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Crime victimization and the Right to Health: Comparative Perspectives from India, UK and USA

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ABSTRACT: Crime victimization is conventionally treated as a matter for police, prosecution and courts, yet its most durable consequences are often borne by health systems. This comparative review examines whether and how the legal frameworks of India, England and Wales, and the United States translate victim status into access to emergency treatment, mental-health care, rehabilitation, compensation and supportive services. A structured doctrinal-public-health method was used, combining primary legislation, leading judicial authority, official victim-service instruments and contemporary public-health and victimization data. The analysis finds a convergent recognition that victimization produces physical, psychological and social harm, but substantial divergence in legal architecture. India provides an unusually explicit statutory bridge between criminal procedure and free medical treatment for specified victims, reinforced by constitutional right-to-life jurisprudence and victim compensation. England and Wales use a service-rights model strengthened by the Victims and Prisoners Act 2024 and the Victims' Code, with emphasis on information, specialist support and inter-agency coordination. The United States protects procedural dignity and access to services through the Crime Victims' Rights Act, the Victims' Rights and Restitution Act and VOCA-funded assistance, but delivery remains fragmented across federal and state systems. Across all three jurisdictions, the principal gap is not recognition of harm but continuity, enforceability and equity of health-supportive care. The paper proposes a trauma-informed victim health continuum linking acute care, psychological support, legal-social navigation, compensation and long-term rehabilitation, and argues that health outcomes should become a measurable component of victim justice policy.

1. INTRODUCTION

Crime is a legal event, a social event and a health event. The injury caused by assault, sexual violence, robbery, stalking, domestic abuse, trafficking and other offences may be visible at the emergency department, but the health burden frequently extends

beyond the immediate wound. Violence-related trauma can be followed by persistent pain, disability, post-traumatic stress symptoms, depression, anxiety, sleep disturbance, substance misuse, reproductive and sexual-health consequences, lost employment and deterioration of social functioning. The World Health Organization (WHO) estimates that injuries and violence together account for nearly 8% of global deaths and around 10% of years lived with disability; tens of millions of people survive non-fatal injuries that may require long-term physical and mental-health care (WHO, 2024).[1]

A rights-based approach therefore asks a broader question than whether the criminal process treats a complainant fairly. It asks whether public institutions protect the victim's life, bodily integrity, mental health, dignity and realistic opportunity to recover. The United Nations Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power defined victims in terms of physical or mental injury, emotional suffering, economic loss and impairment of fundamental rights, and organized state duties around access to justice, restitution, compensation and assistance (United Nations, 1985). This formulation is important because it places health and rehabilitation within the normative architecture of victim justice rather than treating them as charitable add-ons.[2]

India, England and Wales, and the United States provide useful comparative models. India constitutionalizes protection of life and has codified victim compensation and mandatory free treatment for specified categories of victims under the Bharatiya Nagarik Suraksha Sanhita, 2023 (BNSS). England and Wales operate a codified service-rights approach, now placed on a stronger statutory foundation by the Victims and Prisoners Act 2024. The United States combines federal procedural rights with service duties and a major grant-funded victim-assistance infrastructure under the Victims of Crime Act (VOCA), while substantial variation persists across states. These systems share a normative commitment to dignity and support, yet they differ in whether the victim's health interest appears as a directly enforceable treatment obligation, a code-based entitlement, a funding-supported service, or a derivative constitutional or statutory protection.

This paper addresses four questions: (1) What are the principal health consequences of crime victimization? (2) How do the three jurisdictions legally recognize and operationalize health-related needs of victims? (3) Where do gaps arise between formal rights and practical continuity of care? and (4) What minimum cross-jurisdictional model can integrate health protection into victim justice? The central argument is that modern victim law should be assessed not only by participation and procedural fairness, but by whether it produces timely, trauma-informed and equitable health recovery.

