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UTILIZATION OF MENTAL HEALTH SERVICES AT DOMESTIC VIOLENCE AGENCIES IN PENNSYLVANIA

A Dissertation Presented to

the Faculty of the Doctor of Social Work Program of

Kutztown University

In Partial Fulfillment

of the Requirements for the Degree Doctor of Social Work

By Kealsey McNeil LCSW, CAADC

March 2024

This Dissertation for the Doctor of Social Work Degree

by Kealsey McNeil

has been approved on behalf of

Kutztown University

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Date

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ABSTRACT OF THE DISSERTATION

UTILIZATION OF MENTAL HEALTH SERVICES AT DOMESTIC VIOLENCE AGENCIES IN PENNSYLVANIA

By

Kealsey McNeil

Kutztown University, 2024

Kutztown, Pennsylvania

Directed by Yasoda Sharma, PhD

In this research, I examined the use of mental health services at domestic violence (DV) programs in rural and urban Pennsylvania and agency size. I examined the needs, characteristics, and availability of mental health services for DV survivors across the Commonwealth of Pennsylvania. I looked at DV service use from a variety of sources to provide a well-rounded understanding of the factors that contributed to mental health service use. I used three secondary data sources: the Lethality Assessment Program (LAP), Adequacies of Network of Services Provided to the Survivors of Domestic Violence in Pennsylvania–Phase II study, and data obtained from publicly available DV agency websites. Each resource helped me to create an in depth understanding of service utilization for DV survivors across the Commonwealth of Pennsylvania from a variety of a perspectives. In this study, I included data from 214 DV survivors at DV agencies, 49 DV agency websites, and 6,139 DV survivors in Pennsylvania communities. I examined

factors that impacted mental health service use by reviewing descriptive statistics and analyzing website content. I found there was an overall lack of mental health service support across the Commonwealth of Pennsylvania at DV agencies, regardless of agency size and location. There were slightly more services at large agencies than small agencies; however, there was no difference based on agency locality. In this study, I used feminist and ecological theories, the healthcare beliefs model, and the Andersen and Newman model to inform the factors impacting mental health service use. I uncovered the following themes: agency use of nonmental health counseling services, overarching use of crisis services, and no psychiatry at DV agencies. The results have several policy implications regarding federal and state government programs, especially the Violence Against Women Act. Based on the findings of this study, I propose specific considerations should be made to fund training to for mental health providers in the treatment of DV survivors and funding should be increased for agencies where onsite and community mental health programs are not accessible.

Keywords: utilization, mental health, domestic violence, intimate partner violence, Pennsylvania, urban, rural

DEDICATION

This study is dedicated to all social workers who work tirelessly to help those affected by trauma and domestic violence. Sometimes this can be a thankless field, but what you do matters, and I am hoping these findings help you to expand and enhance your practice.

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I would like to express my deepest gratitude to Dr. Sharma for guiding me through this dissertation journey. Thank you for your patience, guidance, and willingness to share your knowledge and expertise. Thank you for pushing me professionally and academically to be the best I can be. I would also like to thank my dissertation committee members Dr. Vafeas and Dr. Lyter for your support, feedback, and guidance throughout this process. I would like to extend my sincere thanks to Dr. Gasker and Dr. Stanfa for proofreading and providing guidance, advice, and suggestions.

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Lastly, I would be remiss in not mentioning my family, especially my parents, close friends, babysitters, and son Archie. Their belief in me has kept my spirits and motivation high during this process. I would also like to thank my dog for all the entertainment and emotional support.

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Chapter I: Introduction

Statement of the Problem

Domestic violence (DV) is defined as a pattern of abusive behavior where one intimate partner uses power and control over others (U.S. Department of Justice, 2022). The abuse can be sexual, physical, emotional, psychological, economic, threats, technological action, or controlling behavior. It includes any behavior that is intended to manipulate, intimidate, frighten, isolate, threaten, blame, coerce, hurt, wound, or injure another person (Centers for Disease Control and Prevention, 2023; U.S. Department of Justice, 2022). Often when looking at DV, one looks at the effects of the violence. DV is a broader term often used interchangeably with the term intimate partner violence (IPV) to describe abuse of a spouse, boyfriend/girlfriend, or any other intimate partner (Centers for Disease Control and Prevention, 2021). DV, according to the United Nations (n.d.) is defined as "a pattern of behavior or any relationship that is used to gain or maintain power and control over an intimate partner" (p. 1).

Types of Violence

It is critical to understand the underlying causes and types of violence. A systematic literature review by the World Health Organization (Garcia-Moreno et al., 2005), found the main forms of DV were physical trauma, fear and control, and psychological trauma/stress. The World Health Organization study provided a model for understanding how the causes impacted health by showing the prevalence of distress among those who experienced DV. The researchers found violence alone, regardless of demographic factors, caused significant health problems through direct and indirect health impacts on a number of health outcomes (Garcia-Moreno et al., 2005). All areas

directly impacted mental health and substance abuse problems, which also impacted physical health issues (Jamison et al., 2013).

Disparities in DV

According to the National Coalition Against Domestic Violence (2023), nearly 10 million people in the United States experienced DV each year, and 95% of men who physically abused their partners also psychologically abused them. It is important to note that, although women had historically reported significantly higher rates of DV, men were also recipients of DV services with 1 out of every 9 men having experienced severe IPV during their lifetime (National Coalition Against Domestic Violence, 2023). Even with the high numbers of people who experienced DV, not all individuals used DV services in the same way. Black et al. (2011) reported African American women were 1.3 times more likely to suffer from domestic abuse than White women and 1.2 times more likely to suffer from domestic abuse than Hispanic women. According to the National Death Reporting System, data collected from 2003–2020 showed that Caucasian people died by homicide in disproportionately higher numbers (more than 70% of the overall population); however, African Americans (1.43%) and American Indian/Alaska Natives (1.8%) died by homicide at higher rates than Caucasians (.36%) and Asian (.2%) (Centers for Disease Control, 2023).

Despite the high numbers of racial minorities experiencing DV, previous research has shown they were less likely to seek and use services than their White counterparts. In a systematic review studying the relationship between mental health utilization and stigma in racial and ethnic minorities, researchers found stigma and cultural beliefs impacted clients' willingness to seek services (Misra et al., 2021). Lucea et al. (2013)

surveyed 545 DV survivors and found DV survivors that identified as African Americans and those that identified as African Caribbean used DV services at a rate of only 18%. This was less than their Caucasian counterparts and showed how race could impact service use. The study found if the survivors had a formal diagnosis of posttraumatic stress disorder (PTSD), regardless of race, they were more than twice as likely to seek DV services. However, those with formal mental health diagnoses of PTSD were less than half of the population of the African-American and African Caribbean populations utilizing services. This study cited beliefs about providers' cultural competence and service availability as primary reasons for survey participants not utilizing services.

Another study by Lipsky et al. (2006) looked at DV service utilization using surveys from 329 female IPV survivors from an emergency department in Texas and found only 9.5% used mental health services, and Hispanic women had the lowest level of mental health service utilization across all races measured. Findings from this study indicated beliefs around sociocultural factors and language may have played a part in decreased utilization with this population. Hispanic female IPV survivors cited language preference as one barrier that impacted their use of mental health services. The findings from this study showed similar rates of DV service utilization, including mental health services, between Caucasians and African Americans (Lipsky et al., 2006). Both studies showed that beliefs around culture and racial stigma were factors in decreased service use. Additionally, an ethnographic research study by Websdale (1998) reported that women from racially minoritized groups had an added struggle of having to deal with racism that their Caucasian counterparts may not have experienced.

DV and Mental Health Connection

The National Coalition Against Domestic Violence (2023) stated, "Seven out of 10 emotionally or psychologically abused women display symptoms of post-traumatic stress disorder and/or depression" (p. 1), and at least 25% of all women in the United States had been victims of DV one or more times in their lifetimes. In the Commonwealth of Pennsylvania, 2,574 DV survivors were served on average per day, and approximately 90,000 people used DV services in 2020 (Pennsylvania Coalition Against Domestic Violence, 2023). In 2022, 112 people died from DV in the Commonwealth of Pennsylvania (Pennsylvania Coalition Against Domestic Violence, 2023). It is important to note these numbers reflected only the people who used services and reported having experienced DV, and they may not have been reflective of the total number of people who experienced DV across the United States and in the Commonwealth of Pennsylvania. The actual numbers may have been much higher, as many people who experienced DV may not have been willing or able to seek services (Fugate et al., 2005).

People who experienced DV were at significantly higher risk for mental health and substance abuse-related diagnoses than the general population (Coker et al., 2000; Golding, 1999; National Coalition Against Domestic Violence, 2023; Pill et al., 2017), with suicidal ideation, depression, anxiety, neurological disorders, PTSD, and substance use disorders leading the diagnoses. As a result, survivors of DV were reported to need comprehensive mental health services from DV agencies (Golding,1999; Holtzworth-Munroe et al., 1997; Jones et al., 2001). Research has suggested crisis services, counseling, and support groups were helpful for survivors of DV (Bowker & Maurer, 1986; Gordon, 1996; Hamilton & Coates, 1993). Additionally, psychotherapy for such

resultant conditions as PTSD, has been reported to be efficacious (Longden et al., 2012; Perez et al., 2012; Tarquinio et al., 2012). Henning and Klesges (2002) studied 1,746 participants regarding mental health treatment utilization for DV and found only 14.9% of women impacted by DV that were interviewed by pretrial services reported having used formal counseling or supportive services. Some of the reasons for under-utilization of mental health services included survivor demographics, characteristics of prior DV including prior injury by partner, forced sexual activity, prior psychological abuse, and children having witnessed the violence (Henning & Klesges, 2002). This showed there were multiple factors that impacted service use for DV survivors and their willingness/ability to obtain mental health services.

Not only does DV negatively impact mental health for DV survivors, DV also impacts families and communities at large through other forms of violence, general health, and both household and social economics. According to the Centers for Disease Control and Prevention (2019), DV cost the U.S. economy approximately $3.6 trillion annually. This was due to a multitude of factors including, but not limited to, missed work, medical costs, and costs associated with the criminal justice system.

Despite this multifactorial account of DV and its consequences, the urban and rural locality in which the violence and available services exist needs more research to be more accurately understood. The literature examining where the DV and the available services exist reveals a paucity of published research comparing differences between urban and rural DV agencies. Despite this paucity of data, it is known that access to DV services in the United States is based on population density. As a result, women in rural communities had less access to mental health professionals, legal assistance, and DV

shelters than their urban counterparts (Peek-Asa et al., 2011). Making clear this disparity, when shelters were available, they frequently offer counseling, legal advice, crisis intervention, and system navigation (Bennett et al., 2004).

Previous research has shown women who live in rural areas were twice as likely to be denied or turned away due to a lack of services and limited staffing (Iyengar & Sabik, 2009; Lanier & Maume, 2009; Riddell et al., 2009). Peek-Asa et al. (2011) found women living in isolated rural areas had significantly higher rates and severity of physical abuse than urban respondents, and that rural residents had a three times greater distance to their nearest DV agency. Sharma and Vafaes (2022) interviewed 45 DV agencies across the state of Pennsylvania and found that only 33.1% provided onsite mental health support, but 100% of these agencies provided crisis services. This study also found a disparity between the availability of on-site mental health support, with 22% of rural agencies providing mental health and 45% of urban agencies providing services. This disparity in the availability of the services undoubtedly played an important role in service utilization. According to the National Academies of Sciences et al. (2018), “Healthcare utilization is determined by the need for care, by whether people know that they need care, by whether they want to obtain care, and by whether care can be accessed” (p. 22).

Rural and Urban Considerations

There is a particular variance between the needs of rural versus urban populations. Nineteen-point three percent of the nation’s population identified as rural (U.S. Census Bureau, 2021). Professionals must develop a better understanding of the differences between urban and rural areas regarding DV (Eastman et al., 2007). DV survivors who

lived in rural areas have been shown to have less access to resources and experience cultural implications for engaging in services (Banyard et al., 2020; Murray et al., 2019; Pruitt, 2008). According to Lanier and Maume (2009), the rate of vulnerability to DV among women was higher in rural areas due to differences in the characteristics of the rural and urban populations. Rural victims were more likely to be Caucasian women who had experienced childhood trauma and a partner who had alcohol/substance use issues. A study of DV among patients seen in family practice clinics in both urban and rural localities concluded that women in rural settings were more likely to be in an abusive relationship than their urban counterparts (Johnson & Elliott, 1997).

In many rural communities, DV is still considered a private matter that is often addressed in families or the church. Attitudes and norms related to family privacy and fear of embarrassment/shame have been identified as factors that influence rural victims from engaging with formal supports, including mental health professionals (Hartley, 2004; Krishnan et al., 2001; Robinson et al., 2012). Additionally, many families in rural areas had the expectation that women stand by their marital promises, which is often supported by local religious establishments even in the event of abuse (Grama, 2000; Krishnan et al., 2001; Olson, 1988). Van Hightower and Gorton (1998) found many DV survivors at a rural healthcare clinic were scared to leave and worried their safety may be compromised due to lack of anonymity at the DV agencies in their communities. A cultural ethnography by Grama (2000) had similar findings. Concerns around anonymity and confidentiality may be another factor in the rural and urban service use disparity.

Although poverty is not unique to rural localities, studies have shown poverty and DV were correlated (Grama, 2000; Logan et al., 2001; Pinn & Chunko, 1997; Websdale,

1998). Rural family violence survivors who live in poverty sometimes lacked transportation and support necessary to obtain needed services (Grama, 2000). Pervasive poverty experienced by rural regions often prevented access to quality care (Hoeft et al., 2018). Socioeconomic distress has shown a direct correlation with the prevalence of mental health problems (Evans & Sunde, 2016; Hudson 2005). The cycle of poverty and the combination of worsening poverty and worsening mental health have made it difficult for rural survivors to access care (Statz et al., 2022). Geographic isolation, cultural attitudes, and limited resources were major issues that impacted victims of DV in rural areas (Grama, 2000; Logan et al., 2001; Van Hightower & Gorton, 1998). Some survivors may have had to travel more than 40 miles to reach a shelter. According to the Bureau of Health Resources, in 2003, more than 34 million rural residents were found to live in designated mental health professional shortage areas. I included some dated studies in this section to highlight the intergenerational and ongoing impact DV has had on rural communities due to survivors' inabilities to access and use services.

The impact of these unmet needs is vast. Some of the reasons for these unmet needs have been identified as a lack of access to health, prevention, and protection services across the United States. Rural women had less access to these services than urban women and were nearly twice as likely to be turned away from services because of the insufficient number of programs, geographic differences, and inadequate staffing of community-based health programs (Allard et al., 2003; Iyengar & Sabik, 2009; Lanier & Maume, 2009; Riddell et al., 2009). Peek-Asa et al. (2011) studied survivors of DV in rural Iowa found that women in rural and isolated places reported significantly higher rates of DV, and the severity of the physical abuse was greater than reported by their

urban counterparts. Additionally, the study highlighted woman in these areas had less access to resources and greater challenges in getting to DV programs due to distance (Peek-Asa et al., 2011). As stated by Hetling and Zhang (2010), “Services are only useful, however, if they are accessible to and utilized by those in need” (p. 1145).

A multitude of factors contributed to the disproportionate rates of behavioral health service utilization for rural areas (Scafe et al., 2021). One study found rural patients attended fewer follow-up mental health care appointments and demonstrated lower levels of engagement than urban patients (Chan et al., 2016). Cully et al. (2008) found comparable rates of treatment engagement among urban and rural patients and hypothesized it was due to behavioral health services being integrated into primary care clinics, which may have increased convenience and added to destigmatization. Lack of confidentiality and anonymity were identified barriers for survivors of DV in rural areas, and these barriers were directly related to cultural stigma and attitudes (Judd et al., 2007; Kohtala et al., 2023). Confidentiality regarding shelter location was shown to impact beliefs about service use and may have impacted DV survivors’ willingness to accept services, particularly in rural areas (Haaken & Yragui, 2003).

