about RHW in victim service agencies regarding provider-level outcomes and client-level outcomes.

2. Methods

A scoping review is a "systematic approach to map evidence on a topic and identify main concepts, theories, sources, and knowledge gaps" (Tricco et al., 2018, p. 467). Scoping reviews are useful in an emerging field to determine the "scope" of a body of literature on a topical area and report on the types of evidence available and the ways such evidence has been collected (Munn et al., 2018). In the current scoping review, we examine the existing research on RHW within victim service agencies and the ways in which this knowledge has been gathered.

2.1 Stages of Scoping Review

Below we describe details on each of the four stages included in the current scoping review: (a) establishing eligibility criteria; (b) identifying relevant studies; (c) screening relevant studies; and (d) charting and organizing data. The PRISMA framework for conducting and reporting scoping reviews (Tricco et al., 2018) was utilized. Our protocol was preregistered with Open Science Framework.

2.2 Eligibility Criteria

Studies were considered eligible for inclusion if they (a) reported findings from an empirical study (i.e., not literature reviews, theoretical articles, commentaries or conceptual papers); (b) were written in English; and (c) examined remote and/or hybrid work in community- and/or systems-based victim service agencies. No studies were excluded based on the year of study. Unpublished theses, dissertations, and reports were included.

2.3 Information Sources and Search Process

MeSH and other terms combined with Boolean Operators (OR and AND) were used to create the following search equation: ("remote" OR "hybrid" OR "online" OR "web-based" OR "virtual") AND ("victim*" "survivor*" OR "victim services"). The search equation was run for title, abstract, and keywords in 4 electronic databases: PubMed, PsycINFO, SCOPUS, and Web of Science and in abstract and summary text in ProQuest Dissertations and Theses and ProQuest Social Science Premium Collection (which includes NCJRS Abstracts). We also searched Google Scholar using a combination of "remote work and victim service agencies" and "hybrid work and victim service agencies"; the first 10 pages of records sorted by relevance were reviewed. We also reviewed the reference lists of included studies.

2.4 Study Selection

All records were reviewed, and after removing duplicates, two Co-Investigators independently screened articles based on the title and abstract (Stage one review). Disagreements in screening were resolved using a third screener, a trained, doctoral-level research assistant. Studies screened in at this stage were read in full by one of the Co-Investigators and the doctoral-level researcher (Stage two review). Again, disagreements were resolved using the third screener. Inclusion/exclusion was tracked at each stage using the PRISMA flow chart (See Figure 1). Rayyan software was used to manage and organize the review process.

At Stage one, 1,998 records were identified. After removing 712 duplicates manually and using the duplicate detection function in Rayyan, 1,286 records were included in the Stage one review. During the Stage one review, 1,245 records were excluded because they did not meet the inclusion criteria leaving 41 records for the Stage two review. At Stage two, the 41 remaining records were read in full; 14 records were removed because they did not meet the topical inclusion criteria. The remaining 27 records were included in this scoping review. In addition, the reference pages for these 27 records were reviewed for additional records that met the inclusion criteria; none were identified.

2.5 Data Charting

Key information about included records (i.e., included after Stage two review) were extracted and charted including author(s), year, study location, sample, data, research questions, and main findings regarding provider-level challenges and benefits and client-level challenges and benefits.