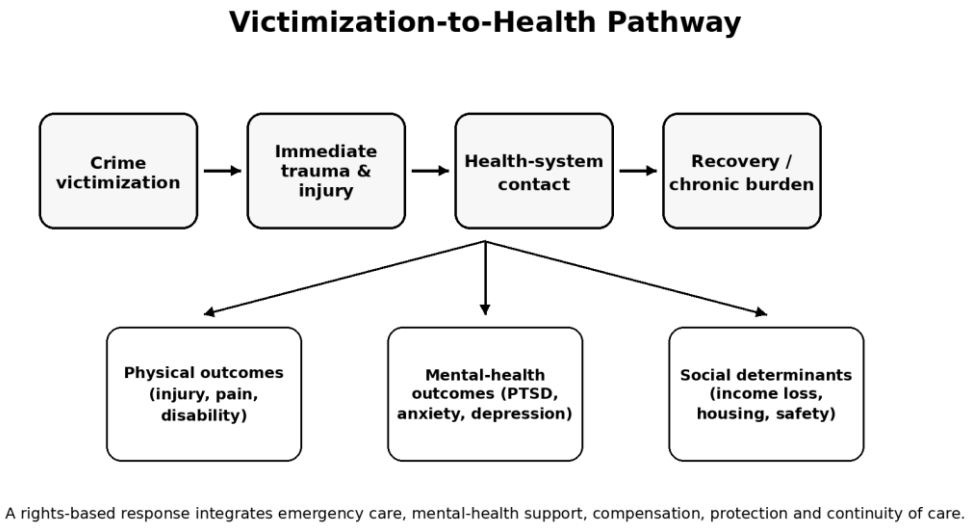

Figure 1. Conceptual pathway linking crime victimization to acute and long-term health burden (original synthesis).

[1]WHO reports that injuries and violence account for nearly 8% of global deaths and an estimated 10% of years lived with disability; violence-related injuries kill about 1.25 million people each year.
[2]UN General Assembly Resolution 40/34 (29 November 1985), Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power.

2. MATERIALS AND METHODS

2.1 Study design

The study uses a comparative doctrinal and public-health review design. The doctrinal component identifies primary legal rules governing victim status, emergency care, support services, compensation and procedural dignity. The public-health component evaluates how these rules correspond to established health consequences of victimization and to the service continuum needed for recovery. The unit of comparison is therefore not the criminal justice system as a whole, but the legal-health interface experienced by a person after victimization.

2.2 Sources and selection

Primary sources included the Constitution of India and Supreme Court of India jurisprudence on emergency medical treatment; the BNSS 2023 provisions on victim compensation, treatment and witness protection; the Victims and Prisoners Act 2024 and the Victims' Code architecture for England and Wales; and the United States Crime Victims' Rights Act (CVRA), Victims' Rights and Restitution Act (VRRA) and Office for Victims of Crime guidance on VOCA-supported services. International normative sources included the 1985 UN Victims Declaration and WHO materials on the health burden of violence. Official victimization data were used illustratively, including the Crime Survey for England and Wales and the US National Crime Victimization Survey. Because official indicators are not methodologically equivalent across countries, no direct cross-national prevalence ranking was attempted.[3]

2.3 Analytical framework

Each jurisdiction was coded across six domains: (i) recognition of victim status and harm; (ii) access to immediate medical treatment; (iii) psychological and trauma support; (iv) compensation and financial mitigation; (v) protection, information and participation; and (vi) continuity, coordination and enforceability. The analysis then assessed whether these domains together approximate a health-rights continuum. The paper is a documentary review and did not involve human participants, patient records or identifiable personal data; institutional ethics approval was therefore not required.

3. RESULTS AND DISCUSSION

3.1 Victimization as a determinant of health

The public-health significance of victimization is clearest in violent and sexual offences, but it is not confined to them. WHO describes violence-related injury as a source of mortality, disability and long-term physical and mental-health need (WHO, 2024). In sexual and intimate-partner violence, health effects can include acute injury, reproductive and sexual-health consequences, chronic pain, mental distress and increased risk of harmful coping behaviours. WHO further notes that health effects may persist after violence stops and may become more severe when victims experience multiple forms or repeated episodes of violence (WHO and PAHO, 2012).