When studying providers who work with DV victims in rural Virginia and North Carolina, Eastman et al. (2007) found DV survivors reported concerns regarding community rejection due to cultural beliefs. Another study by Youngson et al. (2021) found service providers in DV agencies had concerns about protecting client confidentiality and anonymity in rural areas due to clients’ fears of being seen obtaining services and the close-knit nature of the rural environment. Additionally, service providers reported concerns around collaboration with outside agencies due to these same

concerns around client confidentiality (Youngson et al., 2021). Concerns around client confidentiality and anonymity could pose a barrier for those living in close knit communities.

Relevance of DV Research to Social Work

DV victims' service utilization in rural and urban settings has important implications for the field of social work. In this section, I highlight the relevance and implications of this study for social work education. I also address relevance and for leaders in the social work field.

Social Work Education

Gelles (1993) categorized models of DV into three general classes: individual (psychological), sociological (sociopsychological), and social-structural (feminist) models. On an individual level, having mental health professionals (MPHs) who can address the mental health of survivors of DV is imperative for ensuring survivors' personal well-being and improved quality of life. The National Alliance on Mental Illness (2019) defined MHPs as those having the ability to evaluate a person's mental health, diagnose, and provide therapeutic interventions. MHPs include psychologists, therapists, counselors, and clinical social workers. Danis and Lockhart (2003) found 92% of social workers stated that they had had professional contact with DV survivors, and more than 50% reported having experienced DV themselves. This demonstrated the prevalence of social workers' involvement in the mental health management of DV survivors.

According to the National Association of Social Workers (2023), "Social workers' primary responsibility is to promote the well-being of clients" (p. 1). The mental well-being of a client is part of the primary social work responsibility. Through

DV counseling, social workers ensure client safety and well-being through a holistic approach to both assessment and intervention. Although availability is the first step in service delivery, it does not necessarily yield service utilization. From a generalist social work perspective, the utilization of mental health services for DV can play a major role in ensuring family units can function optimally by addressing the needs and psychological effects on the family as a unit. The National Association of Social Workers (2023) code of ethics states social workers "demonstrate skills in the provision of culturally informed services that empower marginalized individuals and groups" (p. 1). Dwyer et al. (1995) found from a sociocultural perspective, understanding the utilization of mental health resources played a major role in impacting community and organizational policy, increasing understanding of the need for social action within the community, and increasing education in communities.

Social work education is beneficial not only to professionals and social work students, but also to other mental health professionals and laypersons. By following theory and ethical guidelines for practice, the factors that impact service utilization can be better understood. Not only do these theories for understanding human behavior help to inform social work practice, but they also help to provide a holistic lens through which to understand the experience of DV survivors. According to Honig and Fendell (2000), the curriculum used for mental health professionals often excluded education on working with survivors of DV. Additionally, the article noted mental health professionals, substance abuse counselors, and DV workers did not coordinate across disciplines, and, as a result, the needs of DV survivors remained unmet. Increased understanding of DV service utilization will help future social work practice by increasing confidence and

competence with which social workers address survivors' needs.   Rose et al. (2011) found clinicians with training in treating survivors of DV reported low confidence and competence in addressing their client's needs. Murray et al. (2016) showed many mental health clinicians had never received training in treating survivors of DV. Additional studies revealed many mental health professionals lack sufficient training to both recognize and provide treatment for DV survivors, and there were serious gaps in professional knowledge of DV issues (Gauthier & Levendosky, 1996; Murray & Graves, 2013; Nyame et al., 2013; Rose et al., 2011; Trevillion et al., 2016; Wingfield & Blocker, 1998). Mental health professionals reported fear, discomfort, and low levels of professional competency, confidence, and self-efficacy related to limited knowledge about working with DV survivors (Sprague et al., 2012).

Some researchers have suggested professionals working in mental health fields needed increased education for working with DV survivors (Tower, 2006; Trevillion et al., 2016). Increased training for providers has been shown to increase positive outcomes for victims of DV (Burns et al., 2020; Forsdike et al., 2019). Social workers traditionally have played a critical role in helping survivors of DV to recover and achieve wellbeing (Crabtree-Nelson et al., 2016). Additionally, "a groundbreaking initiative to champion social progress powered by science" (Grand Challenges for Social Work, 2021, para. 1) known as Build Healthy Relationships to End Violence, has been identified as one of the social work grand challenges.

Social Work and Leadership

This study increased the breadth of knowledge for social workers and social work students to understand the needs of their clientele with the hope of increasing

professional competence and confidence in the provision of mental health services for DV survivors and enhance the knowledge around mental health services use of DV survivors. Ultimately, this study will help survivors of DV obtain the services they need. Additionally, the research from this study guides leadership to advocate for changes in policy by enhancing knowledge of the factors that impact service use and understanding of the services provided for survivors of DV. By enhancing the knowledge of the factors that impact service mental health service use, DV agency leaders and staff will be better equipped to meet the needs of their clientele.

Additionally, this research provides leaders in the social work field with greater understanding of cultural implications that impact client service utilization and quality of care. This study enhances the knowledge of leaders and professionals working with DV survivors around factors that impact service use. Social workers must understand their client demographics, and social workers' cultural competence is of the utmost importance in providing quality care. Deepening the understanding of the clients' experience can help leaders to make their most informed decisions.

Problem Statement

In a systematic review of 2,568 peer reviewed journal articles, Rodríguez et al. (2009) found survivors of DV underused mental health resources, despite reporting increased levels of mental health disorders. Mental illness impacted DV survivors at significantly higher rates than the general public, despite underuse of mental health services. This study examined a variety of factors that impacted service use. There were disparities between urban and rural localities regarding service utilization for DV survivors. In this study, factors were compared by rurality and agency size to understand

the differences impacting DV survivor service use. Prior research has shown women from rural areas have challenges when obtaining DV services due to geographical, sociocultural, and psychological reasons (Cheng & Lo, 2015; Cho & Kwon, 2018; Edmond et al., 2013). Additionally, agency size impacted the availability of resources (Lyon et al., 2008). There was a paucity of studies examining service utilization specific to rural populations, and little was known about similarities and differences between both rural and urban communities and agency size.

Statement of Purpose

Research supported the conclusion that a person's utilization of services directly impacted treatment outcomes (Ahmed & McCaw, 2010; Folger & Wright, 2013; Sullivan & Bybee, 1999; Tan et al., 1995; Tutty et al., 1999). Without understanding service availability and the complexities that factor into service use, mental health needs would continue to go unmet or under-used among survivors of DV. There was a particular need to understand the service use for DV survivors who lived in rural areas due to a paucity of research about that population (Peek-Asa et al., 2011).

Research on the topic had been "fragmented" (Schmidt, 2014, p. 258). There also was limited research studying comprehensive mental health services. Most research to date has looked at one mental health service, such as crisis counseling or peer support, and has not addressed mental health services within agencies as a whole. Having an operational definition of mental health services helps both clients and agency staff to have a common language so everyone knows the exact services being provided and the issues those services address (see Appendix A). According to the American Psychological Association (2023), mental health services were defined as "any

interventions—assessment, diagnosis, treatment, or counseling—offered in private, public, inpatient, or outpatient settings for the maintenance or enhancement of mental health or the treatment of mental or behavioral disorders in individual and group contexts" (p. 1). Mental health services provided by DV agencies included crisis services, peer support services, individual mental health therapy, and group mental health therapy. Some agencies provided counseling more broadly, and others used evidence-based treatments such as eye movement desensitization and reprocessing, prolonged exposure, and cognitive behavioral therapy to treat mental health diagnoses such as depression, PTSD, substance use disorders, and anxiety. Other agencies referred clients to local mental health agencies to meet their mental health needs. This study examined on-site mental health psychiatric services.

DV survivors' unmet needs have been shown to place a financial and social burden on society (Peterson et al., 2018). As a first step toward understanding and overcoming the barriers to mental health services for DV survivors, a more comprehensive understanding of the utilization of mental health services, especially those affected by urban and rural locality, was required. The primary purpose of this research was to examine DV and related mental health services in Pennsylvania and the differences in utilization between urban and rural DV agencies across the state of Pennsylvania. In doing so, this study provides a deeper understanding of the barriers to mental health treatment services faced by DV survivors.

Research Questions

This study was guided by the following research questions:

- Research Question 1: Is there a difference in DV survivors' utilization of mental health services between urban and rural Pennsylvania?
- Research Question 2: Is there a difference in DV survivors' utilization of mental health services between large and small agencies in Pennsylvania?
- Research Question 3: What are the barriers for receiving DV and mental health services based upon locality and agency size?
- Research Question 4: What are the differences in demographic characteristics of those seeking mental health services at DV agencies based upon locality and agency size?

Potential Impact

There are several benefits from this study. The first benefit is adding to the body of knowledge surrounding DV that will eventually impact social work education and social work practice. This research has implications for clinical practice in understanding more about the delivery of clinical services to DV survivors by providing a rationale and road map for decreasing, expanding, or revamping the delivery of services. This study could also impact policy and how funds are disseminated to DV agencies to address mental health needs. Some of the policies that could be impacted by this study include the Prevention from Women Against Domestic Violence Act, Affordable Healthcare Act, Family Violence and Service Prevention Act and community and agency policies.

Additionally, the Violence Against Women Act, which defines who is responsible for the mandatory reporting of danger to others could be expanded to professionals other than mental health professions, especially in areas where there is low utilization of mental health services for DV survivors, as this might help to prevent loss of life. These larger

policies impact state and then agency policy. Understanding who is providing mental health services and understanding each person's role within an agency helps to clarify roles for staff and clients. This clarity helps not only to safeguard the client, but also the staff. This study could help to provide incentive for agencies on the national, state, and local levels to have a common language and categorization of mental health services. This would help to ensure DV survivors receive the services they need to address psychiatric and substance abuse diagnoses. Factors that impact DV survivors on a national level can be applied on a programmatic level and effect the client population. Additionally, understanding the level of service utilization impacts DV agencies' assessments of the need for additional services. Most of all, this research provides a reference point for additional research to elucidate mental health service delivery for victims of DV.

Organization of the Dissertation

The remaining chapters delve into the literature and provide a review of current literature published relating to the utilization of mental health services in DV centers in both rural and urban Pennsylvania. Later chapters also discuss the research methods, findings, analysis of the data, and interpretation.

Chapter 2: Literature Review

The literature review focused on the following: the conceptual and theoretical frameworks that laid the foundation for this dissertation, prior research on domestic violence (DV) and mental health, importance of service utilization, barriers to seeking mental health treatment, prior methodological limitations, Pennsylvania and DV, and implications. This literature review included peer-reviewed articles about the relationship between DV and mental health services use in both rural and urban Pennsylvania. This literature review examined mental health services used for DV survivors broadly, as there was a clear gap in the literature available when comparing urban and rural services used by DV survivors (Gauthier & Levendosky, 1996; Murray & Graves, 2013; Nyame et al., 2013; Rose et al., 2011; Trevillion et al., 2016; Wingfield & Blocker, 1998). As explained in the problem statement, there was a particular need to understand service use for those living in rural areas.

Theoretical Perspective

In this literature review, I examined two theories relevant to DV and service utilization. Two of the most relevant theories were feminist theory and ecological systems theory. Each of these theories provided important insight into understanding social work practice as it related to service utilization of DV survivors.

Feminist Theory

Feminist theory is a well-established and well-founded theory that looks at various factors that impact women, including gender roles, "power and perceived vulnerabilities in explaining several social problems such as poverty, intimate partner violence and poor health among women in particular" (Sharma, 2012, p. 40). According

to Payne (2014), feminist theory played a major role in social work practice through helping social workers to respond to the oppression of women in many societies. The main aim of the feminist theory is to promote women's rights and interests by understanding how gender inequalities lead to unequal treatment of women in the society (Chodorow, 1989; Gilligan, 1977; Sharma, 2012). Additionally, feminist theory helps to explain how intersectionality between certain factors can cause DV to women and their families (Crenshaw, 1991; Harcourt, 2016; McKibbin et al., 2015). Feminist theory was important to this study, as women have been disproportionately victims to DV due to unequal power dynamics between both genders (Herzog, 2007; Hunnicutt, 2009; Sharma, 2012).

Feminist theory derived from the feminist movement. The feminist movement dated to the 1930s when women fought for equal rights to vote and to obtain legal property rights. In the second wave of feminism, from the 1960s until the early 1990s, the primary focus was equal social, political, and economic rights (Drucilla, 1988; Payne, 2014). Many of those same themes remained in what was considered the third wave of feminism from the 1990s through 2024 (Payne, 2014). As of this writing, women have continued to fight for equal rights in those arenas. Feminist theory suggests the patriarchal systems and structure continue to maintain an unequal distribution of power between both genders (Drucilla, 1998; Echols, 2019; Sharma, 2012). During the feminist movement, rape, crisis, and battered women's shelters were developed and used to house and provide support to women who experience DV (Goodmark, 2020). Such shelters have continued to exist to safeguard women (Goodmark, 2020; Sharma, 2012).

Feminist theory can be divided into different categories focused on various perspectives related to the unequal treatment of women. Some of these perspectives include liberal feminism, radical feminism, socialist feminism, Black modernist feminism, and postmodern feminism (Payne, 2014). Liberal feminism seeks to improve the unequal treatment between men and women with a particular focus on the workplace and family responsibilities. This theory states physical sex difference has been equated to assumptions around gender differences. Liberal feminists work promote equality though the use of dispelling assumptions around gender differences. Radical feminism attacks patriarchal structures and seeks for women to be separate. In radical feminism, women coexist with men and have separate social structures to impart less influence from the patriarchic structures that currently exist, therefore reducing harm from men. Socialist feminism plays particular attention to women's roles within capitalistic structures. Social Feminist theory also recognizes the intersectionality and oppression of race and disability and how the oppression of women interacts (Dominelli, 2002; Payne, 2014; Reynolds, 1993).

Black feminist theory suggests Black women are oppressed disproportionality to their White counterparts due to the intersectionality of race, gender, and oppression (Collins, 2000; Dominelli, 2002; Payne, 2014). Postmodern feminism examines social relationships and how male dominated industries work to oppress and discipline women, particularly those in positions of power and authority (Dominelli, 2002; Payne, 2014; Sands & Nuccio, 1992). Despite the differences between each perspective, feminist theory ultimately states the male gender has greater power than the female gender, which results in the exploitation of women (Sharma, 2012). Because women have

disproportionally used DV services and reported DV, this theoretical framework helped to guide this study though the understanding of intersectionality and the oppression of women.

Regarding DV, using feminist theory helped to explain inequities within society by explaining how the patriarchy encouraged a dynamic in which women were subordinate to men (Ruiz-Pérez et al., 2006; Sharma 2012; Wood, 2015). Patriarchal societies socialized men to exert power over women through expecting more privileges than women, treating women unequally by suppressing them, and controlling women by physical strength and domination. Feminist theories have shown gender roles for men included characteristics of dominance, independence, strength, and rationality, but women were passive and weak (De Coster & Heimer, 2020; Messerschmidt, 2018; Miller & Mullins, 2006). Ultimately, this dynamic led to DV (Pence & Paymar, 1993; Schechter, 1982; Sharma, 2012), which has not only hurt women, but also hurt their male partners through perpetuating an idea that if they did not exemplify these characteristics, they were somehow lesser than other men. Furthermore, when violence was inflicted upon men, it was not taken as seriously (De Coster & Heimer, 2021). Additionally, women were in fear for their safety at times when leaving a violent relationship (De Coster & Heimer, 2021; DeKeseredy & Schwartz, 2009; Rezey, 2017; Stark, 2007),

Societal norms have played an integral role in the continuation of DV. Because the perpetual power imbalance between men and women has been a societal problem, it has seeped into a multitude of areas of women's lives and affected them economically, socially, and politically (Anderson, 2013; Dobash & Dobash, 1979; Hunnicutt, 2009; Johnson, 2011).