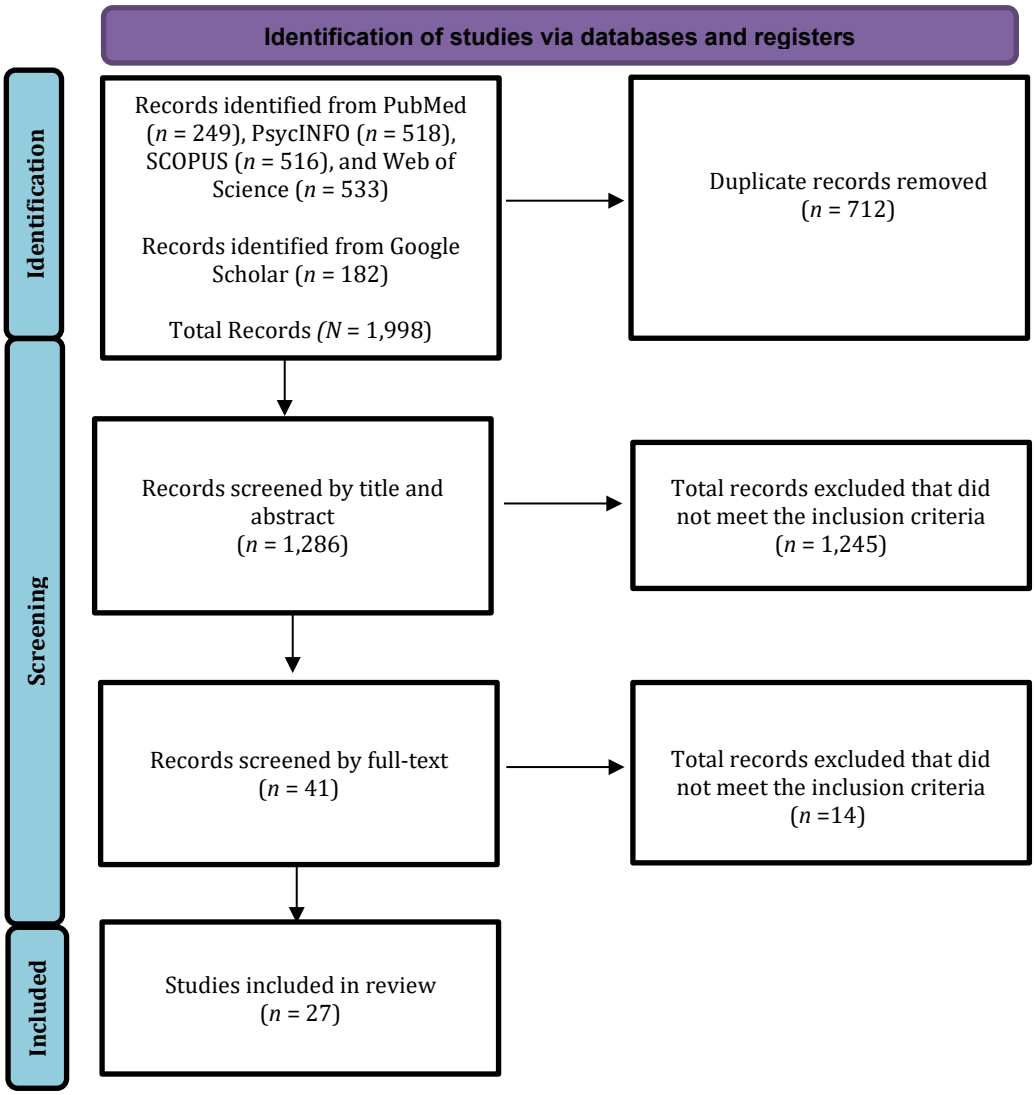

Figure 1. Identification of studies via databases and registers using the PRISMA framework.

3. Results

The 27 articles included in this scoping review span publication dates from 2011 to 2025, with only three studies taking place prior to the onset of the COVID-19 pandemic (i.e., Chen 2019; Gloor & Meier, 2020; Hassija and Gray, 2011). The studies were conducted in the following countries: the United States (*n* = 15), Australia (*n* = 3), United Kingdom (n = 2), Portugal (*n* = 2), Canada (*n* = 1), England (*n* = 1), Spain (n =1), and Scotland (*n* = 1). Virtual service delivery ranged from video- and teleconferencing, to application-based services, chat-and voice-based hotlines, texting/emailing, and synchronous and asynchronous remote counselling among other services (See Table 1).

Most studies (*n* = 15, 55.6%) reported on qualitative research only, either using open-ended survey responses or interview methods. Two studies (7.4%) used only quantitative methods, while a mixed methods approach was adopted in the remaining 10 studies (37.0%). Sample sizes for qualitative studies varied widely, with as few as seven participants engaging in interviews to as many as 564 participants completing surveys with open-ended responses; samples sizes for quantitative analyses were relatively small ranging from 15 to 352 participants. Given these small sample sizes, it is unsurprising that the quantitative studies relied on descriptive and bivariate statistics rather than multivariate analyses. Most studies (*n* = 23, 85.2%) focused on the transition to remote victim services and remote and hybrid victim service work environments during COVID-19. All these studies used convenience samples and acknowledged their exploratory nature; only two reported response rates (18.7% and 26.5%, respectively). These studies mostly focused on the perspectives of professionals working for domestic violence (DV) and/or SA response organizations, although one study interviewed child protective service workers (Renov

et al., 2021), one surveyed professionals who supported victims of torture (Santamarina et al., 2023), and two interviewed a range of professionals, including providers who supported child abuse and trafficking victims (Voth Schrag et al., 2021a, 2022). Further, only four studies included the perspectives of crime victims.

As noted above, three studies took place or used data collected before COVID-19. The first assessed change in PTSD and depressive symptoms as well as client satisfaction associated with a synchronous videoconferencing therapy for DV and SA victims in a rural area who did not have access to in-person therapy (Hassija and Gray, 2011). The second examined the feasibility and acceptability of an asynchronous counselling service for DV victims (Gloor & Meier, 2020), while the third described support providers' use of technology to contact and serve trafficking victims as well as trafficking victims' concerns regarding technology use (Chen et al., 2019).

3.1 Virtual Victim Services During COVID-19 Challenges and Benefits to Service Providers

As noted above, 23 studies focus on virtual victim services after the onset of COVID-19 and predominantly examined service providers' perspectives. As seen in Table 2, there was significant overlap across studies regarding the challenges and benefits for VSPs. Nineteen studies discussed provider challenges with providing virtual services. In three studies, VSPs identified difficulties in "accessing technology" or with internet connectivity specifically while three indicated that they had problems obtaining the necessary hardware (e.g., computers, tablets, phones) or that they had to use their personal computers/phones to provide virtual services. In addition, service providers in seven studies reported having limited technical or digital literacy or limited knowledge regarding digital videoconferencing or videotelephone platforms (e.g., Zoom, Skype) and one study mentioned problems obtaining information technology support from their organization. Popular videoconferencing sites did not have the necessary encryption and safety features required to meet some providers' policies, so providers had to search to find platforms that were compliant. Likewise, two studies discussed providers having to learn about technology safety and teach their clients; finding that "technology safety is part of the job now" (Voth Schrag, 2022, p. 230).