US survey evidence illustrates the persistence of these effects. CDC analysis of intimate-partner violence found high levels of injury and PTSD-related symptoms among affected victims and documented recent health impacts even among some persons whose most recent victimization occurred earlier (Basile et al., 2022; CDC, 2022). The significance for law is straightforward: a criminal case may end at acquittal, conviction or dismissal, but the health consequences do not necessarily track the procedural timeline.[4]

The same pattern appears in population well-being. Office for National Statistics analysis in England and Wales found victims of crime reporting significantly lower life satisfaction, sense that life is worthwhile and happiness than non-victims, although causal attribution is complex because victimization interacts with demographic and socioeconomic factors (ONS, 2015). More recent CSEW data show the continuing scale of exposure to crime: the year ending March 2026 survey estimated 9.6 million incidents of headline crime in England and Wales (ONS, 2026). In the United States, the 2024 NCVS estimated 23.3 violent

[3]The CSEW, NCVS and Indian police/administrative statistics use different sampling frames, offence definitions and reporting bases. Cross-national numerical comparisons should therefore be interpreted cautiously.
[4]CDC NISVS reporting documents substantial injury, PTSD symptoms and continuing impacts among victims of intimate-partner violence; the estimates are survey-specific and should not be generalized to all crime victims.

victimizations per 1,000 persons aged 12 or older (Tapp and Coen, 2025). These figures should not be directly compared, but they demonstrate that victim health is not a niche concern.[5][6]

Health vulnerability is also unevenly distributed. Children, older persons, persons with disabilities, migrants, victims of domestic and sexual violence, people exposed to repeated victimization and those with low income may face greater barriers to safety, reporting, treatment and follow-up. A formally equal service can therefore produce unequal recovery. The relevant legal standard should move beyond availability to effective accessibility: care must be physically reachable, financially affordable, culturally and linguistically usable, confidential, disability-inclusive and sufficiently continuous to address delayed trauma.

3.2 International normative foundation: assistance as justice

The 1985 UN Victims Declaration remains a foundational normative instrument because it defines victimization by harm rather than by successful prosecution. A victim may qualify regardless of whether the offender is identified, apprehended, prosecuted or convicted, and the definition may extend to immediate family, dependants and persons harmed while assisting victims. Its sections on assistance anticipate a multi-sector response in which medical, psychological and social services are elements of justice. This approach reduces the conceptual separation between courts and health systems: the state response to crime is incomplete if it processes evidence while leaving untreated trauma unaddressed.

The right-to-health dimension can also be understood through the classic availability, accessibility, acceptability and quality framework used in international health-rights analysis. Applied to crime victims, availability requires sufficient emergency, forensic, mental-health and rehabilitation services; accessibility requires non-discriminatory and affordable entry; acceptability requires confidentiality, informed consent and trauma-sensitive practice; and quality requires clinically appropriate, timely care. Although domestic constitutional structures differ, this framework is useful as a functional benchmark.

3.3 India: constitutionalization, compensation and mandatory treatment

3.3.1 Constitutional right to life and emergency medical care

India's strongest contribution to the comparative framework is the constitutional link between life, medical treatment and state responsibility. Article 21 provides that no person shall be deprived of life or personal liberty except according to procedure established by law. Supreme Court jurisprudence has interpreted protection of life to include urgent medical care. In Pt. Parmanand Katara v. Union of India, the Court emphasized the paramount professional obligation of doctors to preserve life and rejected procedural impediments to immediate treatment of injured persons. Subsequent Supreme Court decisions have reiterated that emergency medical aid cannot be subordinated to police formalities.[7]

Paschim Banga Khet Mazdoor Samity v. State of West Bengal further developed the positive dimension of Article 21 by holding the state responsible for failure to provide timely medical treatment in the public health system. The doctrinal importance for crime victims is that health protection is not merely a private doctor-patient matter; it can generate a public obligation to organize functioning emergency care. This constitutional baseline can support victims even beyond the specific offences expressly covered by criminal-procedure treatment provisions.

3.3.2 BNSS victim compensation and free treatment

The BNSS 2023 gives this constitutional principle a more concrete victim-law form. Section 396 requires every state government, in coordination with the central government, to prepare a scheme for providing funds for compensation to victims or dependants who have suffered loss or injury and require rehabilitation. The provision allows courts to recommend compensation when conventional compensation is inadequate and also addresses situations ending in acquittal or discharge where rehabilitation remains necessary. This is significant because rehabilitation needs can survive the failure of a prosecution.[8]

[5]BJS Criminal Victimization, 2024 estimates 23.3 violent victimizations per 1,000 persons age 12 or older and 1.45% experiencing at least one violent victimization during 2024.
[6]Office for National Statistics, Crime in England and Wales: year ending March 2026, released 23 July 2026 and corrected 13 August 2026.
[7]See Pt. Parmanand Katara v. Union of India, (1989) 4 SCC 286; the Supreme Court has repeatedly described preservation of life and emergency medical aid as paramount over procedural formalities.
[8]Bharatiya Nagarik Suraksha Sanhita, 2023, s. 396 (victim compensation scheme).