According to Echols (2019), feminist theorists have argued men felt a sense of supremacy over women by devaluing them in domestic and public realms. In this dynamic, men exert dominance over women by perpetuating existing gender roles. Traditional patriarchal power coupled with factors such as socioeconomic status, household income, and educational level have created an environment where women are pressured to stay in an abusive relationship (Ali & Naylor, 2013; Stark 2007). If women are economically, physically, or emotionally dependent on their male partners, they may fear the consequences of leaving their abusive relationship (Stark, 2007). In general, men's domination of women is likely to increase the women's vulnerability in almost all aspects of life (health, social, and psychological) because of the higher status of men in the patriarchal society. Feminist theory suggests when men perceive various vulnerabilities in their partners, they are more likely to engage in DV, especially when they perceive themselves as less vulnerable (Sharma, 2012; Yick, 2000). For some women, this vicious cycle creates an environment where they are unable to leave due to the multifaceted layering of barriers.

It was vital to understand some barriers survivors of DV faced when seeking mental health treatment from a feminist perspective. Studies such as Broverman et al.'s (1970) U.S.-based study highlighted men's mental health issues and women's mental health issues were viewed very differently, with women who experience mental health issues being considered unhealthy and men experiencing the same mental health issues being considered within a normal range. Broverman et al.'s study sparked some feminists to claim that psychological structures oppress women (Tavris, 1993; Weisstein, 1993). Similarly, Bankey (2001) found women were often seen as too "hysterical" (p. 39) for

intellectual work in industrialized societies, but also too physically weak for physical labor. This demonstrated the weaponization of mental illness as another way to oppress women.

For this study, it was important to highlight women have been abused by the psychiatric system throughout history (Bondi & Burman, 2001) where both chemical means and forms of talk therapy have been used to encourage women to be more docile (Bondi & Burman, 2001; Penfold & Walker, 1984; Plumb, 1993). From a group of women already oppressed by societal structures in the form of DV, intersectionality with the oppression of women in the mental health field made it difficult for women to seek treatment for fear of being pathologized and/or over medicated to become more docile. This represented an added barrier mental health providers faced when providing services to survivors of DV.

Ecological Systems Theory

This paper used the ecological perspective of community that states human reactions result from values, behaviors, skills, and understandings that communities cultivate (Kelly, 1968, 1986; Koss & Harvey, 1991). Ecological systems theory was developed by Bronfenbrenner in 1979 from both behavioral and sociocultural theories. It was originally used to describe child development but has since been used with a variety of client populations to explain behavior (Härkönen, 2001). This theory helps examine environmental systems and how they impact behavior.

Ecological theory is a framework that structures and describes the relationships between people and their environment (Bronfenbrenner, 1979). The ecological perspective conceptualizes violence as a phenomenon resulting from a variety of factors

(Heise, 1998). Researchers have described environmental factors of particular importance in an ecological understanding of trauma and recovery, including community attitudes and values; cultural constructions of race and gender; political and economic factors attending victimization; and the quality, quantity, accessibility, and cultural relevance of the larger community's victim care and advocacy resources (Dutton et al., 2004; Harvey, 1996). The ecological theory shows violent and traumatic events are ecological threats to the adaptive capacities of individuals and their communities (Koss & Harvey, 1991; Norris & Thompson, 1995). The ecological model states violent and traumatic events and how the members of a community react to them are influenced by the combined attributes of those communities and that person (Harvey, 1996). Ecological theory has been used to explain how various external factors impact a DV survivors' use of services.

There are four levels in the ecological systems theory, including personal history factors, microsystem factors, exosystem level factors (institutions and social structures), and macrosystem factors (general views and attitudes; Crowell & Burgess, 1996; Heise, 1998). According to Eastman et al. (2007), ecological theory could be applied to both individuals and community levels to understand the variables affecting DV. Understanding social trauma in combination with ecological theory could be used to help people struggling to understand their problems and possible solutions (Gitterman & Germain, 2008; Sheafor & Horejsi, 2015). Ecological theory has helped to illustrate the complexity of the impact of violence using a person-in-environment perspective on family resiliency.

Gitterman and Germain (2008) highlighted the interdependence between individuals and systems in ecological theory and developed it into a recognized

framework to conceptualize prevention of family violence. Sampson and Wilson (1995) suggested community context shaped “cognitive landscapes or ecologically structured norms (e.g., normative ecologies) regarding appropriate standards and expectations of conduct” (p. 50). When looking at services utilization it was important to understand the environment from with the services were being provided. From a public (mental) health perspective, McLaren and Hawe (2005) suggested ecological thinking could help practitioners to better understand the context from which a person used services by looking at more than a person’s attributes.

Theoretical Models

After examining the various theories relevant to this study, I began to examine various models relevant to DV service utilization. Two well-known models, the Andersen and Newman model and the health belief model, were applicable to this research. Each model is described in the sections that follow.

Andersen and Newman Model

The Andersen and Newman (1973) framework of health services utilization is one of the most popular and frequently used models for understanding the consumption of healthcare in general (Babitsch et al., 2012). Although this model is a general healthcare model, it can be applied profitably to mental health as well. Andersen and Newman (1973) identified some of the advantages of the model as having “(1) characteristics of the health services delivery system, (2) changes in medical technology and social norms relating to the definition and treatment of illness, and (3) individual determinants of utilization” (p. 95). Additionally, the Andersen and Newman model provides a holistic framework for understanding the complex nature of DV survivors by including

predisposing, enabling, and need factors. This framework defines predisposing factors that include client demographics and other social components impacting access, attitudes, values, and beliefs about services. The enabling factors include access to resources and mental know-how to obtain services; agency community facts including the physical facilities, staff, and wait times; and patient genetic factors and psychological predispositions. Need factors include the client's perceived need and the agency's evaluation of need (Andersen and Newman framework of health services utilization, n.d.).

The Andersen and Newman (1973) framework is also consistent with ecological theory (Phillips et al., 1998). Ecological theory states that people are parts of multiple systems, and each system impacts the others. Andersen and Newman stated this model considered both societal and individual determinants. This builds upon the person in the environmental perspective of social work practice and incorporates a systems approach to change, impacting at the micro, mezzo, and macro levels (Guy-Evans, 1970). This model provides a framework for multilevel intervention and change (Dwyer et al., 1995). Anderson and Bang (2012) studied girls with posttraumatic stress disorder (PTSD) who were exposed to DV and stated, "Ecological theory is inclusive of both risk and protective factors" (p. 3). Ungar (2002) described ecological theory as a theory that promoted each person's intrinsic value despite their position within their social environment. Additionally, past research has used the Andersen and Newman model to look at utilization with a wide variety of racial and ethnic minorities and disadvantaged populations to understand reasons for lower levels of utilization (Ayele et al., 2020; Barney, 1994; Loeb et al., 2022).

Health Belief Model

The health belief model (HBM) is one of the oldest and most popular health behavior theories. It was heavily influenced by Lewin's (1935) seminal theory of behavior (Greene, 2018). The HBM was originally developed to better understand human behavior and motivation (Rosenstock, 1974). It was developed in the early 1950s by social psychologists at the U.S. Public Health Service who were attempting to understand why people were not engaging in preventive health and screening tests. The HBM later evolved to be applied to patients' responses to symptoms and understanding patents medication compliance (Janz & Becker, 1984). The HBM has continued to be used as a framework to understand healthcare beliefs and healthcare utilization.

The model is broken down into subcategories to help to increase understanding of health beliefs. Kurt Lewin, who was instrumental in the creation of the HBM, believed this instrument was beneficial because it focused on the present moment and helped assess beliefs in real time, instead of past beliefs like many other models (Rosenstock, 1974). HBM provides a holistic framework for predicting healthcare utilization. Additionally, this model specifies how an individual's characteristics and demographic variables interact with perceptions and motivation, and how perceptions impact action steps toward engaging in the use of healthcare services. HBM helped researchers understand areas of perception, including perceived susceptibility, severity, benefits, barriers, and health motivation.

These beliefs provide information about why an individual is not accessing services (Lewin et al., 1944). According to Henshaw and Freedman-Doan (2009), the HBM "can be a useful framework for identifying culturally specific barriers in order to

tailor interventions and evaluations of their effectiveness" (p. 433). Additionally, the HBM can inform practitioners about the need for interventions to destigmatize and decrease false beliefs impeding people from engaging in services and help leaders ensure clients who need services receive them (Henshaw & Freedman-Doan, 2009).

Becker and Maiman (1975) described HBM as a value-expectancy model that helped explain an individual's health actions in conditions of uncertainty. According to Nobiling and Maykrantz (2017), the HBM included six constructs that were traditionally used to understand healthcare utilization; however, several studies have applied five of the constructs (i.e., perceived susceptibility, perceived severity, perceived benefits, perceived barriers, and self-efficacy) when studying mental health services utilization (Henshaw & Freedman-Doan, 2009; Saleeby, 2000; Waite & Killian, 2008). According to Greene (2018), Henshaw and Freedman-Doan (2009) successfully applied HBM to mental health service utilization and defined the concepts of HBM in terms of mental health service use behaviors. In their study, researchers used:

> perceived susceptibility being an individual's acceptance of a mental health diagnosis, perceived severity being the perceived severity of mental health symptoms, perceived benefits as being the benefits of therapy, perceived barriers being the barriers to committing to therapy, and perceived self-efficacy being an individual's belief that they can change through therapy. (Greene, 2018, p. 15)

Although very limited research has used HBM to study survivors of DV, it has been popularly used in the study of mental health treatment and in understanding barriers to services utilization (Bromley et al., 2020; Mansoor & Mansoor, 2022; Nobiling &

Maykrantz, 2017; Schneider et al., 2023). HBM had been used and extensively tested in predicting health-related behavior (Carpenter, 2010).

Although the HBM had been shown to be effective for predicting healthcare utilization, there were some limitations to this model. Despite the extensive use of this model for many different health issues, there has been a continued need for testing this model to verify its usefulness in testing mental health service utilization (Henshaw & Freedman-Doan, 2009). Another limitation, according to Greene (2018), was HBM did not consider interpersonal, cultural, and contextual issues and did not assess behavior patterns over time. When studying healthcare beliefs for telehealth and for a mental health service group, Townsend et al. (2012) found that in combination, the Andersen and Newman (1973) model and HBM helped to address cultural and contextual issues that the HBM could not do alone.

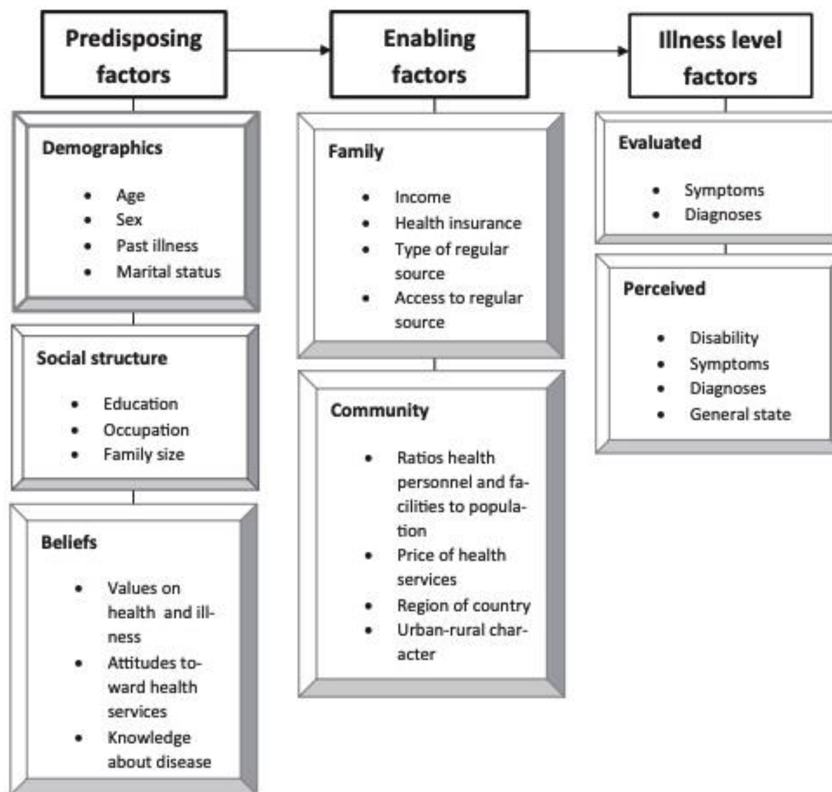
The Andersen and Newman (1973) model, HBM, and ecological theory all help to answer questions about the utilization of DV services by considering all validated factors that impact service utilization. Each model and theory help to define the issues that most impacted service utilization, but from different perspectives. The HBM specifically considers beliefs that impact service use, but the ecological theory and the Andersen and Newman model take a more thorough look into demographics and environmental barriers to obtaining or utilizing services.

Both the HBM and the Andersen and Newman model include environmental factors that impact services utilization. When used in combination they provide a more holistic understanding of the factors that contribute to DV survivors' utilization of mental health services. Both models have been used and adapted to assess utilization of mental

health services (Dhingra et al., 2010; Greene, 2018; Henshaw & Freedman-Doan, 2009; Hochhausen et al., 2011; Van der Draai et al., 2021; see Figures 1–4).