Providers also discussed the challenges in assessing victim's physical safety and home environment virtually with several providers specifically mentioning the difficulties in reading body language with videoconferencing technology and the lack of any cues (e.g., body language, tone of voice) with chat, email, and application-based services. Four studies found that providers were concerned about their ability to build trust and rapport virtually, and in turn, about the quality and effectiveness of the services they were providing (see for examples, Evans et al., 2023, Speed et al., 2020) and two studies noted that clients were less likely to show up for virtual appointments. Remote work was also isolating for many providers, with six studies discussing the difficulties in connecting with co-workers to seek advice about clients and/or debrief after an especially difficult client interaction. Providers across several studies also indicated that remote work decreased their work/life balance because it blurred the lines between their work, which focused on traumatic events, and their home, which was their safe space. Two studies mentioned new difficulties in setting boundaries between work and home when they transitioned to providing remote services.

In addition to challenges, 12 studies identified benefits to providers. Providers noted that videoconferencing had expanded their access to trainings (three studies), had notetaking and recording features that assisted them in their client and co-worker interactions (one study), and increased their ability to engage with new partners despite physical distance (three studies). Providers also noted the cost effectiveness of remote services to their clients and/or virtual staff trainings (two studies) and their newfound ability to provide services to clients even when clients travel or relocate (i.e., continuity of services; one study). In three studies, providers noted that virtual visits had increased their productivity through efficiency (i.e., no travel time between appointments) and that their clients had better attendance at remote appointments (two studies). In two studies, providers noted that remote work gave them *better* work life balance, with providers citing more personal flexibility in working from home and more control over their physical workspace (i.e., to create a positive workspace) as specific benefits.

Table 1. Summary of Studies Included in Scoping Review*.						
	Author/Year	**Study Location**	**Sample**	**Purpose**	**Qualitative/ quantitative**	**Remote modalities/services**
1	Evans et al. (2023)	Ohio, USA	Agency workers (n = 170; 26.5% response rate).	Surveys asked about how the COVID-19 pandemic changed victim service work.	Qualitative	Videoconferencing
2	Roebuck et al. (2022)	Canada	VSPs and adult volunteers (N = 564).	Surveys asked about spending more time working from home during the COVID-19 pandemic as a service provider.	Qualitative and quantitative	Videoconferencing
3	Voth Schrag et al. (2021a)	USA	VSPs for IPV, SA, child abuse, or human trafficking (n = 33).	Semi-structured interviews focused on approaches used by the interpersonal violence workforce to address social distancing needs during COVID-19.	Qualitative	Teleconferencing
4	Waid et al. (2022)	Midwestern state, USA (rural)	Administrators and/or supervisors of direct service staff from federal, state, and local entities or non-profit, community-based settings serving victims of crime (n = 9).	Interviews focused on how service providers adapted to work with victims, the types of victimization experienced, the training received, and any technical or financial assistance received during the COVID-19 pandemic.	Qualitative	Videoconferencing; Participants were working remotely or in a hybrid format.
5	Bibi (2021)	North Dakota, USA (rural)	VSPs in rural agencies (n = 8).	Interviews focused on the strategies agencies developed during COVID-19 and how they can better serve victims/survivors in rural communities.	Qualitative	Videoconferencing; Participants were working remotely or in a hybrid format.
6	Cambell et al. (2023)	Detroit, Michigan, USA	Advocate/counseling staff (n = 12) at largest SA service agency in Detroit.	Interviews focused on how the agency responded to pandemic restrictions, how their clients engaged with these changes in service, and what they saw as key lessons learned from the pandemic regarding services and organizational planning.	Qualitative	Videoconferencing and online crisis chat hotline.
7	Caridade et al. (2021)	Portugal	Support professionals from the Portuguese National Support Network for victims of DV (n = 196).	Surveys focused on the type of support provided to victims during the COVID-19 pandemic compared to before the pandemic; their level of training to provide support remotely; the advantages and barriers of remote support, and their institutional policies regarding remote support.	Quantitative	Phone, email, social applications, and videoconferencing; Participants were working remotely or in a hybrid format.