Section 397 creates a direct treatment obligation for specified victims: all hospitals, public or private, must immediately provide first aid or medical treatment free of cost to victims of enumerated sexual offences and certain offences causing specified bodily harm, as well as specified offences under the Protection of Children from Sexual Offences Act, 2012, and must inform the police. The provision is notable internationally because it expressly binds both public and private hospitals. It transforms access to immediate treatment from a general ethical expectation into a statutory command linked to victim status.[9]

The limitation is scope. Section 397 does not create a universal free-treatment entitlement for every crime victim. Victims of serious assaults falling outside enumerated categories, trafficking-related harms, acid or burn injuries covered through other legal schemes, stalking-related psychiatric trauma, cyber-enabled sexual abuse, hate crime, robbery or long-term psychological consequences may depend on general health entitlements, state schemes or judicial principles. The health system also needs a continuum beyond first aid: emergency stabilization is essential, but post-traumatic stress, reproductive-health complications, disability, physiotherapy and livelihood disruption may require months or years of coordinated care.

3.3.3 Compensation as a health intervention

Victim compensation is often treated as a monetary remedy external to health. In practice, it can determine whether victims can obtain medicines, travel to hospitals, take leave from work, relocate for safety, access psychotherapy or continue rehabilitation. A health-rights reading of compensation therefore emphasizes speed, predictability and linkage to assessed needs. Delayed compensation may have lower therapeutic value than smaller but immediate interim assistance. Indian victim compensation schemes would be strengthened by standardized health-needs assessment, automatic referral from treating institutions and transparent time limits for interim awards.

3.4 England and Wales: service rights, specialist support and coordination

The Victims and Prisoners Act 2024 gives the victim-services architecture a stronger statutory basis in England and Wales. It defines harm to include physical, mental or emotional harm and economic loss, and expressly recognizes victim status even where an offence is not reported, no one is charged, or no conviction follows. This mirrors the harm-based logic of the UN Victims Declaration and is particularly important for health services, because access to support should not depend upon willingness or ability to participate in prosecution.[10]

Section 2 requires a Victims' Code and provides that its services must reflect four principles: victims require information to understand the criminal justice process; access to supportive services, including specialist services where appropriate; an opportunity to make their views heard; and an ability to challenge decisions directly affecting them. The health significance lies principally in the second principle. Specialist victim support commonly includes therapeutic services, advocacy and independent advisers for sexual and domestic violence, which can connect criminal justice engagement with healthcare, safeguarding and psychosocial recovery.

The UK model is consequently less focused than India on a single statutory free-treatment clause and more focused on service navigation and coordinated entitlement. That design has advantages for complex trauma: a victim may need information, counselling, advocacy, housing support and clinical referral rather than only emergency treatment. The Victims and Prisoners Act also places emphasis on collaboration in commissioning victim support services, encouraging a system-level rather than institution-specific response.

The principal weakness is enforceability and variability. Code-based rights and commissioned services may be experienced differently depending on local capacity, waiting times, eligibility thresholds and the availability of specialist providers. A victim can formally possess a right to referral or support but still face delayed mental-health care. The public-health measure of success should therefore include time to first therapeutic contact, continuity between crisis and long-term services, dropout rates, and equitable access across geography and protected characteristics.

[9]Bharatiya Nagarik Suraksha Sanhita, 2023, s. 397 requires all public and private hospitals immediately to provide free first aid or medical treatment to victims of the enumerated offences and to inform police.
[10]Victims and Prisoners Act 2024, ss. 1–2. The Act defines harm to include physical, mental or emotional harm and economic loss and recognizes victim status irrespective of reporting, charge or conviction.