Figure 1

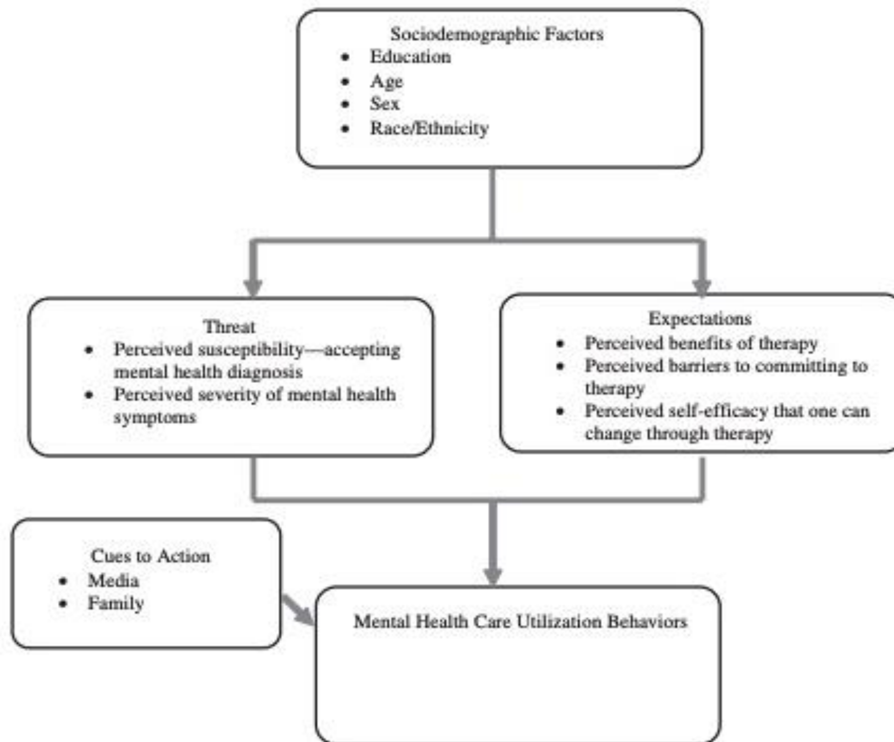
Illustration of Andersen and Newman's Model for Healthcare Utilization



Note. Adapted rom *Factors of Specialized Mental Health Care Use in the Netherlands: A Scoping Review Applying Andersen-Newman's Care Utilization Model*, by D. A. Van der Draai, E. Van Duijn, D. P. De Beurs, A. Bexkens, & A. T. F. Beekman, 2021, *Health Services Insights*, *14*, Article 11786329211048134. (https://doi.org/10.1177/11786329211048134)

Figure 2

Illustration of the Healthcare Beliefs Model



Note. Adapted from *Conceptualizing Mental Health Care Utilization Using the Health Belief* Model, by E. J. Henshaw, & C. R. Freedman-Doan, 2009. *Clinical Psychology: Science and Practice, 16*(4), 420–439. (https://doi.org/10.1111/j.1468-2850.2009.01181.x)

Figure 3

Research Question 1 Conceptual Diagram

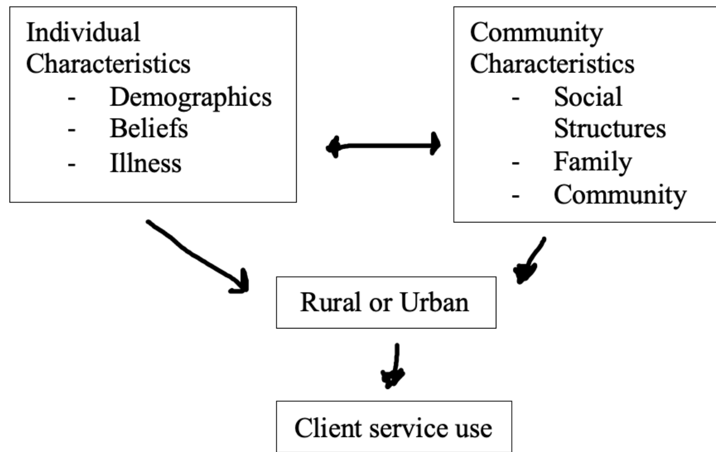
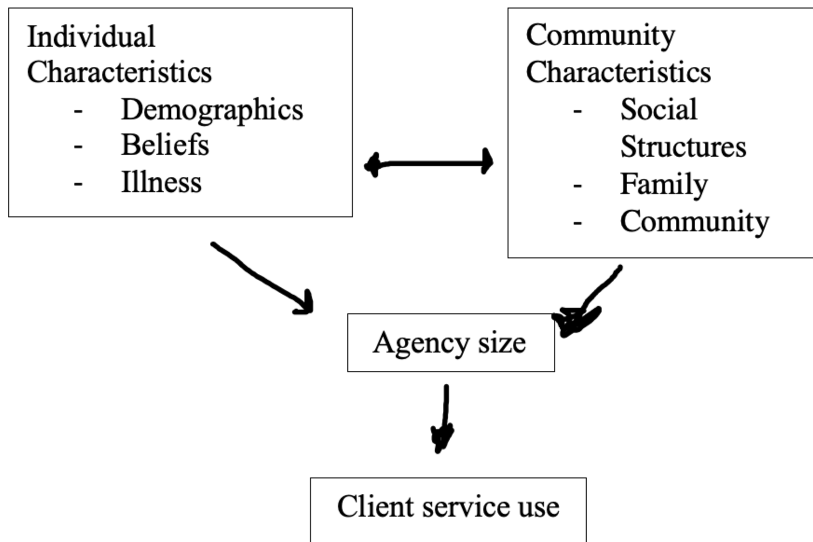


Figure 4

Research Question 2 Conceptual Diagram



DV and Mental Health

Researchers have shown a relationship between wellness, poor mental health, and poor physical health outcomes (Bell & Goodman, 2001; Goodman et al., 2016; National Coalition Against Domestic Violence, 2023; Stubbs & Szoeke, 2022). Additionally, DV has had the highest rate of repeated victimization of any violent crime (Dodd et al., 2004; Kershaw et al., 2000; Trevillion et al., 2010). According to Coker et al. (2002), there was a direct linkage between mental health issues, substance abuse issues, and DV. Coker et al. looked at the National Violence Against Women Survey data and found 28.9% women and 22.9% of males were identified as DV survivors. Those survivors displayed an increased risk of current poor health, depressive symptoms, substance use, and development of a chronic disease, chronic mental illness, and injury (Coker et al., 2002). Additionally, Abdo et al. (2020) found, "There are reports demonstrating that violence in the domestic setting could also be associated with the development of general health conditions, including cardiovascular disease, chronic pain, sleep disturbances, gastrointestinal problems, sexually transmitted infections, and traumatic brain injury" (p. 2). DV has been associated with comorbidity of mental disorders and substance use disorders (Garcia-Moreno et al., 2005; Tirado-Muñoz et al., 2018). For example, Stein and Kennedy (2001) found in a sample of 44 DV survivors, 42.9% displayed both PTSD and major depressive symptoms. According to Warshaw et al. (2009), DV survivors often reported dissociation, avoidance, and/or use of drugs or alcohol, which may protect against feelings that have become unbearable and could, along with societal constraints, have restricted a survivor's capacity to reach out for help. Additionally, DV survivors were 3–5 times more likely to experience substance abuse problems, depression, and

suicidal ideation and more than seven times more likely to experience PTSD (Devries et al., 2013; Golding, 1999; Logan et al., 2002; Trevillion et al., 2012).

Prevalence of Mental Health Challenges

A seminal meta-analytic review by Golding (1999) showed prevalence rates of mental health problems among women with DV histories ranged from 8.9% (substance use disorders other than alcohol) to 63.8% (PTSD), and the women were 3.6–5.6 times more likely to experience ongoing mental health issues including depression, suicidality, PTSD, alcohol abuse, and drug abuse than people not exposed to DV (Golding, 1999). Fowler (2007) examined a sample of 102 women in a DV shelter and found over two thirds of women scored in the moderate to high category for risk of substance use. In another study conducted with 71 DV shelters for women living in North Carolina, Martin et al. (2008) reported more than half of DV victims had substance abuse problems. All these studies had similar findings, which showed there was a distinct relationship between mental health disorders, substance use disorders, and DV. To effectively alleviate the impact of poor mental health and physical health and increase safety, survivors needed access to quality treatment (Guthrie & Kunkel, 2016).

DV and the Effect on Mental Health Services

DV could trigger and worsen mental health symptomology which has been shown to affect engagement in services (Flicker et al., 2011, Lipsky et al., 2006). Perpetrators of DV had been shown to control and limit DV survivors' access to treatment, which could exacerbate mental health symptomatology (Warshaw et al., 2009). Experiencing DV was associated with higher mental health services use and was established as a community crime by the Centers for Disease Control (2021). Despite the financial impact, many DV

survivors have not used mental health services (Dillon et al., 2013, Goodman et al., 2018; Spinazzola et al., 2014). One study from a sample of 2,000 women of Mexican and Cuban descent found only 43.1% of victimized women sought formal mental health help (Cuevas et al., 2014).

According to Bennett et al. (2004), receiving support from formal service agencies that provided programs including counseling significantly reduced the impact of violence. In a sample of 54 DV agencies in Illinois, Bennett et al. found survivors who used DV services gained substantial benefits from engaging in DV counseling. Accessing mental health services was linked to reduced negative posttrauma outcomes and increased general well-being for DV survivors (Folger & Wright, 2013; Sullivan & Bybee, 1999; Tan et al., 1995; Tutty et al., 1999).

Despite the relationships between substance use, DV, and mental health issues, substance abuse treatment programs, mental health programs, and DV agencies "do not usually address the complementary program" (Collins & Spencer, 2002, p. 1). Historically, there has been very little interaction between the three types of programs (Fals-Stewart & Kennedy, 2005; Warshaw et al., 2009). Although many agencies would like to integrate, there have been several barriers and challenges in doing so. According to the U.S. Department of Health and Human Services' official report on the connection between DV and substance abuse, the two fields have mostly worked in isolation from each other for reasons including, but not limited to, a lack of training and resources, and differing treatment philosophies (Center for Substance Abuse Treatment, 1997). Due to the increased recognition of the co-occurring nature and overlap between victimization, substance abuse, and mental health disorders, DV advocates have advocated for increased

collaboration and education in the treatment of co-occurring disorders for DV survivors (Blanch, 2003). When women were not accurately diagnosed and treated, they were more likely to become "high end users" (Blanch, 2003, p. 4). These women tended to have high recidivism rates. Despite the need for quality treatment, there were some barriers DV survivors experienced that negatively impacted their ability to access or use services. These barriers included the scheduling of services, transportation and location of the program, language barriers, wheelchair accessibility, awareness of the program, and clients' negative impressions of the program and staff. Some women who experienced DV also struggled to engage in services due to fear their abuser would find out. There were a multitude of factors that impacted mental health service utilization.

A Common Language

Mental health service utilization is impacted by a multitude of factors. One factor that could impact service use is the way that services negatively impact are defined. Ambiguity of definitions can determine how and what services are catalogued. Having a common language around defining services is imperative when trying to understand service use. Many domestic violence agencies use terms such as "Domestic Violence Counseling" and "Empowerment counseling" to help describe the counseling services provided. However, these forms of counseling are not used to directly treat mental health diagnoses such as depression, anxiety, and PTSD and may not produce effects as potent as others. There is, however, evidence that using an empowerment approach reduces secondarily, depression and PTSD (Goodman et al., 2016; Wright et al., 2010). Empowerment models have been shown to be effective in helping domestic violence survivors to seek stabilization through empowering the survivor to make healthy choices

and escape violence (Busch & Valentine, 2000). These models are not used for the sole purpose of treating mental health diagnoses, and therefore there needs to be a clear differentiation between Domestic Violence/Empowerment Counseling models and Mental Health Counseling as both may play an important role in treating DV survivors and at the same time each serve a different function. Crabtree-Nelson (2010) states "The lack of research guiding counselors and agencies on what constitutes the best approach in domestic violence counseling perpetuates the bifurcation among agency practices and may create a wider system problem (p19.)". This could be the reason for some agencies using an Empowerment model versus using evidenced based treatments such as Cognitive Behavioral Therapy, Prolonged Exposure or Eye Movement Desensitization and Reprocessing. It is important that DV agencies define whether the treatment practices that are in place are used to treat mental health disorders so that if the survivor has a more serious or persistent mental illness, they are able utilize and be referred to services appropriately.

Importance of Service Utilization

Ahmed and McCaw (2010) stated:

> Assessment of utilization patterns is important because the ultimate goal of DV identification is the receipt of assistance that the client can use to address her mental health needs, improve her safety, and change her situation. However, few data are available about the frequency or predictors of utilization of MHS among IPV-affected women. (p. 731)

According to Figueroa et al. (2017), several environmental factors have impacted service utilization. The National Academies of Sciences et al. (2018) identified these factors as

the need for the specific treatment, the person's characteristic, physical environment, behavioral characteristics, unmet social needs, and social determinants of health. Access to care was also a variable identified as having a strong impact on service utilization (Figueroa et al., 2017). Despite evidence that DV has occurred in a variety of ways (Coker et al., 2000; Smith et al., 2002; Sullivan et al., 2012), most of the research on resource utilization has focused specifically on exposure to physical victimization, regardless of the impact all DV types had on women's mental health (Edwards et al., 2009; Hedtke et al., 2008; Perry, 1996). Women's resource utilization varied based on the types of DV experienced (Cattaneo et al., 2008; Duterte et al., 2008; Flicker et al., 2011; Young-Wolff et al., 2013). For this study, I included all forms of DV.

Negative beliefs, mental health disorders, attitudes and stigma have been identified as reasons for low utilization of mental health services for DV survivors (Elliott, 2015; Li et al., 2015; Vogel, 2018; Wong et al., 2011). Low utilization of mental health services has been specifically problematic in the cases of disorders such as depression (World Health Organization, 2023). Psychological determinants, such as expectations and emotions associated with treatment, were also thought to impact services utilization (Constantino et al., 2015). Specifically, outcome expectations, defined as a patient's perception of the likelihood a particular treatment will help reduce mental health concerns, were found to influence those seeking psychological services and entering or continuing therapy (Constantino et al., 2015; Westra et al., 2011).

Barriers to Seeking Mental Health Treatment

Few studies have attempted to identify individual factors that predict DV utilization of formal services, and the studies that did mainly were focused on access to

supports through the criminal justice system and shelters (Harris & Dewdney, 1994; McFarlane, 1998; Sullivan, 1991; Wauchope, 1988; Wiist & McFarlane, 1998). Most studies had looked at help-seeking behaviors. Kaukinen (2004) analyzed help-seeking strategies of survivors and found one third reported violence to the police or law enforcement and less than a quarter sought help from medical or psychiatric providers. From a sample of 15 stalking survivors, Nikupeteri (2017) found female DV survivors preferred to speak to family members and nonprofessionals due to beliefs that mental health professionals lacked knowledge and ignored the complex nature of their situations. Nikupeteri also found survivors considered professional interventions inadequate and inconsistent. Survivors shared mental health professionals focused solely on diagnosing and treating psychiatric symptoms and failed to explore the underlying causes of their illness. Survivors reported they felt their experiences were minimized by the focus on treating the mental illness using the biomedical model (Anderson & Boldt, 2022; Trevillion et al., 2012).

Minority communities have historically shown less utilization of services, including people with disabilities, men, immigrants, and racial minorities (Crowe, 2015; Gerken, 2022; Kulkarni, 2019; Mengo et al., 2022; Sabri et al., 2015; Trevillion et al., 2016). Research has indicated DV has been more pervasive for disabled women than for not-disabled women and disabled women have faced significantly more severe forms of IPV (Brownridge, 2006; Plichta & Falik, 2001). As previously noted, African American survivors were less likely to use formal social support systems than Caucasian victims and more likely to turn to the police for assistance (Burman et al., 2004; Gondolf & Foster, 1991). West et al. (1998) and Donovan (2021) observed Latino victims underused

formal resources compared to Caucasian victims. Henning and Klesges (2002) shared prior negative experiences with mental health professionals were more common for African Americans than Caucasians and noted these prior negative experiences could lead to a pattern of underutilizing related services.

Current research has suggested many DV organizations were underfunded, and resources within those agencies were not allocated efficiently. Additionally, DV service providers reported feeling “ill-equipped” to deal with the impacts of DV due to multiple reasons, including organizational and staff capacity, high staff turnover, and crisis orientation of shelters (Chang et al., 2003). In a study of 42 DV agencies in North Carolina, researchers found DV service providers experienced a lack of funding that made it difficult to ensure adequate staffing, training, equipment (Chang et al., 2003). They also found structural changes were needed to assist IVP survivors with disabilities (Chang et al., 2003). Due to DV programs’ heavy reliance on private donations and grant funding, these issues are likely to continue. Graff and Snowden (2019) described the need for Medicaid and community-based programs to relax eligibility for those in need of mental health services and to provide mental health services as a part of patients’ health coverage.

In addition to issues within agencies, barriers to obtaining services have continued to be an issue for DV victims who had medical and mental health issues. In a study of 4,587 homeless and mentally ill individuals, Rosenheck and Lam (1997) found those who had a mental illness and sought services on their own were more likely to have a greater level of confusion about the services than those who were provided outreach and information at the shelter level. As a result, they did not use the services. Additionally,

there were no recommended or standard protocols in DV or behavioral health services agencies for screening and addressing both behavioral health and safety needs of women with more severe forms of mental illness who experienced DV (Macy et al., 2010).