8	Carrington et al. (2021)	Australia	Domestic and family violence service providers in Australia (n = 362).	Surveys asked about the impact of the COVID pandemic and associated lockdown restrictions experienced by the DV workforce and their clients.	Qualitative	Phone, email, social applications, and videoconferencing; Participants were working remotely or in a hybrid format.
9	Chen et al. (2019)	USA and Southeast Asia	Staff members at VSPs and survivors of trafficking (n = 17).	Semi-structured interviews focused on how VSPs use technology in their interactions with clients and what, if any, concerns exist around this technology usage.	Qualitative	Phone, hotline, SMS, social media (e.g., Facebook), and email.
10	Gloor & Meier (2020)	Zurich, Switzerland	Counselling service users during first 10 months (n = 200) and during a six-week period (n = 33); Experts in information technology (IT) (n = 3) and counselling (n = 3).	Review of user data and user survey data; interviews with experts in IT and counselling to examine the development, performance, and acceptance of the remote counselling service.	Qualitative and quantitative	Asynchronous web based individual counselling service via a protected area on the provider website.
11	Downes & Barbosa (2024)	United Kingdom	All Advocate Educators and Clinicians in the Identification and Referral to Improve Safety (IRIS)-Network (n = 187), and convenience sample of clinicians in IRIS-trained practices (n = 8) and patients/service users (n = 4).	Survey and interview data examined whether confidentiality can be guaranteed in remote consultations; IRIS training effectiveness and acceptability to clinicians when delivered virtually; and virtual IRIS advocacy support effectiveness and acceptability to patients.	Qualitative and quantitative	Virtual training and service delivery for IRIS program (i.e., DA screening and referrals to victim services).
12	Santamarina et al. (2023)	Madrid and Barcelona, Spain	Professionals (n=21) and torture survivors (n=21) from a sample of Istanbul Protocols (IP) interviews between 2019 and 2021.	Surveys asked about the evaluation process, satisfaction, difficulties encountered, and compliance with therapeutic aspects and compared across remote and in person formats.	Qualitative and quantitative	Videoconferencing.
13	Pedersen et al. (2023)	North East Scotland and Orkney Islands, UK (rural)	Managers of domestic abuse services (n = 12).	Semi-structured interviews focused on the move to digital and telephone provision of support due to COVID-19.	Qualitative	Telephone and online.
14	Speed et al. (2020)	United Kingdom	Service providers at gender-based violence organizations (n = 52; 18.7% response rate).	Surveys on the impact of COVID-19 gender-based violence services operations and support to victims.	Qualitative and quantitative	Telephone helpline/webchat or online.
15	Wood et al. (2022)	USA	IPV and SA service workers (n = 352) from 24 states.	Online surveys about service adaptation and technology use at work before and during the COVID-19 pandemic.	Qualitative and quantitative	Videoconferencing, texting, computer chats, email, phone call, and video calls (e.g., Facetime).

16	Perez (2022)	California, USA	DV service providers, including case managers, therapists, and program coordinators (n = 9).	Interviews focused on the barriers, benefits, and strategies in providing services during COVID-19.	Qualitative	Telephone and videoconferencing.
17	Sleath et al. (2025)	England	Sexual violence service professionals (n = 22) and service users (n = 221) from 15 Sexual Assault Referral Centers.	Surveys asked about pandemic impact on survivors of sexual violence and abuse and their help-seeking and recovery journeys; pandemic impact on service delivery and staff; and challenges and opportunities.	Qualitative and quantitative	Telephone and videoconferencing.
18	Wood et al. (2020)	USA	Individuals with active safety concerns from violence, threats, stalking, or abuse (n = 53).	Surveys about the use of virtual and phone services during COVID-19.	Qualitative and quantitative	Virtual counseling and/or advocacy services.
19	Domingo-Cabarrubias et al. (2023)	Victoria, Australia	Legal practitioners (n = 7) who support victims of domestic/family violence.	Interviews explored benefits, limitations, risks, and future innovation opportunities in remote legal support during the COVID-19 pandemic.	Qualitative	Telephone, videoconferencing, Skype or Zoom, email, online chat, text messaging, websites, self-help centers, and online tools.
20	Renov et al. (2021)	USA	Child Protective Service (CPS) caseworkers and administrators (n = 37).	Interviews assessed how the COVID-19 pandemic changed the way CPS staff conducted investigations and provided services to families in the CPS system.	Qualitative	Virtual home visits, care portal.
21	Klein et al. (2022)	Midwestern University USA	Hotline staff and volunteers (n = 9).	Interviews assessed perspectives regarding the benefits and challenges of offering a chat service, as well as the strategies used to adapt services to the chat modality.	Qualitative and quantitative	Telephone and web-based hotline.
22	Pfitzner and McGowan (2023)	Australia	Victim-survivors who sought domestic/family violence advice or support (n = 61).	Surveys asked about experiences and challenges in accessing support during lockdowns; the method by which remote support was provided during lockdowns and whether that method was helpful; what service providers could have done better during lockdowns.	Qualitative and quantitative	Telephone support, hotline.
23	Voth Schrag et al. (2022)	USA	VSPs for IPV, SA, child abuse, or human trafficking (n = 33).	Semi-structured interviews asked about strategies used to help clients address violence, threats, stalking, or abuse since the coronavirus pandemic began and changes as the pandemic unfolded.	Qualitative	Teleconferencing, telephone/web hotline, texting/chat, Google voice numbers, email; Uber account for transportation.

24	Ferreira et al. (2024)	Portugal	Professionals from DV support service (n =24).	Semi-structured interviews focused on the primary challenges faced by DV professionals during interventions.	Qualitative	Video and phone calls.
25	Nahar et al. (2023)	Dallas-Fort Worth, Texas, USA	VSPs (n = 15).	Interviews examined experiences providing telehealth services during COVID-19.	Qualitative	"Telehealth services".
26	Voth Schrag et al. (2021b)	Southwestern State, USA	For interviews: campus and community-based advocates (n =23) For surveys: survivors (n = 63). Participants were drawn from 3 universities.	Interviews and surveys asked how advocates were using technology with emerging adults who are survivors of IPV and sexual violence in the year immediately preceding the COVID-19 pandemic; and what survivor recommendations for advocacy and service engagement via technology were.	Qualitative	Text messaging, apps, My Plan, email, phone; Website for making appointments.
27	Hassija and Gray (2011)	Wyoming, USA (rural)	Clients referred to the Wyoming Trauma Telehealth Treatment Clinic (WITIC) for psychological services after DV/SA (n = 15).	Pre-and post-treatment PTSD and depression symptoms were assessed as was client satisfaction.	Quantitative	Videoconferencing-based psychological services delivered using secure technology.