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3.5 United States: procedural rights plus a decentralized service infrastructure

At federal level, the Crime Victims' Rights Act, 18 U.S.C. § 3771, guarantees rights including reasonable protection, notice, participation, restitution, proceedings without unreasonable delay, and treatment with fairness and respect for dignity and privacy. These are predominantly procedural rights; the CVRA does not itself create a universal federal right to healthcare for victims. Nevertheless, protection, privacy and timely proceedings can be health-relevant because repeated exposure to offenders, avoidable delay and insensitive process may aggravate psychological distress.[11]

The Victims' Rights and Restitution Act complements the CVRA with service-oriented obligations. Federal justice agencies provide victims information about places where medical and social services are available and about public and private counseling, treatment and support programs. This service-navigation duty recognizes that effective victim assistance requires linkage beyond the courthouse. The Office for Victims of Crime further confirms that VOCA victim-assistance funding may support direct mental-health counseling and care, including outpatient therapy and, where directly related to victimization, substance-use treatment.[12]

The strength of the US model is its large and diverse victim-service ecosystem, including state compensation programs, rape crisis services, domestic violence programs, child advocacy centers, hospital-linked intervention, legal advocacy and community-based organizations. Its weakness is fragmentation. Eligibility, benefit levels, application procedures and service availability vary significantly by state and locality. Insurance status and network rules may further shape access to healthcare. A victim-centered health-rights strategy therefore requires coordination across justice agencies, Medicaid and other payers, state compensation programs, hospitals and community providers.

Contemporary victimization data underscore the scale of this challenge. BJS estimated that 1.45% of persons aged 12 or older experienced at least one violent victimization in 2024 and recorded 23.3 violent victimizations per 1,000 persons (Tapp and Coen, 2025). Only a portion of violent victimizations are reported to police, making police-based referral alone insufficient. Health and community systems must therefore be capable of identifying and supporting victims even where no criminal complaint is made.

3.6 Comparative synthesis

Dimension	India	England & Wales	United States
Core legal architecture	Article 21 jurisprudence; BNSS 2023; state victim compensation schemes	Victims and Prisoners Act 2024; Victims' Code; commissioned specialist services	CVRA; VRRA; VOCA; state victims' rights and compensation systems
Definition/recognition of harm	Constitutional life and dignity; statutory victim concept in criminal procedure	Express inclusion of physical, mental/emotional harm and economic loss	Federal statutory "crime victim" definitions vary by instrument; strong dignity/protection rights
Immediate medical care	BNSS s.397 mandates immediate free treatment for specified victims in public and private hospitals	General NHS access plus specialist victim pathways; no equivalent universal victim-specific treatment clause	No universal federal victim healthcare right; medical/social-service information and grant-supported direct services
Mental-health support	Available through general health system, schemes and compensation;	Specialist services and advocacy integrated into Victims' Code/service	VOCA can fund counseling; substantial state/local variation

[11]Crime Victims' Rights Act, 18 U.S.C. § 3771, including rights to reasonable protection, timely notice, participation, restitution, proceedings free from unreasonable delay, and fairness, dignity and privacy.
[12]Under federal victim-service rules and VOCA guidance, victims may be directed to medical and social services and eligible programs may fund direct mental-health counseling and care related to victimization.

	continuity uneven	commissioning	
Compensation	BNSS s.396 + state schemes; rehabilitation rationale	Criminal Injuries Compensation Scheme and other supports operate separately from Victims' Code	State compensation programs, often VOCA-supported; rules vary
Principal strength	Explicit treatment duty + constitutional foundation	Broad harm definition and coordinated service-rights model	Diverse service infrastructure and strong procedural dignity rights
Principal gap	Narrow offence coverage of mandatory free treatment; implementation variability	Waiting times, local capacity and limited direct enforceability	Fragmentation and geographic/insurance disparities

Table 1. Comparative legal-health architecture for crime victims.