Prior Methodological Limitations

The current study attempted to address some of the limitations of previous studies. There has been extensive research on both the topics of DV and its relationship to mental health and substance use; however, there has been much less data surrounding the use of services for those living in rural areas. According to Lipsky and Caetano (2007), most studies looking at the unmet mental health needs of DV survivors used convenience sampling. There were concerns that prior research studying DV survivors was solely from convenience sampling and, therefore, may not be representative of the population being studied (Ruiz-Pérez et al., 2007).

Another limitation of many research studies (e.g., Bowker & Mauer, 1986; Bromley et al., 2020; Westra et al., 2010) was they used self-reported data. Thyer (2010) reported the response in self-reported data may have varied from observable facts due to social-desirability bias, which could cause a threat to validity of the study. Additionally, Thyer stated it was important to make sure all self-report measures were valid, reliable, and culturally appropriate, as one survey may not have been appropriate for all who used it.

Measurement issues across the studies were also a concern. Studies such as the ones by Anderson and Bang (2012), Edmond et al. (2013), and Sales (2020) defined mental health services as psychotherapy, counseling, and formal mental health services only, but others, such as the studies by Barney (1994), Cho and Kwon (2018), Lipsky and

Caetano (2007), and Statz et al. (2022), included peer support, group counseling and crisis services, and alternative mental health treatments. Some studies also defined DV differently choosing only to include people who had experienced physical violence, and others included survivors of psychological and sexual violence. This current study included all forms of abuse and all forms of mental health treatment, as previously stated. Studies have also varied in which mental health disorders they chose to study and include. Most studies included PTSD, depression, and anxiety. In this study, participants were not asked about their specific mental health diagnoses; however, participants who acknowledged they had a mental health disorder were included, regardless of what mental health disorder the person had. All data related to these variables were obtained from secondary data, which used a standardized instrument to collect the data.

There were several limitations to using secondary data. Secondary data were originally collected in the past for other reasons and to answer other questions, so the data were not being used for its original purpose. Additionally, key variables that might have been helpful in answering the research questions were absent. Secondary research could be limited by the original researcher's quality of research. As a researcher using secondary data, I had no control over the methods used in the past and original data collection.

Pennsylvania and DV

The Commonwealth of Pennsylvania is in the northeast of the United States. Rural Pennsylvania and urban Pennsylvania have very different demographics. Rural Pennsylvania, particularly in Appalachia, has been known for being poor, less educated, and highly conservative, as opposed to the urban areas that have had higher rates of

education and tended toward more politically liberal views. At the time of this study, Pennsylvania had an approximate population of 12,972,008 residents, of which 81% were White non-Hispanic, 12.2% were Black or African American, .4% were Indian or Alaska Native, 3.9% were Asian, and .1% were Native Hawaiian or Pacific Islander; 50.6% of residents were women (U.S. Census Bureau, 2022). For all Pennsylvania residents, 91.4% had a high school diploma or above, and 33.1% had a bachelor's degree or higher. The average household income was $67,587, and the average income per capita was $37,725. The percentage of overall persons in poverty was 12.1% (U.S. Census Bureau, 2022).

In 2021, the Commonwealth of Pennsylvania created a prevention state action plan to address DV. In this action plan, policymakers particularly highlighted rural areas of the state that need additional resources and had particularly vulnerable populations This action plan specifically looked at economic equalities and how they impacted DV, but there was very little information about initiatives to address community stigma and cultural barriers (Pennsylvania Coalition Against Domestic Violence, 2023). Approximately 2,630 DV victims/survivors have received services in Pennsylvania on a given day. The National Network to End Domestic Violence (2020) estimated 252 people's needs for services went unmet. As Sharma and Vafaes (2022) explained, "The Commonwealth of PA cannot meet the needs of 21,168 people annually" (p. 49).

Within the Commonwealth of Pennsylvania, there were approximately 58 DV programs at the time of this study. Many of the shelters received funding from grants, private donations, and federal funding through the Violence Against Women's Act and the Office on Violence Against Women. Most of the programs were located in populous

areas, and fewer were located in rural areas. A study by McCall-Hosenfeld et al. (2014) found in rural areas of central Pennsylvania, women's social perceptions of DV led to their need to be self-reliant, thus dissuading them from seeking help. The cultural factors of tight-knit rural communities added to women's fear, and, as a result, they were not comfortable disclosing their experiences to service providers (McCall-Hosenfeld et al., 2014). Women in rural communities were apprehensive about seeking services, as they were not confident their experience would remain confidential with the service providers (Sharma & Vafeas, 2022).

In comparing Pennsylvania to other states, Pennsylvania has been very close to the average across the board when it came to population size and density. Other states are more rural, such as Montana and Wyoming, and some states had higher population density, such New Jersey and Rhode Island. Pennsylvania also had a higher number of Caucasian residents than minorities, with minority populations predominantly residing in the more urban areas. This may have been different in other states that were more racially diverse, especially in more rural areas. In their county-wide, county-level analysis, Tiefenthaler et al. (2005) found only 42% of counties nationwide had a DV program, and services were more likely to be available in the northeast and western regions of the United States. Additionally, they found richer counties with larger majority populations had more access to services.

Implications

This study includes possible implications. Results from this study could impact social work education by increasing students' awareness of the factors that impacted DV service utilization and, as a result, increase clinical competence for those who have

contact with DV survivors. The study could also help leaders to better understand reasons for decreased client utilization of services through understanding the factors that contributed to service utilization. This understanding could help leaders to know where to focus their efforts and funding (e.g., allocating more funds to mental health services or to building awareness and rapport within their local communities).

This study enhances providers' understanding of how beliefs impacted clients' use of services provided. Because of this study, leaders will be better able to justify the need for interventions to address factors that have inhibited service utilization. There is a plethora of possible social implications, including empowering agencies, leaders, staff, and students to work to decrease negative beliefs and stigmas related to the use of mental health services. By increasing awareness of social and economic issues, agencies and communities can support those who have been negatively affected. Increased understanding of the barriers impacting DV survivors use of services could help providers identify ideas to mitigate these barriers. This could impact how providers engage with client populations with low utilizations rates. Additionally, this study could provide a framework for other states to study service utilization in their DV and mental health communities.

Conclusions

In conclusion, this study examined the relationship between the factors that impacted mental health service utilization for DV survivors in rural and urban Pennsylvania. The first two chapters discussed the relevance and purpose of the study. The second chapter provided a literature-supported background of the issues that informed the rationale for the study and some of the factors that impacted this study.

Additionally, there was an introduction to the theoretical framework, models, and the value and importance of this project to the social work field and education. Limitations and implications for this work were discussed. The following chapters provide a more informed review of the information creating a complete understanding of the study construct, development, and data interpretation.

Chapter 3: Methodology and Research Approach

This chapter provides an overview of the methods used to conduct this study. This chapter also presents the methods for the study of the utilization of Pennsylvania's mental health programs for victims/survivors of domestic violence (DV). This chapter describes the rationale for the research questions and presents the study design, sampling strategies for the secondary data sources, and proposed statistical analyses.

This study examined the differences in utilization of mental health services in both rural and urban Pennsylvania stratified by agency size. Understanding the use of services between rural and urban Pennsylvanians will help to make services available to those impacted by DV. The needs of rural and urban DV shelters may be dependent on proximity to other community resources, number of professionals, availability of trained staff, and the size of the agency. As a result, the roles of trained staff may look different at different agencies. At smaller agencies, professionals may be forced to have many roles, and roles may not be as clearly defined as in larger agencies (Wood et al., 2022).

The Commonwealth of Pennsylvania has three major urban areas consisting of Allegheny County, Dauphin, and Philadelphia. Other urban counties include Beaver, Burks, Chester, Cumberland, Delaware, Erie, Lackawanna, Lancaster, Lebanon, Lehigh, Luzerne, Montgomery, Northampton, Westmoreland, and York. All of the other 48 counties are rural. Secondary data for this study were used from three different sources: the Lethality Assessment Program (LAP), the Adequacies of Network of Services Provided to the Survivors of Domestic Violence in Pennsylvania–Phase II study, and data obtained from publicly available agency websites.

Rationale

This study used publicly available and secondary data from a variety of sources. Data were obtained from the LAP, Adequacies of Network of Services Provided to the Survivors of Domestic Violence in Pennsylvania–Phase II study, and data obtained from publicly available agency websites. This study used a combination of data sources to understand DV survivors' use of mental health services. By using multiple data sources from a variety of perspectives, I was able to obtain a more holistic view of the factors that impact service use for DV survivors. One data source alone would not answer the questions asked; however, in combination, all of the data sources provided a more complete picture of the factors that impact mental health service use. Each data source provided information from a different lens and helped to fill in the gaps regarding knowledge around DV survivor service use across the Commonwealth of Pennsylvania.

Research Hypothesis and Questions

This study was guided by the following research questions:

- Research Question 1: Is there a difference in DV survivors' utilization of mental health services between urban and rural Pennsylvania?
- Research Question 2: Is there a difference in DV survivors' utilization of mental health services between large and small agencies in Pennsylvania?
- Research Question 3: What are the barriers for receiving DV and mental health services based upon locality and agency size.
- Research Question 4: What are the differences in demographic characteristics of those seeking mental health services at DV agencies based upon locality and agency size?

Hypotheses

Hypothesis 1: Barriers for receiving DV and mental health services will differ between rural and urban agencies. Rationale: This hypothesis was based on ecological theory. Past research has shown geographical differences were a factor in an access and availability of resources (Figueroa et al., 2017; Sharma & Vafeas, 2022). Additionally, the community stigma in rural areas was a factor in observed differences between geographical locations. Those in urban areas had access to more resources which may make it less likely that they would have experienced barriers to receiving services. Variables used to determine barriers included scheduling of services, transportation/location of program, language barriers, wheelchair accessibility, awareness of program, and survivors' negative impression about services or shelter compared by locality. Locality variables were rural and urban.

Hypothesis 2: Barriers for receiving DV and mental health services in large and small agencies will differ. Rationale: This hypothesis was based on ecological theory. Smaller agencies may have access to less funding sources and staff may have to play multiple roles within the agency, thereby reducing availability for fund raising and revenue generation. This could cause DV survivors to have less access to mental health services in those agencies. Small agencies may also have less space for a variety of resources; therefore, some services may not have been provided or there may have been barriers to obtaining some services. Variables used to determine barriers included scheduling of services, transportation/locating of program, language barriers, wheelchair accessibility, awareness of program, and survivors' negative impression about services or shelter compared by agency size. Size variables used were small and large.

Hypothesis 3: There are more mental health services at urban DV agencies than rural agencies. Rationale: This hypothesis was based on feminist theory and ecological theory. Feminist theory suggests that patriarchal sources of power and control play a major role in most acts of abuse and dominance over women. Due to sociocultural factors that impact a community's willingness to fund services, communities may be less likely to fund or support DV agencies in their area. Additionally, there may be less emphasis on obtaining mental health services due to stigma and worries about confidentiality and anonymity. The ecological model states that violent and traumatic events and how the members of a community react to them are influenced by the combined attributes of those communities and that person. Variables used included mental health services, which were counseling, psychiatric, and crisis services. They were compared by locality, which included urban and rural variables.

Hypothesis 4: There are more mental health services offered at large agencies than small agencies. Rationale: Larger agencies may have more staff and, therefore, provide more services and offer more specialized services. This hypothesis used ecological theory. Ecological theory explains that multiple factors may impact resource use. When looking at services utilization it was important to look at the environment from with the services were being provided. Smaller agencies are typically able to provide fewer services. Variables used included mental health services, which were counseling, psychiatric, and crisis services. They were compared by agency size, which included large and small agencies.

Hypothesis 5: There are differences in demographic characteristics of those seeking services in rural and urban DV agencies. Rationale: This hypothesis used

ecological theory. Ecological theory explains that multiple factors may impact resource use. When looking at services utilization it was important to look at the environment from which the services were being provided. Additionally, this hypothesis used feminist theory to explain the how patriarchic structures impacted women's desire or abilities to seek services. Demographic variables assessed included age, highest level of education, gender, race, language, sexual orientation, mental health condition, physical health condition, employment status, and health insurance. These variables were compared by agency locality. Localities measured were urban and rural.

Hypothesis 6: There are differences in demographic characteristics of those seeking services in large and small DV agencies. Rationale: This hypothesis used ecological theory. Ecological theory explains that multiple factors may impact resource use. When looking at services utilization it was important to look at the environment within which the services were being provided. Demographic variables assessed included age, highest level of education, gender, race, language, sexual orientation, mental health condition, physical health condition, employment status, and health insurance. These variables were compared by agency size. Sizes compared included large and small agencies.

Operationalization of Variables

In this study, I operationalized both dependent and independent variables. This section defines and explains each variable I examined in the study.

Dependent Variables

The dependent variables for this study included barriers to services, mental health services, and demographic variables. Within those categories, specific questions were

asked to gain a deeper understanding of what the barriers, demographic variables, and mental health services were. All the survey data from the LAP and the Adequacies of Network of Services Provided to the Survivors of Domestic Violence in Pennsylvania–Phase II study were descriptive and exploratory in nature.

Barriers

In the Adequacies of Network of Services Provided to the Survivors of Domestic Violence in Pennsylvania–Phase II study, respondents were asked to identify barriers to seeking services by checking each barrier they had experienced. Barriers included scheduling of services, transportation/locating of program, language barriers, wheelchair accessibility, awareness of program, and respondents' negative impressions about services or shelters.

Mental Health Services

Mental health services were operationalized by using the LAP data through the Pennsylvania Coalition Against Domestic Violence (PCADV) website, website data, and data from the Adequacies of Network of Services Provided to the Survivors of Domestic Violence in Pennsylvania–Phase II study. Data from the LAP study helped to determine how many people were receiving services at DV agencies across the state of Pennsylvania and how many were not seeking services. The study measured both overall service usage and crisis service usage. Data from the Adequacies of Network of Services Provided to the Survivors of Domestic Violence in Pennsylvania–Phase II study helped to explain utilization rates from those who did seek services and which mental health services were being used. In this study, respondents were asked to answer which services they received. Content analysis data from agency websites were used to clarify what

mental health services were being provided at each agency. All data were then compared by locality and agency size.

Crisis Hotline. Usage data about crisis hotlines was obtained from the Adequacies of Network of Services Provided to the Survivors of Domestic Violence in Pennsylvania–Phase II study. In this study, DV survivors were asked whether they used the crisis hotline and which services they received. All the respondents were current DV agency clients.

The LAP study provided data about how many people police interacted with who did and did not use crisis hotline services from outside of the agency. This study helped provide a clearer picture about who was obtaining services from the community and how many people in the community were using services. Use of crisis services and use of DV agency services were measured through these data. Agency website data provided information regarding the use and availability of crisis services. Whether services were provided at the agency level was determined using content analysis.

Mental Health Therapy. The Adequacies of Network of Services Provided to the Survivors of Domestic Violence in Pennsylvania–Phase II study asked DV survivors if they had received mental health therapy. Additionally, I confirmed the existence of mental health services at each agency by obtaining data from agency websites regarding the services provided. Listings of evidence-based practices offered and qualifications of the staff providing services provided information about whether the DV survivors were receiving mental health services. Data from the LAP indicated whether those who had contact from police were using shelter services after police interaction, which indicated if

people had contact with DV agencies to obtain services. This indicated what percentage of the greater population who suffer from DV sought services.

Psychiatric Services. In the Adequacies of Network of Services Provided to the Survivors of Domestic Violence in Pennsylvania–Phase II study, DV survivors were asked if they had received psychiatric services. Additionally, I confirmed the existence of mental health services at each agency by obtaining data from agency websites regarding the services provided.

Counseling (Nonmental Health)/Alternative Therapies. Services that were not evidenced-based for treating mental health disorders and counseling services that were not used for providing mental health treatment were measured by gathering data from the information provided on agency websites.