*Full citations are available upon request.
Common Acronyms: IPV=intimate partner violence; DV=domestic violence; SA=sexual assualt

3.2 Virtual Victim Services During COVID-19 Challenges and Benefits to Service Victims

Nineteen studies discussed victim challenges with virtual services; however, only four studies included the perspectives of service users (i.e., victims). In eight studies, difficulties with victims accessing technology or accessing hardware such as computers, tablets, and phones was noted, while eight discussed victims' challenges navigating technology, limited digital literacy, or discomfort using technology. Further, two studies described challenges working applications or videoconferencing platforms as particularly difficult for older clients and clients with complex health needs. Four studies noted that virtual services felt impersonal; for example, one victim said that they wanted to talk with someone face-to-face for a "a proper chat" (Sleath et al., 2025 p. 146). Another study reporting victims' perspectives discussed how the quality of virtual services was dependent on the provider and their knowledge and skills to provide remote services (Pfitzner & McGowan, 2023).

The most noted concern was about victim safety and confidentiality when accessing virtual services. Twelve studies mentioned concerns about victims having a private space to connect with service providers (i.e., to access confidential services), as well as the risk for victims seeking services while in physical proximity to their perpetrators. Likewise, three studies specifically mentioned victim's fear about using virtual services because their abuser monitored their digital devices (e.g., checked their call or browser history, read their email, etc.).

Fifteen studies also addressed victim benefits regarding virtual services. Increased flexibility and access to services was highly valued (12 studies) with multiple studies specifically noting that virtual serives did not require transportation or childcare and expanded access to rural victims. The immediacy of services in virtual formats such as text/chat-based services was also noted in one study. Other identified benefits included virtual translation systems that allowed for broader language access and the ability of videoconferencing to hold virtual visits or assessments without victims needing to be in the same physical space, and sometimes without even seeing their perpetrators (i.e., using breakout rooms). Studies also discussed the benefits of increased anonymity in virtual services for disclosing victimization and/or accessing services (five studies). For example, some noted that it was easier for victims to discuss their victimization remotely (i.e., less fear, stigma, shame) while others noted that remote services reduced victims' fear of physically accessing a victim service provider and being recongized by someone they know (see Pedersen et al., 2023; Pfitzner & McGowan, 2025).

3.3 Challenges and Benefits of Virtual Victim Services Outside of COVID-19

Four studies were focused on virtual victim services outside of the COVID-19 pandemic context. In the oldest study from 2011, clients obtained trauma-focused psychotherapy services from a university-based therapy clinic via videoconferencing at domestic violence/rape crisis centers in their home areas (Hassija and Gray, 2011). Survivors experienced large reductions in PTSD and depressive symptoms overall and by trauma type, and reported high satisfaction with services. Similarly, Gloor & Meier (2020) piloted an asynchronous counselling service for victims of DV accessible via a specially protected area on the support provider's website. Review of user data and user survey data showed that users increased over time by 50%, that 57.5% of users engaged in multiple sessions, and that 52.5% of users accessed the service outside of traditional work hours when in-person counselling services are not readily available; more than 93% of users rated the responses from counsellors as 'very comprehensible', 'very helpful', and 'very sensitive'. Further, Klein et al.'s (2022) formative evaluation described the feasibility and acceptability of a chat-based hotline for college students. Their work showed that students were willing to use the chat hotline at similar rates as a voice hotline. Hotline staff perceived that "chatters" felt greater safety to disclose and more control over their disclosure in chat over voice hotlines (1) given the greater anonymity and (2) ability to write out and edit their chat messages. At the same time, chat hotline staff reported more pressure to type the "right thing" than they did in responses via the voice hotline and concerns that they could not always perceive the chatter's emotional state or emotional needs through text alone. Finally, Chen and colleagues (2019) explored support providers' use of technology to contact and serve victims of trafficking as well as trafficking survivors' concerns regarding technology use through in-depth interviews. Providers noted that their primary way to make/recieve contact with survivors was through remote means such as voice hotlines, SMS, email, or via social media and that continued support was often delivered remotely until a survivor could escape their trafficker. A wide range of difficulties for survivors were identified including their often limited access to technology and/or the control of their digital devices by the perpetrator. Results are presented in Table 2.