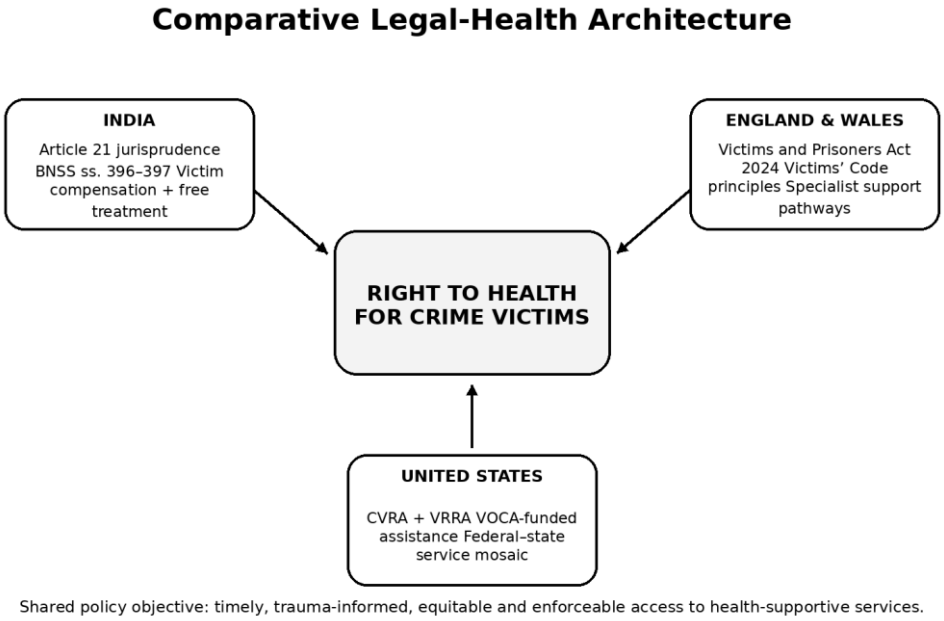

Figure 2. Comparative legal-health architecture across the three jurisdictions (original synthesis).

3.7 The implementation gap: from formal entitlement to usable care

Across the three systems, the largest gap is implementation rather than normative recognition. Five recurrent failures are visible. First, health care and victim services may be activated only after police reporting, even though many victims never report. Second, emergency care is often better defined than long-term trauma care. Third, financial support may arrive after the period in which victims incur the greatest treatment, transport and income costs. Fourth, victims must repeatedly narrate traumatic events to disconnected institutions. Fifth, there is insufficient outcome measurement: systems count prosecutions, referrals and compensation awards more readily than symptom improvement, functional recovery or sustained treatment access.

A rights-based system should minimize "administrative revictimization." Repetitive proof demands, confusing eligibility rules, insensitive interviewing, uncoordinated referrals and long delays can create additional distress. Trauma-informed administration does not mean abandoning evidentiary standards. It means designing evidence collection to reduce avoidable repetition, offering choice and clear information, protecting confidentiality, accommodating disability and language needs, and ensuring warm referrals rather than merely handing victims a telephone number.

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3.8 A minimum victim health rights framework

The comparative analysis supports a minimum framework with seven components. First, every victim presenting with urgent health needs should receive stabilization without precondition of police reporting or ability to pay. Second, sexual and serious-violence victims should have access to clinically appropriate forensic services with informed consent and confidentiality. Third, all victims should receive early psychosocial screening with rapid referral for evidence-based mental-health care where indicated. Fourth, safety planning must link healthcare with protection, housing and safeguarding. Fifth, financial assistance should include interim support for health-related costs. Sixth, a designated navigator should coordinate justice, healthcare and social-service contacts. Seventh, long-term outcomes should be measured using health and functioning indicators, not solely criminal-case outputs.

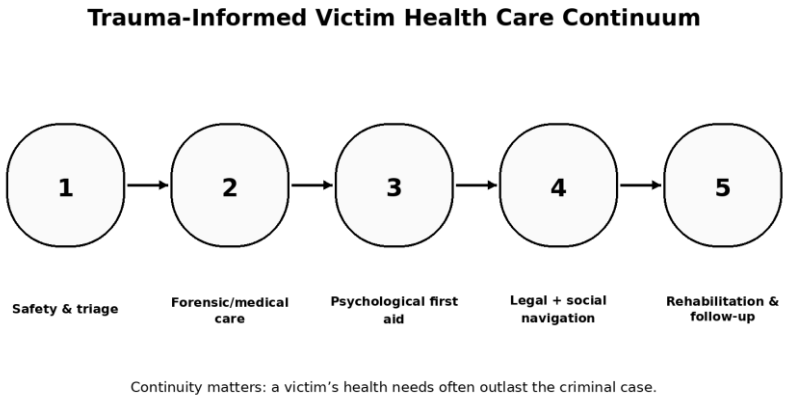

Figure 3. Proposed trauma-informed victim health care continuum (original synthesis).