Demographic Variables

All demographic variables apart from health insurance came from the Adequacies of Network of Services Provided to the Survivors of Domestic Violence in Pennsylvania–Phase II study.

Age. Respondents were asked to write down their exact age.

Highest Level of Education. Respondents were asked to choose the highest level of education attained from the categories listed.

Gender. Respondents were asked to choose their gender by selecting from the list of categories provided.

Race. Respondents were asked to choose their race by selecting from the list of categories provided.

Language. Respondents were asked to choose their language by selecting from the list of categories provided.

Sexual Orientation. Respondents were asked to choose their sexual orientation by selecting from the list of categories provided.

Mental Health Condition. Respondents were asked whether they identify with having a health condition. Mental health conditions were measured by whether a respondent selected this option from the list provided.

Physical Health Condition. Respondents were asked whether they identify with having a physical health condition. Physical health conditions were measured by whether a respondent selected this option from the list provided.

Employment Status. Respondents were asked to choose their employment status by selecting from the list of categories provided.

Independent Variables

Locality. Variables were compared in terms of locality looking at both urban and rural environments. For the purpose of this study, I used the Center for Rural Pennsylvania (2020) definitions of urban and rural.

Rural. A municipality where the number of people per square mile in the municipality is fewer than 291 or a county that has fewer than 2,500 residents (Center for Rural Pennsylvania, 2020).

Urban. "All other municipalities are considered urban" (Center for Rural Pennsylvania, 2020, p. 1).

Size. I defined agencies in terms of size by using the same criteria as was used in the Adequacies of Network of Services Provided to the Survivors of Domestic Violence in Pennsylvania–Phase II study.

Large. Agencies serving greater than 1,000 clients.

Small. Agencies serving between 100–1,000 clients.

Sampling

In this section, I explain the various procedures I used for selecting study participants. Additionally, I describe the selection process I used from each of the three study resources. I also define samples sizes.

Procedures for Selecting Participants

In this section, I explain how researchers selected the participants for each data source. I also describe each study's procedures for data collection. Additionally, I explain selection criteria for the website analysis.

LAP 2022 Data. All participants in LAP were included in the data analysis for this study. Data were obtained in 48 programs with partnerships between 436 police departments across the Commonwealth of Pennsylvania. In participating departments, officers asked a series of questions when they respond to calls involving DV. According to the PCADV (2022), police provided DV survivors with a series of screening questions and, based upon the survivor's potential for lethality based upon the responses given, police placed the survivor in touch with their local DV program. Respondents were then asked at a later date if they had obtained shelter services and crisis hotline services. All data were collected for the year 2022.

Adequacies of Network of Services Provided to the Survivors of Domestic Violence in Pennsylvania—Phase II Study Data. These data were obtained using survey data. The Adequacies of Network of Services Provided to the Survivors of Domestic Violence in Pennsylvania–Phase II study had a response rate of 214 current DV survivors from DV agencies across the state of Pennsylvania. The sample size for this study was 48, as there were 48 agencies that participated in the study. This study used cluster sampling at the agency level. Researchers asked for a simple random selection of several participants until the specified number of participants for the size of the agency participated.

Website Data. Qualitative data were obtained from 49 agency websites. Agencies that did not have an official website were not used. All agencies were included from across the Commonwealth of Pennsylvania. Textual and content analysis were used to determine what mental health services, if any, were being offered at each agency. Data were obtained from each website and coded. Information regarding mental health, counseling, and crisis services were analyzed. According to Rubin and Babbie (2016), content analysis could be used for "discovering patterns and meaning" (p. 321) behind various forms of communication. I observed evidence of the use of evidence-based practices to determine if counseling was used to treat mental health disorders or not.

Based on my analysis, I coded services as mental health services, nonmental health services, or unknown. Services deemed as mental health services were coded as such based upon the services either being called mental health counseling or evidence of the use of evidence-based practices such as cognitive behavioral therapy, eye movement decentization and reprocessing and prolonged exposure to treat mental health disorders

common for DV survivors, including posttraumatic stress disorder (PTSD), depression, and anxiety. Nonmental health services were coded as such if the website explicitly said the services were not for treating mental health disorders or were labeled as empowerment counseling. Those labeled unknown were located at agencies whose websites were unclear about whether their services help with the treatment of mental health disorders. Inter observer reliability was used to maintain reliability for the qualitative data. I used cluster sampling to obtain data by looking at the resources provided within the websites.

Inclusionary Criteria

Research participants all lived in Pennsylvania. Additionally, all data sources obtained data from people 18 years and older. Information from all participants were de-identified; therefore, participant anonymity was protected. I conducted website analysis using only agencies who had a publicly available website.

Exclusions Criteria

Participants who did not reside in Pennsylvania were not included in this study. DV agency web presence on LinkedIn and Facebook was not used for this study.

Participant Characteristics

Secondary data were obtained from the Study of the Adequacies of Network of Services Provided to the Survivors of Domestic Violence in Pennsylvania–Phase II and PCADV. In that study, Dr. Sharma and Dr. Vafaes, professors at Kutztown University of Pennsylvania and in partnership with the PCADV, surveyed clients at DV agencies across the Commonwealth of Pennsylvania. The focus of the study was to understand the adequacy of the services provided and to gain a deeper understanding of service use and

service availability. I obtained permission from both researchers to use their data for the purposes of this study.

I analyzed publicly available information from 49 agency websites for content related to mental health services provided, including mental health therapy, psychiatric services, crisis services, and counseling. I coded information using predetermined definitions for each criterion. These data were used to better understand what services were being provided at each agency to support the mental health needs of DV survivors and whether agencies referred DV survivors to outside mental health agencies.

Data Management

All secondary data used procedures to protect human subjects in previous studies. I managed all the data for this study. I stored all data and any documents used digitally on a password protected computer. Only my dissertation committee and I had access to the data obtained from the surveys, other than the publicly available data and PCADV LAP data, which were public government data. All secondary data obtained from the Adequacies of Network of Services Provided to the Survivors of Domestic Violence in Pennsylvania–Phase II study were used for solely for the purposes of this study and will not be used for my future research. All the data from the Study of the Adequacies of Network of Services Provided to the Survivors of Domestic Violence in Pennsylvania–Phase II were previously de-identified.

Research Approval

Before conducting the research, formal written approval was obtained from Dr. Sharma and Dr. Vafaes at Kutztown University to use the data from the Adequacies of Network of Services Provided to the Survivors of Domestic Violence in Pennsylvania–

Phase II study (see Appendix B). The research proposal and its formal letters of support were submitted to the Institutional Review Board (IRB) at Kutztown University, Kutztown, Pennsylvania, and the study was approved on October 2, 2023. The IRB approval letter may be found in Appendix C.

Data Collection Methods

In the following sections, I explain data collection methods for each of the three data sources. I also further explain the variables I examined from each data source.

PCADV LAP Data

LAP data were publicly available and displayed on the PCADV dashboard through a partnership between the PCADV, Pennsylvania State Data Center, and Institute for State and Regional Affairs at the Pennsylvania State University Harrisburg (PCADV, 2023). According to the National Institute of Justice (2018), the LAP has been shown to "significantly reduce the severity and frequency of the violence that survivors experienced" (p. 1). Additionally, this study found that the LAP was an effective assessment tool in helping DV survivors to increase help seeking and safety planning behaviors, and LAP participants were more likely to reduce partners' access to lethal means. For this study, the LAP data helped to determine if there was a difference between mental health service use based upon locality and agency size. This was done through measuring the use of crisis services and DV shelter services. These data helped to determine the mental health service use from the local community.

Adequacies of Network of Services Provided to the Survivors of Domestic Violence in Pennsylvania—Phase II Study

The Adequacies of Network of Services Provided to the Survivors of Domestic Violence in Pennsylvania–Phase II study used secondary data originally obtained using a survey that was both valid and reliable. The survey consisted of multiple questions which provided a plethora of information about service use and adequacy of services. Data from this study were obtained directly from DV survivors. These data helped to answer all the research questions. The Adequacies of Network of Services Provided to the Survivors of Domestic Violence in Pennsylvania–Phase II study helped determine from DV survivors if they were able to obtain counseling, mental health therapy, and crisis services to help answer the question of what mental health services were offered. Adequacies of Network of Services Provided to the Survivors of Domestic Violence in Pennsylvania–Phase II study data also answered both demographic questions by showing the differences between locality and agency size for variables age, highest level of education, gender, race, language, sexual orientation, mental health condition, physical health condition, and employment status. Barriers to receiving services were also obtained from these data. Variables used to assess the barriers to obtaining services included scheduling of services, transportation/locating of program, language barriers, wheelchair accessibility, awareness of program, and respondents' negative impression about services or shelters.

Website Analysis

I analyzed website text data using predetermined categories through use of content analysis. I used thematic analysis of data to identify common themes in the text.

Instrumentation

In the following sections, I discuss the validity and reliability of each of the three data sources. This section helps to further explain how I used each of the various instruments.

Validity and Reliability of Instruments Used

Data from PCADV and The Adequacies of Network of Services Provided to the Survivors of Domestic Violence in Pennsylvania–Phase II study all used instruments that have been validated and have been shown to be reliable. Reliability was obtained from the website analysis using interrater reliability. According to Rubin and Babbie (2016), "Validity is a common problem with content analysis, the concreteness of the materials studied in quantitative approaches to content analysis strengthens the likelihood of reliability" (p. 337). The websites were concrete text that could be observed with less subjectivity around coding of the content due to the nature of the coding.

Reflexivity Statement

As a White, cisgendered, heterosexual women, I believe it is important to identify how these factors played a role in my outlook and experiences in life. It is important for me to share how areas of my life may have impacted my thought processes and caused bias. Because of my experiences as a woman having experienced sexism and in working as a trauma therapist with people who have suffered from pain caused by DV, I may have developed some level of bias. I have had male clients who have come to me with struggles of DV; however, the greater majority of my DV clients have been women.

As a White woman with an above average level of educational attainment, I have many privileges that others may not have and, therefore, must be cognizant of the implicit

biases I may have. As a heterosexual woman, I have not experienced many of the challenges that those from the LGBTQ population have and do not have a full understanding of the LGBTQ individuals are impacted by DV. I am not disabled; therefore, although I am aware of some of the challenges the DV survivors who have disabilities face, I am not acutely aware of all the struggles those individuals may face daily related to mental health or physical disabilities. In spite of this, historically, most DV survivors who seek services have a similar profile to mine, apart from my educational attainment level. That does not account for those that may not participate or experience barriers related to different beliefs and demographic factors.

Limitations

In this section, I discuss some of the limitations of this study. Identifying the study's limitations helps to better inform future research and areas for improvement.

Secondary Data

One limitation to this study was all the sources were secondary data. This means I did not collect the data; therefore, I was looking at the data for a second time. Additionally, some of the data used for this study were not originally collected with the intention of understanding mental health care use.

Lack of Relevance

Some of the measures that impact service utilization were not found within the secondary data. Factors such as severity of illness and healthcare beliefs were not obtained from the secondary data sources and, therefore, were not included in this study. Those factors could potentially impact service use based upon the healthcare beliefs model and the Andersen and Newman model and, as a result, could be a limitation to this

study. Additionally, the factors that were not explored in this study could impact how the results are perceived.

Cultural and Other Types of Bias

As stated in the reflexivity statement, there is the potential for my cultural, racial, and gender biases to impact this study. Although most of the data were obtained through secondary resources, there was the potential for bias to impact the ways in which I interpreted the data. This was particularly true for qualitative data that were coded for the website analysis.

Conditions and Design

All data were secondary data but were obtained from multiple sources. Data that were missing or omitted by respondents were omitted and not counted in data analysis; those responses were removed from the relevant variables. As the study was exploratory and descriptive in nature the need to deal with statistical outliers was low; therefore, no plan was made.

Analytic Strategy

The data analysis plan included data cleanup, description, and data analysis. The data were transferred to SPSS where data cleanup was performed before data processing. All data involving clients were previously de-identified. Other than the Adequacies of Network of Services Provided to the Survivors of Domestic Violence in Pennsylvania–Phase II data, which were previously approved for student use under the Kutztown University IRB, all other data were de-identified, government data and open to the public; therefore, IRB approval was not needed under federal regulations for human subjects (45 CFR Part 46).

Data Analysis Methods

Descriptive statistics were used to describe the sample data. The data were analyzed by using various statistical processes. First, the preliminary analysis was done to obtain descriptive statistics of the data from the Adequacies of Network of Services Provided to the Survivors of Domestic Violence in Pennsylvania–Phase II dataset. Then descriptive data from the LAP were analyzed in separate SPSS files. This study used quantitative methods to summarize, analyze, organize, and interpret the data gathered using the survey tool. I used SPSS to perform various analyses on the data.

The descriptive information included frequencies, percentages, means, and standard deviations from the mean. Secondly a *t* test was used to compare data from large and small agencies and rural and urban agencies. Specifically, I examined differences between demographic characteristics and agency size and locality using this method. I analyzed qualitative data from the websites using content analysis and examined this data in relation to the hypotheses while searching for patterns, themes, contradictions, and exceptions.

Chapter 4: Findings

I examined mental health service utilization for domestic violence (DV) survivors from three independent secondary data sources: the Adequacies of the Network of Services Provided to the Survivors of Domestic Violence in Pennsylvania–Phase II study data, Lethality Assessment Program (LAP) data, and a website content analysis. Each secondary data set was examined separately and compared by locality and agency size, and the findings are discussed as such in this chapter. These analyses are intended to provide a deeper and broader understanding of various factors that impacted mental health service use.

Demographic Characteristics: The Adequacies of Network of Services Provided to the Survivors of Domestic Violence in Pennsylvania–Phase II Study

Descriptive statistics were computed to characterize subject demographics. Results showed that out of the total respondents (N = 214), 45.3% (97) of the respondents came from small agencies, and 54.7% (117) came from large agencies. There were 37.4% (80) respondents that came from urban agencies and 62.6% (134) from rural agencies. I used chi-square analyses to compare demographics based on agency size and locality.

Age

Findings displayed in Table 1 show of the 214 total respondents, most of the DV survivors (118, 55.1%) were between the ages of 21–40 years of age, eight (.07%) were under 20 years of age, 79 (67%) were between 41–60 years of age, eight (3.7%) were between 61–80 years of age, and one (.5%) was 81 years old or older.