Table 2. Summary of Provider and Client Level Findings Related to Remote Victim Services.				
	Provider level challenges/negative outcomes	**Provider level benefits/positive outcomes**	**Client level challenges/ negative outcomes**	**Client level benefits/positive outcomes**
1	(1) Mixed feelings about the utility and effectiveness of virtual services (e.g., reduced effectiveness in therapeutic work with children, clients being less likely to show up for virtual appointments, or difficulties related to internet access technology).	(1) More personal flexibility in working from home.	(1) Difficulties with accessing technology, (2) difficulties navigating the technology, (3) challenges exacerbated for victims with disabilities (e.g., Deaf).	(1) Increased access to services (e.g., more flexibility, no need for transportation, childcare).
2	(1) Working from home decreased work-life balance which in turn a decrease in mental health, (2) difficulties negotiating and setting boundaries, (3) virtual format makes it difficult to draw on co-worker support.	(1) More personal flexibility in working from home, (2) remote work improved work life balance, (3) remote work at home allows for more control over their physical workspace (i.e., a "positive space" to work).	none discussed.	(1) Increased access to services (e.g., more flexibility, no need for transportation, childcare).
3	Regarding virtual services (1) empathic connection is harder, (2) assessing environment (e.g., for home visits on children) is challenging, (3) technological challenges, (4) boundary maintenance, (5) technology safety is part of the job.	none discussed.	(1) Difficulties with accessing technology, (2) difficulties navigating the technology.	(1) Increased access to services (e.g., no need for transportation, childcare), (2) immediacy of services, (3) language access, (4) anonymity & comfort disclosing.
4	(1) Security on videoconferencing sites (e.g., Zoom), (2) reduced networking opportunities when using a virtual format.	(1) Note taking and recording features in videoconferencing platforms, (2) reduced costs of training staff virtually, (3) increased access to collaboration through virtual meetings	none discussed.	(1) Increased ease of serving victims and perpetrators in the same meetings (e.g., using breakout rooms, coming and going as needed without seeing each other).
5	(1) Concerns about patient acceptance, especially regarding the privacy and intimacy of virtual exams, (2) space limitations for machinery in small EDs, (3) lack of staff training, (4) concerns regarding the quality of exams.	(1) Telemedicine can improve patient care and evidence collection in SA cases, (2) 24/7 IT support is key to addressing technical challenges.	none discussed.	none discussed.

6	(1) Security on videoconferencing sites, (2) Identifying a videoconferencing site that would meet strict agency requirements (e.g., could not use Zoom).	none discussed.	Telehealth options were not widely utilized by the client population of this agency (e.g., low income, urban population) due to (1) difficulties accessing technology, (2) inadequate privacy to utilize telehealth, (3) limited comfort in discussing traumatic events remotely.	none discussed.
7	(1) Limited knowledge/training on technology/in providing support remotely.	none discussed.	(1) Difficulties accessing technology, (2) difficulties navigating the technology, (3) risk of control of digital devices by the perpetrator, (4) proximity to the offender (i.e., inadequate privacy to utilize telehealth).	(1) Reduced financial costs, (2) reduced inhibition, fear, shame.
8	(1) Difficulties conducting services remotely (e.g., difficulty building rapport/trust, interpreting body language), (2) difficulties assessing client's environmental risk/home conditions/physical safety, (3) clients were less likely to show up for virtual appointments, (4) lacked equipment, (5) limited knowledge/training on technology/in providing support remotely.	none discussed.	(1) Difficulties accessing technology, (2) difficulties navigating the technology, (3) risk of control of digital devices by the perpetrator, (4) proximity to the offender (i.e., inadequate privacy to utilize telehealth), (5) exacerbated challenges for victims with disabilities or complex health needs.	none discussed.
9	(1) Limited knowledge/training on digital platforms, (2) boundary maintenance, (3) technology safety is part of the job.	none discussed.	(1) Difficulties accessing technology, (2) difficulties navigating the technology, (3) risk of control of digital devices by the perpetrator, (4) proximity to the offender (i.e., inadequate privacy to utilize remote services), (5) victims may not believe the VSP can be trusted (due to relationship only being virtual).	(1) Increased comfort level communicating digitally (i.e., "less raw" p. 92).

10	(1) Trained counselors who are dedicated to the online service (only) are needed (2) professional technical support is essential, (3) technical realization of the service was challenging (i.e., balancing safety/security requirements, user ease, and user interface).	none discussed.	none discussed.	(1) Increased flexibility (i.e., 52.5% of users accessed outside of traditional work hours), (2) users noted increased comfort level communicating digitally.
11	(1) Most clinicians felt more confident identifying and asking about DA in person versus virtually, (2) more confident responding to disclosures of DA in person versus virtually (3) nearly 49% had received a disclosure of DA virtually, but only about a third reported making a referral to an Advocate Educator during a remote consolation, (4) most Advocate Educators were concerned about difficulties in concentration or IT issues with online training, (5) difficulties in assessing service users safety or risk virtually, (6) difficulties in asking sensitive questions virtually.	(1) Most clinicians felt confident identifying and asking about DA virtually, (2) most clinicians had asked about DA virtually, (3) most clinicians preferred online training to face-to-face.	(1) Nearly half of Advocate Educators reported a delay/difficulty in getting their service users to survivors' groups or other relevant services.	(1) Most Advocate Educators reported their users were just as positive about the remote support as the face-to-face support, (2) users reported increased access, (3) users reported decreased fear/stigma in disclosing virtually.
12	More professionals in the remote format compared to the face-to-face format (1) needed an interpreter, (2) reported privacy issues/inadequate interview location, (3) problems in connection/ material resources, (4) timing problems, (5) difficulties in understanding the survivor's emotional response.	none discussed.	Fewer survivors in the remote format reported (1) feeling well emotionally immediately after the process, (2) feeling well emotionally after the process was findings, and (3) post-process resilience (4) more felt they needed subsequent psychological support.	(1) All survivors in the remote format reported being satisfied overall (2) being satisfied with the interview process and report writing.