3.9 Policy matrix

Policy lever	Minimum standard	Implementation indicator
Emergency access	Immediate stabilization independent of reporting status or payment capacity	Median time to treatment; proportion denied/delayed
Trauma screening	Validated screening and consent-based referral	Proportion screened; time to first mental-health contact
Specialist care	Sexual violence, domestic abuse, child and disability-sensitive pathways	Coverage by district/locality; waiting time
Navigation	Named case navigator / warm referral	Referral completion rate; victim-reported coordination
Compensation	Interim health-cost support with simple application	Days to interim decision; health expenses reimbursed
Privacy and dignity	Confidential, minimal-repeat, trauma-informed procedure	Repeat interviews; complaints; privacy incidents
Outcome measurement	Health, functioning and safety outcomes	Validated symptom/function change; return to work/education where appropriate

Table 2. Proposed policy and evaluation matrix for victim health rights.

3.10 Jurisdiction-specific recommendations

India

India should retain the clarity of BNSS section 397 while expanding the practical continuum around it. A national model

protocol could require every emergency department to provide a victim-health referral pack, trauma screening and a single point of contact. State victim compensation schemes should adopt uniform interim-payment benchmarks for urgent treatment and rehabilitation. Digital integration should allow victims, with consent, to avoid repeatedly submitting the same medico-legal and identity documents. Crucially, psychological treatment should be explicitly recognized as rehabilitation rather than an optional welfare service.

England and Wales

England and Wales should use the statutory principles of the Victims and Prisoners Act 2024 to develop measurable health-related standards within victim support commissioning. Specialist psychological services should have transparent maximum waiting-time ambitions, and local commissioners should publish equity indicators. The Victims' Code should be operationalized through warm referral protocols connecting police, independent advisers, sexual assault referral centres, NHS mental-health services and voluntary-sector providers. Complaints and review mechanisms should capture failures of support access, not only failures of information or communication.

United States

The United States would benefit from stronger portability and interoperability across state systems. VOCA-funded services and state compensation should use simplified common data elements, and health providers should be able to refer victims directly to compensation navigators. Federal guidance could promote presumptive eligibility for specified urgent services while formal claims are assessed. Because many victimizations are not reported to police, community and healthcare pathways should remain independent of criminal-case participation, consistent with a harm-based public-health approach.

3.11 Implications for natural-resources and human-health scholarship

Although victimization is not a conventional natural-products topic, the analysis is relevant to human-health scholarship insofar as it examines determinants of injury, trauma, access to care and rehabilitation. Interdisciplinary health research increasingly recognizes that biological outcomes are shaped by legal and social environments. For a health-focused journal, the strongest contribution of this paper is therefore not criminal-law doctrine in isolation but the translation of law into health-system access, continuity and recovery. Future empirical work could test whether particular victim-rights models are associated with shorter treatment delays, improved mental-health outcomes, better adherence to rehabilitation and reduced catastrophic health expenditure.

4. LIMITATIONS

This study has four limitations. First, it is a doctrinal and policy review rather than a systematic review or primary empirical study. Second, the term "UK" in the title is operationalized principally as England and Wales because the Victims and Prisoners Act 2024 and Victims' Code framework discussed here has a jurisdiction-specific territorial application; Scotland and Northern Ireland have distinct justice and victim-support arrangements. Third, the United States is highly decentralized and federal law does not capture the full diversity of state constitutional, statutory and compensation frameworks. Fourth, official victimization data across jurisdictions use different survey instruments, populations and crime definitions and are therefore presented contextually rather than as directly comparable prevalence estimates.[13]

5. CONCLUSION

Crime victimization should be understood as a health event with legal consequences and as a legal event with health consequences. India, England and Wales, and the United States each recognize important parts of this relationship, but through different legal technologies. India provides a strong constitutional and statutory treatment foundation for specified victims; England and Wales emphasize broad victim status, specialist services and coordinated service rights; and the United States combines procedural dignity with a decentralized but substantial assistance infrastructure. None fully guarantees seamless recovery from emergency care to long-term rehabilitation.