Table 1

Sociodemographic Characteristics of the Adequacies of Network of Services Provided to the Survivors of Domestic Violence in Pennsylvania—Phase II Study Participants

Demographic characteristics	Total population		Urban		Rural		Small		Large	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
Gender										
Female	198	6.1	79	98.8	12	9	88	90.7	110	94
Male	13	6.1	1	1.3	119	88.8	8	8.2	5	4.3
Trans+	3	1.4	0	0	3	2.2	1	1	2	1.7
Age										
Under 20 years	8	3.7	2	2.5	6	4.5	5	5.2	3	2.6
21–40 years old	118	55.1	49	61.3	69	51.5	53	54.6	65	55.6
41–60 years old	79	36.9	25	31.3	54	40.3	35	36.1	44	37.6
61–80-years old	8	3.7	4	5	4	3	4	4.1	4	3.4
81+years old	1	.5	0	0	1	.7	0	0	1	.9
Race										
Other	18	8.4	20	25	14	10.4	15	15.5	19	16.2
White	114	67.3	42	52.5	102	76.1	68	70.1	76	65
Black	28	13.1	15	18.8	13	9.7	10	10.3	18	15.4
Latinx	8	3.7	3	3.8	5	3.7	4	4.1	4	3.4
Prefer not to answer	16	7.5	0	0	0	0	0	0	0	0
Sexual orientation										
LGBTQ	33	15.4	9	11.3	24	17.9	21	21.6	12	10.3
Heterosexual	148	69.2	58	72.5	90	67.2	61	62.9	87	74.4
Declined to answer	33	15.4	13	16.3	20	14.9	15	15.5	18	15.4
Highest educational level										
Less than high school	24	11.2	8	10	16	11.9	11	11.3	13	11.1
High school	118	55.1	42	52.5	76	56.7	51	52.6	67	57.3
College+	71	3.2	30	37.5	41	30.6	34	35.1	37	31.6
Prefer not to answer	1	0.5	0	0	1	.7	1	1	0	0
Current living condition										
Agency shelter	75	35	36	45	39	29.1	28	28.9	47	40.2
Hotel	13	6.1	8	10	5	3.7	4	4.1	9	7.7
Apartment/house	104	48.6	24	30	80	59.7	57	58.8	47	40.2
Other	16	7.5	11	13.8	5	3.7	5	5.2	11	9.4
Prefer not to answer	6	2.8	1	1.3	5	3.7	3	3.1	1	2.6
Employment status										
Employed	96	44.9	39	48.8	57	42.5	51	52.6	45	38.5
Looking for work	57	26.6	26	32.5	31	23.1	22	22.7	35	29.9
Not looking for work	45	21	12	15	33	24.6	20	20.6	25	21.4
Prefer not to answer	16	7.5	3	3.8	13	9.7	4	4.1	12	10.3

Note. N = 214.

Age by Agency Locality. There were two (.9%) urban respondents and six (2.8%) rural respondents that were under 20 years old. Of those aged 21–40 years old, 49 (41.5%) were from urban agencies and 69 (58.5%) were from rural agencies. Of those aged 41–60 years old, 25 (31.6%) respondents were from urban agencies and 54 (68.4%) were from rural agencies. Of those aged 61–80 years old, four (50%) were from urban and four (50%) were from rural agencies. There was one (100%) person 81 years or older from a rural agency.

Age by Agency Size. Of those aged 21–40, there were 53 (45%) from large agencies and 65 (55%) from small agencies. Of those aged 41–60 years old, 35 (4.3%) respondents were from large and 44 (55.7%) were small agencies (see Table 1).

Gender

Results from Table 1 show 13 (6.1%) identified as male, 198 (92.5%) identified as female, and three (1.4%) identified as trans+.

Gender by Agency Locality. Of those who identified as male one (8%) came from an urban agency and 12 (92%) came from a rural agency. Of those who identified as female, 79 (39.9%) were from urban and 119 (60.1%) from rural agencies. Of those who identified as trans+, four came from rural agencies and none came from urban agencies (see Table 1).

Gender by Agency Size. Findings showed of those who identified as male, there were eight (62%) respondents from small agencies and five (38%) from large agencies. Of those who identified as female, 88 (44.4%) respondents were from small agencies and

110 (55.6%) from large agencies. Of those who identified as trans+, one (33.3%) came from a small agency and two (66.7%) came from large agencies.

Race/Ethnicity

Results from Table 1 show 144 (67.3%) identified as White, 28 (13.1%) identified as Black/African American, eight (3.7%) identified as Latinx and 34 (15.9%) identified as other.

Results by Agency Locality. Results showed 42 (29.2%) White respondents came from urban agencies and 102 (70.8%) came from rural agencies. There were 15 (53.6%) Black/African American respondents from urban agencies and 13 (46.4%) from rural agencies. There were three (37.5%) Latinx respondents from urban agencies and five (62.5%) from rural agencies. Of those who identified as other, 20 were from urban (58.8%) and 14 (41.1%) were from rural agencies.

Results by Agency Size. There were 76 (52.8%) White respondents that came from large agencies and 68 (47.2%) that came from small agencies. There were 18 (64.3%) Black/African American respondents from large agencies and 10 (35.7%) from small agencies. There were four (50%) Latinx from large agencies and four (50%) from small agencies. Of those who identified as other, 19 (55.9%) were from large agencies and 15 (44.1%) were from small agencies (see Table 1).

Sexual Orientation

Results in Table 1 show 33 (15.4%) of respondents reported they were LGBTQ, 148 (69.2%) reported they were heterosexual, and 33 (15.4%) declined to answer.

Sexual Orientation by Agency Locality. Of the 33 individuals that identified as LGBTQ, nine (27.3%) came from urban agencies and 24 (72.7%) came from rural

agencies. Of the 148 who identified as heterosexual, 58 (39%) came from urban agencies and 90 (61%) came from rural agencies.

Sexual Orientation by Agency Size. Findings from those who identified as LGBTQ were as follows: 12 (36.4%) came from large agencies and 21 (63.6%) came from small agencies. Of those who identify as heterosexual, 87 (58.8%) came from large agencies and 61 (41.2%) came from small agencies. There was a total of 33 that declined to answer (see Table 1).

Level of Education

Findings from Table 1 show 24 (11.2%) had less than a high school diploma as their highest level of education, 118 (55.1%) had a high school diploma as their highest level of education, 71 (33.2%) had a college degree or greater, and one individual (.5%) declined to answer.

Level of Education by Agency Locality. Of those who received services at an urban agency, (8 %) had less than a high school diploma as their highest level of education, 42 (52.5%) had a high school diploma, and 30 (37.5%) had a college degree or above. Findings from those who received services in a rural area reported 16 (11.9%) had less than a high school diploma as their highest level of education, 76 (56.7%) had a high school diploma, 41 (30.6%) had a college degree or above, and one person declined to answer.

Level of Education by Agency Size. Results showed of those who received services at a large agency, 13 (11.1%) had less than a high school education, 67 (57.3%) had a high school diploma, and 37 (31.6%) had a college degree or above. Findings from those who received services in a rural area reported 11 (11.3%) had less than a high

school diploma, 51 (52.6%) had a high school diploma, 34 (35.1%) had a college degree or above, and one person declined to answer.

Employment Status

Findings in Table 1 show 96 (44.9%) of individuals were employed, 57 (26.6%) were looking for work, 45 (21%) were unemployed and not looking for work, and 16 (7.5%) preferred not to answer.

Employment by Agency Locality. Findings showed of those who had services in an urban environment, 39 (48.8%) were employed, 26 (32.5%) were looking for work, 12 (15%) were not looking for work and three (3.8%) preferred not to answer. Findings showed of those who received services at rural agencies, 57 (42.5%) were employed, 31 (23.1%) were looking for work, and 33 (24.6%) preferred not to answer.

Employment by Agency Size. Findings showed of those receiving services at a small agency 51 (52.6%) were employed, 22 (22.7%) were looking for work, 20 (20.6%) were not looking for work, and four (4.1%) preferred not to answer. Findings showed of those who received services at large agencies 45 (38.5%) were employed, 35 (29.9%) were looking for work, 20 (21.4%) were not looking for work, and 12 (10.3%) preferred not to answer (see Table 1).

Current Living Condition

Findings summarized in Table 1 showed of the 160 respondents, 27 (35%) were currently living in an agency shelter, 13 (6.1%) were living in a community hotel, 104 (48.6%) were living in an apartment or house, 16 (7.5%) reported other, and six (2.8%) preferred not to answer.

Current Living Condition by Agency Locality. Results showed of those at an urban agency, 36 (45%) were living at a shelter, eight (10%) were living at a hotel, 24 (30%) were living at an apartment/house, 11 (13.8%) were living in other environments, and one (1.3%) preferred not to answer. Of those living in a rural agency, 39 (29.1%) were living at the agency/shelter, five (3.7%) were living at a community hotel, 80 (59.7%) were living at an apartment/house, five (3.7%) reported living in another environment, and five (3.7%) preferred not to answer.

Current Living Condition by Agency Size. Findings showed of those who received services at a small agency 28 (28.9%) were living at an agency shelter, four (4.1%) were living at a community hotel, 57 (58.8%) were living at an apartment/house, five (5.2%) reported other, and three (3.1%) preferred not to answer. Findings showed of those who received services at a large agency, 47 (40.2%) were living at an agency shelter, nine (7.7%) were living at a community hotel, 47 (40.2%) were living at an apartment/house, 11 (9.4%) reported living in another environment, and three (2.6%) reported they preferred not to answer (see Table 1).

Disabilities

Results from Table 2 show 46.3% of those who responded identified as having a mental health disability. Findings showed 10 (4.7%) identified as having a hearing disability, 11 (5.1%) as being blind or visually impaired, and 37 (17.3%) as having a physical health disability.

Table 2

Disability Characteristics of the Adequacies of Network of Services Provided to the Survivors of Domestic Violence in Pennsylvania–Phase II Study Participants

Disability	Total population		Urban		Rural		Small		Large	
	n	%	*N*	%	*n*	%	*n*	%	*n*	%
Deaf/hard of hearing	10	4.7	3	3.7	7	5.5	4	4.1	6	5.1
Blindness/visual disability	11	5.1	4	5	7	5.2	7	7.2	4	3.4
Physical health disability	37	17.3	8	10	29	21.6	24	24.7	13	11.1
Mental health disability	99	46.3	36	45	63	47	46	47.4	53	45.3
Other/not listed	13	6.1	3	3.8	10	7.5	8	8.2	5	4.3
Prefer not to answer	16	7.5	0	0	0	0	0	0	0	0

Note. $N = 214$

Disability by Agency Locality. Of those who identified as having a mental health disability, 34 (36.4%) were from urban agencies and 63 (63.6%) were from rural agencies. Of those who identified as having a physical disability, eight (21.6%) were from urban and 29 (78.4%) from rural agencies. Of those who reported having an unidentified disability, three (23%) were from urban agencies and 10 (77%) were from rural agencies. Of those who reported they were blind or had a visual disability, four (36.4%) were from an urban agency, and seven (63.6%) were from a rural agency.

Disability of by Agency Size. Of those who identified as having a mental health disability, 46 (46.5%) were from small agencies and 53 (53.5%) were from large agencies. Of those who identified as having a physical disability, 24 (65%) were from small agencies and 13 (35%) were from large agencies. Of those who identified as having

blindness or a visual disability, seven (63.6%) were from a small agency and four (36.4%) were from a large agency. Of those who identified as being deaf or hard of hearing, four (40%) were from a small agency and six (60%) were from a large agency. Of those who reported that they had a disability not listed eight (61.5%) were from small agencies and five (38.5%) were from large agencies (see Table 2).

Barriers to Employment

Table 3 summarizes the findings of the 135 respondents; 44 (20.6%) identified childcare as a barrier to accessing DV services, 26 (12.1%) identified health issues as a barrier to accessing services, and 65 (30.4%) identified transportation as being a barrier to accessing services.

Table 3

Barriers to Employment Characteristics of the Adequacies of Network of Services Provided to the Survivors of Domestic Violence in Pennsylvania–Phase II Study Participants

Barriers to employment	Total population		Urban		Rural		Small		Large	
	n	%	*n*	%	*N*	%	*n*	%	*n*	%
Childcare	44	20.6	18	41	26	59	21	47.7	23	52.3
Transportation	65	30.4	30	46.2	35	53.8	25	38.5	40	61.5
Health	26	12.1	14	53.8	12	46.2	15	57.7	11	42.3
Other	25	11.7	7	28	18	72	14	56	11	44

Note. N = 214

Barriers to Employment by Agency Locality. When comparing urban and rural agencies using chi squared and cross tab analysis, I found of those who answered

transportation was a barrier to receiving services, 30 (46.2%) were from urban and 35 (53.8%) were from rural areas. Of those who reported healthcare was a barrier to receiving services, 14 (53.8%) were from urban areas and 12 (46.2%) were from rural agencies. For those who answered childcare was a barrier, 18 (41%) were from urban areas and 26 (59%) were from rural areas (see Table 1).

Barriers to Employment by Agency Size. I conducted a chi-square test to compare the agency size of those who answered that transportation was a barrier to receiving services. Among that population, 25 (38.5%) came from small agencies and 40 (61.5%) came from large agencies. When comparing agency size, of those who answered healthcare was a barrier to receiving services, 15 (57.7%) were from small agencies and 11 (42.3%) were from large agencies. Of those who answered childcare was a barrier to receiving services, 21 (47.7%) were from small agencies and 23 (52.3%) were from large agencies (see Table 1).

Number of Times the Services Were Received

Table 4 shows 201 (93.9%) respondents received services 10 or fewer times, five (2.3%) received services 11–20 times, one (.5%) reported receiving services 41–60 times, and one (.5%) received services 61 or more times. This finding may have been due to respondents having differing interpretations of the question asked. Some may have interpreted each instance that they visited the agency for services as one service use and others may have interpreted each use as each event that led them back for services. Six (3%) of those surveyed did not respond.

Table 4

Recidivism Rates Characteristics of the Adequacies of Network of Services Provided to the Survivors of Domestic Violence in Pennsylvania–Phase II Study Participants

Recidivism rates	Total population		Urban		Rural		Small		Large	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
10 times or less	44	20.6	75	96.2	126	96.9	88	94.6	113	98.3
11–20 times	13	6.1	3	3.8	2	1.5	3	3.2	2	1.7
21+ times	26	12.1	0	0	1	.8	1	1.1	0	0
Other	25	11.7	0	0	1	.8	1	1.1	0	0

Note. N = 214. Several variables total number do not add up to 214 due to missing data including race (n = 128), disability (n = 186), barriers to employment (n = 108) and recidivism rates (n = 108).

Number of Times the Services Were Received by Locality. The findings showed, of those who received services at urban agencies, 75 (96.2%) received services 10 times or less, three (3.8%) received services between 11–20 times, and no DV survivors received services over 20 times. Of those who received services at rural agencies, 126 (96.9%) received services 10 or less times, two (1.5%) received services 11–20 times, one (.5%) received services 41–60 times, and one (.5%) received services more than 61 times.

Number of Times the Services Were Received by Agency Size. Findings as indicated in Table 1 show 88 (94.6%) of those at a small agency received services 10 times of fewer, three (3.2%) received services 11–20 times, one (.5%) received services between 41–60 times, and one (.5%) received services more than 61 times. Of those at

large agencies, 113 (98.3%) received services fewer than 10 times, two (1.7%) received services 11–20 times, and no survivors received services more than 20 times.

LAP Data Findings

Univariate analysis of variance (ANOVA) was completed to determine the relations between the categorical predictor variables of urban, rural, small, and large. Twenty-four (63%) of the agencies were classified as large and 14 (37%) were small. Twenty (53%) were urban and 18 (47%) were rural. There was a total of 41,954 individual police encounters in 2022 for DV survivors. Of those encounters, 6,139 (15%) DV survivors followed up on whether they had received crisis or agency services. Results indicated there was a significant difference in response rates between urban and rural and between agency sizes, with higher rates of respondents coming from small urban agencies and large urban agencies than small rural and large rural agencies.

Spoke to Crisis Services by Locality and Agency Size

Results from Table 5 summarize the finding showing of the 6,139 respondents, 2,298 (37%) received crisis services. I completed frequency crosstabulations to obtain demographic information. Results showed of those who responded, 1,411 (61.4%) received crisis services from urban setting and 887 (38.6%) received crisis services from rural areas. Additionally, 337 (14.7%) received services from small agencies, and 1,961 (85.3%) received services from large agencies. I performed univariate ANOVA to compare the effect of locality on agency size. This analysis revealed DV survivors reported a higher percentage of DV survivors used crisis services at large rural agencies than any other location with an adjusted mean of 50%. Large urban agencies had the least use at 36% service use. Small rural agencies had an adjusted mean score of 37% service

use, and small urban agencies had an adjusted mean score of 39%. There was no statistically significant difference between any of the groups (see Tables 6 and 7).