13	For videoconferencing/ online services (1) difficulties obtaining needed hardware (e.g., computers, phones, tablets), (2) limited knowledge/training on digital platforms, (3) difficulties with internet connectivity. For telephone services, (4) inability to build rapport/read body language, (5) need to concentrate harder led to exhaustion, (6) remote format made it difficult to draw on co-worker support.	(1) Potential to train staff virtually, (2) increased access to collaboration through virtual meetings.	For videoconferencing/ online services (1) difficulties with internet connectivity, (2) limited knowledge about digital platforms, (3) concerns about privacy/abuser proximity, (4) lack of easy access to a computer, (5) fear of control of digital devices/tracking online contacts by the perpetrator.	Providers reported (1) a more flexible approach of remote services being welcomed by some users, (2) preference of phone contact versus videoconferencing, (3) increased access to services (e.g., in rural areas).
14	(1) Difficulties obtaining needed hardware (e.g., computers, phones, tablets), (2) difficulties accessing IT support, (3) concerns about quality of virtual services for victims.	none discussed.	(1) Concerns about privacy/abuser proximity, (2) limited knowledge about digital platforms.	none discussed.
15	Professionals reported (1) limited knowledge/training on digital platforms and in providing support remotely, (2) difficulties conducting services remotely (e.g., difficulty building rapport/trust, interpreting body language), (3) difficulties assessing client's safety/how they are doing, (4) difficulties accessing/connecting to internet, (5) remote format makes it difficult to draw on co-worker support.	none discussed.	(1) Discomfort using phone/technology to receive services, (2) lack of privacy/ concerns about proximity to the perpetrator.	none discussed.
16	(1) Clients were not answering calls/ following up with services.	(1) Law enforcement was more willing to engage victim service partners because it was over the phone (i.e., they did not have to wait for victim services to show up), (2) easier access to the home environment to observe family dynamics, (3) can provide services to clients located anywhere in the US.	(1) Discomfort using phone/technology to receive services, (2) lack of hardware, (3) concerns about victim safety, (4) concerns about client privacy and confidentiality.	(1) Increased accessibility (e.g., more convenient, no need to drive to their office, for childcare).

17	(1) Difficulties conducting services remotely (e.g., difficulty building rapport/trust, interpreting body language), (2) boundary maintenance in working from home, (3) remote format makes it difficult to draw on co-worker support.	(1) Remote services are cost effective.	Most service users surveyed reported that online/telephone service delivery reduced their engagement in help-seeking and support due to difficulties building relationships, interpreting body language (i.e., "having a proper chat").	A minority of service users reported that remote services (1) increased accessibility (e.g., more convenient, no need to drive to their office, for childcare) and that it was (2) easier to disclose over the phone.
18	none discussed.	none discussed.	Concerns about (1) confidentiality, (2) tech safety, (3) technical issues (e.g., delays, technology interruptions), (4) wanted to talk face to face/in person.	Almost half (42%) of respondents had used virtual counseling or advocacy services at a violence prevention or intervention agency since the pandemic. (1) increased accessibility (e.g., more convenient, no need to drive to their office).
19	(1) Difficulties conducting services remotely (e.g., difficulty building rapport/trust, interpreting body language).	none discussed.	(1) Lack of access to technology/hardware, (2) virtual forms in English only/need for translation, (3) concerns about tracking/monitoring online activity by the perpetrator, (4) concerns about privacy/proximity to the perpetrator, (5) digital literacy.	none discussed.
20	(1) Difficulties assessing client's environmental risk/home conditions/physical safety, (2) difficulties with virtual interviews with young children (i.e., easily distractable, hard for them to manage digital device).	(1) Better work-life balance through remote/hybrid work, (2) increased productivity/ability to see their clients more often through virtual visits.	(1) Concerns about privacy/proximity to the perpetrator, (2) need for hardware like phones.	(1) Online care portal increased access to needed goods, (2) improved engagement with families through virtual alternatives.
21	(1) Absence of vocal cues/can be difficult to know a "chatter's" emotional state/needs, (2) difficulty building rapport/expressing empathy, (3) some chats are very dense with multiple topics making responses cumbersome, (4) more pressure to type the "right" thing, (5) pre-generated shortcuts could seem impersonal.	(1) Staff can respond from anywhere in a private/confidential way.	none discussed.	(1) Chat allows for increased privacy/anonymity, (2) written form allows for more control over how users present the information (i.e., they can write out/edit their story via chat).

22	none discussed.	none discussed.	(1) Concerns about privacy/proximity to the perpetrator, (2) virtual services felt impersonal, (3) not all service providers had the same level of virtual service delivery skills (i.e., quality was dependent on the practitioner)	(1) Increased accessibility (i.e., more flexible hours), (2) increased anonymity by not having to access services in person
23	(1) Tech safety is now part of the job for everyone.	(1) Seeing clients more frequently (for shorter interactions) through virtual interactions like emails, (2) increased engagement with partners through virtual meetings, (3) expanding engagement with new communities (e.g., having iPad at the multicultural center with service center's zoom information ready to go), (4) rideshare apps increased access to easy/efficient transportation (i.e., no need for vouchers).	(1) Digital literacy and tech safety needs, (2) concerns about proximity to the perpetrator, (3) concerns about privacy/confidentiality.	none discussed.
24	(1) Isolation of remote work/not seeing co-workers, (2) challenges building and maintaining rapport/personal connections with clients, (3) need to develop technical skills.	none discussed.	(1) Digital literacy needs, (2) concerns about proximity to the perpetrator.	none discussed.
25	(1) Limited digital literacy, (2) challenges building and maintaining rapport/personal connections with clients, (3) isolation of remote work/ not seeing co-workers.	(1) Better attendance by clients for virtual appointments, (2) increased efficiency/productivity.	(1) Concerns about proximity to the perpetrator, (2) concerns about privacy/confidentiality, (3) limited access to hardware, (4) limited access to internet, (5) perpetrator monitored digital devices, (6) limited digital literacy.	(1) Increased accessibility/flexibility