The next generation of victim-rights reform should therefore be evaluated by health outcomes. A meaningful right to health

[13]The Victims and Prisoners Act 2024 primarily extends and applies to England and Wales, subject to specified exceptions. Scotland and Northern Ireland maintain distinct criminal justice arrangements.

for crime victims requires more than a hospital door that is technically open: it requires timely treatment, trauma-informed mental-health care, safety, financial feasibility, privacy, navigation and continuity. Embedding these elements into measurable victim-service standards would move justice systems from recognition of harm toward restoration of health and functioning.

REFERENCES

[1] Basile, K.C., Smith, S.G., Kresnow, M., Khatiwada, S., Leemis, R.W., 2022. The National Intimate Partner and Sexual Violence Survey: 2016/2017 Report on Sexual Violence. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, Atlanta.
[2] Bureau of Justice Statistics, 2026. The Nation's Two Crime Measures, 2015–2024. U.S. Department of Justice, Washington, DC.
[3] Government of India, 1950. Constitution of India, Article 21.
[4] Government of India, 2023. Bharatiya Nagarik Suraksha Sanhita, 2023, ss. 396–398. India Code, Ministry of Law and Justice.
[5] Government of the United Kingdom, 2024. Victims and Prisoners Act 2024, c. 21. The National Archives, legislation.gov.uk.
[6] Ministry of Justice, 2021. Code of Practice for Victims of Crime in England and Wales (Victims' Code). Government of the United Kingdom, London.
[7] Office for National Statistics, 2015. Personal well-being and crime: Crime Statistics, Focus on Public Perceptions of Crime and the Police, and the Personal Well-being of Victims, 2013 to 2014. ONS, London.
[8] Office for National Statistics, 2024. Crime in England and Wales, victim characteristics: year ending March 2023. ONS, London.
[9] Office for National Statistics, 2026. Crime in England and Wales: year ending March 2026. ONS, London.
[10] Office for Victims of Crime, 2026. VOCApedia: Victim Assistance – allowable direct services for mental health counseling and care. U.S. Department of Justice, Office of Justice Programs.
[11] Paschim Banga Khet Mazdoor Samity v. State of West Bengal, (1996) 4 SCC 37 (Supreme Court of India).
[12] Pt. Parmanand Katara v. Union of India, (1989) 4 SCC 286 (Supreme Court of India).
[13] Tapp, S.N., Coen, E.J., 2025. Criminal Victimization, 2024. NCJ 310547. Bureau of Justice Statistics, U.S. Department of Justice, Washington, DC.
[14] United Nations General Assembly, 1985. Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power, Resolution 40/34, 29 November 1985.
[15] United States Congress, 2004. Crime Victims' Rights Act, 18 U.S.C. § 3771.
[16] United States Department of Justice, 2022. Crime Victims' Rights Act: federal rights of crime victims. Office of the U.S. Attorneys.
[17] United States Department of Justice, 2026. Victims' Rights and Restitution Act, 34 U.S.C. § 20141: services for victims of federal crime.
[18] World Health Organization, 2012. Understanding and addressing violence against women: health consequences. WHO/RHR/12.43. WHO, Geneva.
[19] World Health Organization, 2024. Injuries and violence. Fact sheet, 19 June 2024. WHO, Geneva.
[20] World Health Organization, 2021. Violence against women prevalence estimates, 2018. WHO, Geneva.
[21] Campbell, R., 2008. The psychological impact of rape victims' experiences with the legal, medical, and mental health systems. American Psychologist 63, 702–717.
[22] Dworkin, E.R., Menon, S.V., Bystrynski, J., Allen, N.E., 2017. Sexual assault victimization and psychopathology: a review and meta-analysis. Clinical Psychology Review 56, 65–81.
[23] Koss, M.P., 2000. Blame, shame, and community: justice responses to violence against women. American Psychologist 55, 1332–1343.
[24] Kilpatrick, D.G., Acierno, R., 2003. Mental health needs of crime victims: epidemiology and outcomes. Journal of Traumatic Stress 16, 119–132.