26	(1) Need to set boundaries, (2) tech safety is part of the job now.	(1) Technology allows for more options for the "best way" to communicate with a survivor.	(1) Concerns about privacy/ confidentiality, (2) technical glitches can retraumatize survivors (e.g., sad/romantic hold music, preform emails sent months after disclosures).	From survivors: (1) 43% of survivors reported using technology (phone, text message, e-mail, or secure message system) to connect with their advocate more than once. From advocates: (2) increased accessibility/flexibility/speed of response.
27	none discussed.	none discussed.	none discussed.	Survivors experienced large reductions in PTSD (d = 1.17) and depressive symptoms (d = 1.24) overall and by trauma type (DV: (d = 1.00, d = 1.33; SA: d = 2.18, d = 1.05, respectively), and reported high satisfaction with services (M = 52.93 out of 55).

4. Discussion

The present review aimed to describe what is known about hybrid and remote work (RHW) in crime victim services and how such knowledge has been developed. Using the PRISMA framework for scoping reviews, 27 studies were identified that met our inclusion criteria. Given the development of remote services across government sectors and the necessary expansion of RHW since the onset of the COVID-19 pandemic, conducting a review of research in this area is prudent to inform future practice and research in the victim services field.

Although technology has led to increased options for remote service delivery for several decades, studies identified through this review are relatively recent, published since 2011. Only three studies report on data collected prior to 2020, as most studies focused on the transition to remote services in response to the COVID-19 pandemic. There is limited global diversity in this body of research with all studies stemming from the Western world and more than half stemming from the United States. Regarding data and methods (RQ 1), most studies (93%) utilized qualitative data or took a mixed-methods approach. Existing studies are largely exploratory and descriptive in nature, most using small, convenience samples limiting generalizability.

Provider-level outcomes (RQ 2) were organized in terms of challenges and strengths. Common challenges included technological barriers (e.g., access to computers, phones, internet), security of online service provision (e.g., digital security of videoconferencing platforms), the development of rapport with clients virtually, and negative impacts on providers' work-life balance. Strengths/benefits included personal flexibility in work location, the development of new collaborations, efficiency (e.g., reduced travel time), training access, and increased frequency of communication with clients due to remote options (e.g., phone, chat, text, video, etc.).

Client-level outcomes (RQ 2) were also organized in terms of challenges and strengths. Most research on client-level outcomes was from the perspective of service providers. Challenges identified across studies include technology access and digital literacy, hardware access (e.g., phone, computer, etc.), less utility for some populations (persons with disabilities, persons in urban low-income areas, older persons), provider's skill in delivering remote services, and confidentiality and safety concerns with remote services given perpetrators' potential proximity and digital abuse. Strengths/benefits included increased access to services, efficiency in services, reduced cost, and digital communication feeling more comfortable and/or anonymous. Further, there is some indication that clients may equally satisfied and/or more satisfied with technology-facilitated services, although providers may be less satisfied with these service options (e.g., Pedersen et al., 2023; Santamarina et al., 2023).

Existing studies provide valuable insights on experiences with remote and hybrid victim service delivery. However, the vast majority of what we know about virtual victim services - especially during COVID-19 - stems from the perspectives of DV and SA service *providers*, not other VSPs, and not service *users* (i.e., crime victims). Additionally, there have been few evaluation studies that examine outcomes for victims who use or professionals who deliver remote/technology-based victim services and/or the effectiveness of various forms of technology-enhanced or remote service delivery. Expanding research to other types of crime VSPs, crime victims/clients, and enhancing evaluation efforts are important next steps. Finally, while other facets of criminal justice and social services have developed research in the context of human resource management, this has not yet been a focus of hybrid and remote victim service provision research. Research in this vein may be beneficial in terms of enhancing staff retention, reducing burnout, and addressing safety.

In addition to the limitations of existing research, limitations to the current review include that the search – while robust – may not have identified all relevant articles, including those not published in English and/or not captured by our search terms. Although we feel it is important to examine victim services distinct from related, and at times overlapping, services (e.g., healthcare services) there may be relevant findings in a broader literature that contextualize benefits and challenges of remote crime victim services.

5. Conclusions

In conclusion, there is a need for continued and robust research on RHW in victim services. There are common themes across the 27 studies identified in this review. Having flexible service options provides choice, accessibility, and accommodation to crime victims. Some populations may benefit more from remote/virtual services than others, and there may also be differences between providers and clients in terms of their comfort with remote service options. Just as victim safety is a critical concern in offering in-person services, it is also a concern in the offering of virtual services. For providers, there is a need for training in effective online service delivery. Critical to the success of remote services is the infrastructure to make it possible: hardware, digital literacy, broadband internet access, and technological security and support. Remote and hybrid service options have the potential to expand the reach of victim service work, and as technology continues to evolve so too will avenues for meeting the needs of crime victims and supporting those who work with them.

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Due to space constraints, references for the 27 studies included in the scoping review are available from the authors by request

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