Table 5

Services Received Through the LAP 2022 Participants

Services received	Total population		Urban		Rural		Small		Large	
	n	*%*	*N*	*%*	*n*	*%*	*n*	*%*	*n*	*%*
Crisis services	2298	37	1411	61.4	887	38.6	337	14.7	1961	85.3
Agency services	2735	44	2048	75	687	25	326	12	2409	88

Note. N = 6139

Table 6

Test Table Between Subjects Agency Services for LAP 2022 Data

Agency services	Type III sum of squares	*df*	Mean square	*F*	Sig.	Partial eta squared
Small vs. large	.076	1	.076	1.579	.217	.044
Rural or urban	.221	1	.221	4.589	.039	.119
Small vs. large *rural or urban	.298	1	.298	6.170		.018

Note. *R^2 = .199 (Adjusted R^2 = .128)

Table 7

Descriptive Statistics for LAP 2022 Data

Agency size	Locality	Mean	*SD*	*n*
Large	Urban	.3688	.23576	16
	Rural	.3632	.23015	8
	Total	.3669	.22886	24
Small	Urban	.3606	.14028	4
	Rural	.3212	.19804	10
	Total	.3324	.17899	14
Total	Urban	.3672	.21679	20
	Rural	.3399	.20746	18
	Total	.3542	.21000	38

Note. N = 2,735

Received Agency Services by Locality and Agency Size

Of the 6,139 respondents, 2,735 (44%) received agency services. I completed frequency crosstabulations to obtain demographic information. Results showed 2,048 (75%) of respondents were from urban agencies and 687 (25%) were from rural agencies. Additionally, 326 (12%) were from small agencies and 2409 (88%) were from large agencies. I performed univariate ANOVA to compare the effect of locality on agency size, and this analysis revealed that with an adjusted coefficient of determination (R^2), there was a mean service use of 37% at large urban agencies. There was a mean service use of 36% at large rural agencies. There was a mean service use of 36% at small urban agencies and of 32% at small rural agencies. Results showed there was a significance between locality and between groups, but there was no significance between agency sizes (see Tables 8 and 9).

Table 8

Test Table Between Subjects Crisis Services for LAP 2022 Data

Agency services	Type III sum of squares	*Df*	Mean square	*F*	Sig.	Partial Eta squared
Small vs. large	.018	1	.018	.508	.481	.015
Rural or urban	.029	1	.029	.815	.373	.023
Small vs. large *rural or urban	.052	1	.052	1.475	.233	.042

Note. *R^2 = .093 (Adjusted R^2 = .012)

Table 9

Descriptive Statistics for LAP 2022 Data

Agency size	Locality	Mean	*SD*	*n*
Large	Urban	.3590	.15972	16
	Rural	.5048	.13520	8
	Total	.4076	.16471	24
Small	Urban	.3935	.31631	4
	Rural	.3720	.20798	10
	Total	.3782	.23051	14
Total	Urban	.3659	.19010	20
	Rural	.4310	.18717	18
	Total	.3967	.18905	38

Note. N = 2,735

Website Descriptive Analysis

I completed a content analysis on 49 DV agency websites following determination of the agency size and agency locality. All data were double-checked for accuracy. The data were collected using a self-filled questionnaire (checklist) documenting presence of preidentified factors on each website. These factors were

catalogued using yes or no questions. Questions included the following:"Does the agency provide mental health therapy?" "Does the agency provide nonmental health therapy?" "Does the website mention medication or psychiatry?" "Does the website mention mental health referrals?" "Is the website unclear?" "Does the website use evidence-based practices?" and "Does the website mention having a crisis line?"

To obtain an objective analysis of text, I established explicit criteria before data collection. I created definitions for each of seven categories in advance, and I later sent the definitions to an interrater before their analysis. During the data collection, I observed several websites indicated the agency provided counseling, but the agency was not necessarily treating mental health disorders; therefore, I added a new category of nonmental health counseling to the list of services.

I established interrater reliability for the website content analysis with the assistance of another evaluator. This interrater was selected for their extensive knowledge and expertise in providing mental health therapy to DV survivors. In total, the interrater and I rated seven questions for 46 agency websites. Of the 322 observations, the interrater and I agreed on 98% of the answers, and we disagreed on 2%. The five instances of disagreement were resolved by consensus. Areas of disagreement were due to information being more challenging to find on the websites. I used a chi-square test to compare answers to the questions by locality and then by size. Of the 46 agencies, 22 (48%) were small and 24 (52%) were large. Twenty-five were rural, and 21 were urban. I used binary logistic regression, with two dichotomous predictor variables, to examine the relationships among predictor variables (locality and agency size; see Table 10).

Website Mentions of Medication or Psychiatry

When comparing rural and urban agencies and large and small agencies, none of the agencies mentioned having psychiatry or medication management (see Table 10).

Table 10

Sociodemographic Characteristics of Website Analysis

Baseline characteristic	Total population		Urban		Rural		Small		Large	
	N	%	*N*	%	*N*	%	*n*	%	*n*	%
Website mentions of medication or psychiatry	0	0	0	0	0	0	0	0	0	0
Mental health therapy	11	24	6	28.6	5	20	7	31.8	4	16.7
Nonmental health counseling	33	71.7	13	40	20	60	16	48	17	52
Website mentions of the use of evidence-based practices	9	20	4	44	5	56	8	89	1	11
Website mentions mental health referrals	17	36.9	9	53	8	47	10	59	7	41
Website is unclear	27	58.7	11	40.7	16	59.3	13	48	14	52
Crisis hotline mentioned	44	96	21	48	23	52	23	52	21	48

Note. $N = 46$

Agency Provision of Mental Health Therapy

Of the 46-website examined, 11 (24%) reported providing mental health therapy.

Agency Provision of Mental Health Therapy by Agency Locality. Results showed six (28.6%) were urban agencies and five (20%) were rural.

Agency Provision of Mental Health Therapy by Agency Size. Results showed seven (31.8%) were small agencies and four (16.7%) were large agencies (see Table 10).

Agency Provision of Nonmental Health Counseling

As shown in Table 10, 33 (72%) reported provision of nonmental health counseling.

Agency Provision of Nonmental Health Counseling by Agency Locality. Results showed13 (40%) of the agencies were urban and 20 (60%) were rural.

Agency Provision of Nonmental Health Counseling by Agency Size. Results indicated 16 (48%) were small agencies and 17 (52%) were large.

Website Mentions of the Use of Evidence-Based Practices

As reported in Table 10, more agencies did not mention the use of evidence-based treatments than did. Nine (20%) agencies mentioned the use of evidence-based treatments.

Website Mentions of the Use of Evidence-Based Practices by Agency Locality. Results showed, of those who reported using evidence-based treatments, four (44%) were urban agencies and five (56%) were rural agencies.

Website Mentions of the Use of Evidence-Based Practices by Agency Size. Of the agencies with websites that mentioned use of evidence-based practices, eight (89%) were small agencies and one (11%) was a large agency. I compared small and large agencies using a chi-square test, and the results showed significant difference (X^2 [1, N = 46] = 7.561, p = .006).

Website Mentions Mental Health Referrals

As indicated in Table 10, 17 (37%) of agency websites reported providing mental health referrals.

Website Mentions Mental Health Referrals by Agency Locality. Results showed nine (53%) agencies that mentioned mental health referrals on their websites were urban agencies and eight (47%) were rural agencies.

Website Mentions Mental Health Referrals by Agency Size. Ten (59%) websites mentioning mental health referrals belonged to small agencies, and seven (41%) belonged to large agencies. I conducted a chi-square test and determined there was a significant difference when comparing small and large agencies (X^2 [1, N = 46] = 1.307, p = .253).

Website Was Unclear

Twenty-seven (59%) of the agency websites were unclear and 19 (41%) were clear (see Table 10).

Website Was Unclear by Agency Locality. Results showed of those websites that were unclear, 11 (40.7%) were from urban agencies and 16 (59.3%) were from rural agencies.

Website Was Unclear by Agency Size. Results showed of those websites that were unclear, 13 (48%) were from small agencies and 14 (52%) were from large agencies.

Crisis Hotline Mentioned

All small and large urban and large rural agencies' websites reported the availability of a crisis hotline. Two small rural agencies reported they did not provide a

crisis hotline service (see Table 10). Tables 11 and 12 provide data differentiating between the website analysis results for rural versus urban agencies and small versus large agencies, respectively.

Table 11

Chi-Square Test for Website Analysis Data Rural vs. Urban

Website analysis rural vs. urban	X^2	*df*	*p*
Mental health therapy	.461	1	.497
Nonmental health counseling	1.843	1	.175
Website mentions of the use of evidence-based practices	.007	1	.935
Website mentions mental health referrals	.577	1	.447
Website is unclear	.636	1	.425
Crisis hotline mentioned	1.756	1	.185

Note. $p < .05$

Table 12

Chi-Square Test for Website Analysis Data Small vs. Large

Website analysis small vs. large	X^2	*df*	*p*
Mental health therapy	1.448	1	.229
Nonmental health counseling	.020	1	.887
Website mentions of the use of evidence-based practices	7.561	1	.006
Website mentions mental health referrals	1.307	1	.253
Website is unclear	.425	1	.515
Crisis hotline mentioned	.004	1	.950

Note. $p < .05$

Hypothesis Testing

Hypothesis 1

There were more mental health services at urban DV agencies than at rural agencies. The following data came from the Adequacies of Network of Services Provided to the Survivors of Domestic Violence in Pennsylvania—Phase II Study (see Table 13).

Table 13

Mental Health Services From Agencies offering DV and Mental Health Services: The Adequacies of Network of Services Provided to the Survivors of Domestic Violence in Pennsylvania–Phase II Study

Mental health services	Total population		Urban		Rural		Small		Large	
	n	%	*N*	%	*n*	%	*n*	%	*n*	%
Mental health therapy	117	54.7	44	37.6	73	62.4	57	48.7	60	51.3
Crisis hotline	155	72.4	64	41	91	59	62	40	93	60
Support groups	109	50.9	46	42	63	58	47	43	62	57
Peer support	88	41.1	33	37.5	55	62.5	38	43	50	57
Counseling services	136	63.8	50	37	86	63	38	43	50	57
Mindfulness/self-care	113	53.1	41	36	72	64	53	47	60	53

Note. N = 214. There were four individuals that declined to answer if they received crisis hotlines services; therefore, their scores were not added.

Mental Health. There were 117 (54.7%) participants who reported they received mental health services. Of those who reported they received mental health services, 44 (37.6%) received services at urban agencies and 73 (62.4%) received services at rural agencies. Of those that were urban, 55% received services, and of those that were rural,

54.5% received services. There were similar rates among those from both urban and rural agencies (see Table 13).

Crisis Hotline. As shown in Table 13**,** 155 (72.4%) participants received crisis hotline services. Of those, 64 (41%) received services at urban agencies and 91 (59%) received services at rural agencies. Of those who came from urban agencies, 64 (80%) received crisis services and 91 (67.9%) of rural participants received crisis services.

Support Groups. There were 109 (50.9%) respondents who received services who participated in support groups. Results showed 46 (42%) received services from urban agencies, and 63 (58%) received services from rural agencies. Of those who came from urban agencies, 57% participated in support groups and 47% from rural agencies participated in support groups (see Table 13).

Peer Support. There were 88 (41.1%) respondents who participated in peer support. Of those who participated, 64 (41%) were from urban agencies and 91 (59%) were from rural agencies. Of those who came from urban agencies, 41.3% participated in peer support, and of those from rural agencies, 41% participated in peer support (see Table 13).

Counseling. There were 136 (63.8%) respondents who received counseling services. Of those who received counseling services, 50 (37%) were from urban agencies and 86 (63%) were from rural agencies. Of those at urban agencies, 62.5% received counseling services and 64.7% of those from rural agencies reported receiving counseling services (see Table 13).

Mindfulness/Self-Care. There were 113 (53.1%) respondents who received mindfulness and self-care services. Of those who reported receiving mindfulness and

self-care services, 41 (36%) were from urban agencies and 72 (64%) were from rural agencies. Of those who came from urban agencies, 51.2% reported receiving mindfulness and self-care services. Of those who came from rural agencies, 54.1% reported receiving mindfulness and self-care services (see Table 13).

Mental Health Therapy Adequacy. There were 80 respondents from urban agencies. Of those at urban agencies, four (7.5%) rated the services as inadequate, 38 (47.5%) rated the services as adequate, and 36 (45%) reported not having received the services. There were 134 respondents from rural agencies. Of those at rural agencies, 12 (9%) rated the services as inadequate, 62 (46.3%) rated the services as adequate, and 60 (44.8%) reported not having received the services (see Table 14).

Table 14

Adequacies of DV and Mental Health Services: The Adequacies of Network of Services Provided to the Survivors of Domestic Violence in Pennsylvania–Phase II Study

Service	Locality	Total population		Less than adequate		Adequate		Did not receive services	
		n	%	*n*	%	*n*	%	*n*	%
Mental health therapy	Urban	80	100	6	7.5	38	47.5	36	45
	Rural	134	100	12	9	62	46.3	60	44.8
Crisis hotline	Urban	80	100	3	3.8	61	76.3	16	20
	Rural	133	100	13	9.8	82	61.7	38	28.6
Support groups	Urban	80	100	5	6.3	41	51.2	34	42.5
	Rural	134	100	11	8.2	52	38.8	71	53
Peer support	Urban	80	100	5	6.3	28	35.0	47	58.8
	Rural	134	100	9	6.7	47	35.1	78	58.2
Counseling	Urban	80	100	4	5	46	57.5	30	37.5
	Rural	133	100	8	6	80	60.2	45	33.8
Mindfulness/self-care	Urban	80	100	7	8.8	34	42.5	39	48.8
	Rural	132	100	10	7.6	62	47	60	45.5

Note. N = 214. Some of the respondents did not answer some of the questions resulting in variation in N among categories.

Crisis Hotline Therapy Adequacy. There were 80 respondents from urban agencies. Of those at urban agencies, three (3.8%) rated the services as inadequate, 61 (76.3%) rated the services as adequate, and 16 (20%) reported not having received the services. There were 133 respondents from rural agencies. Of those at rural agencies, 13 (9.8%) rated the services as inadequate, 82 (61.7%) rated the services as adequate, and 38 (28.6%) reported not having received the services (see Table 14).

Support Groups Therapy Adequacy. There were 80 respondents from urban agencies. Of those at urban agencies, five (6.3%) rated the services as inadequate, 41 (51.2%) rated the services as adequate, and 34 (42.5%) reported not having received the services. There were 134 respondents from rural agencies. Of those at rural agencies, 11 (8.2%) rated the services as inadequate, 52 (38.8%) rated the services as adequate, and 71 (53%) reported not having received the services (see Table 14).

Peer Support Adequacy. There were 80 respondents from urban agencies. Of those at urban agencies, five (6.3%) rated the services as inadequate, 28 (35%) rated the services as adequate, and 47 (58.8.5%) reported not having received the services. There were 134 respondents from rural agencies. Of those at rural agencies, nine (6.7%) rated the services as inadequate, 47 (35.1%) rated the services as adequate, and 78 (58.2%) reported not having received the services (see Table 14).

Counseling. There were 80 respondents from urban agencies. Of those at urban agencies, four (5%) rated the services as inadequate, 46 (57.5%) rated the services as

adequate, and 30 (37.5%) reported not having received the services. There were 133 respondents from rural agencies. Of those at rural agencies, eight (6%) rated the services as inadequate, 80 (60.2%) rated the services as adequate, and 45 (33.8%) reported not having received the services (see Table 14).

Mindfulness/Self-Care. There were 80 respondents from urban agencies. Of those at urban agencies, seven (8.8%) rated the services as inadequate, 34 (42.5%) rated the services as adequate, and 39 (48.8%) reported not having received the services. There were 132 respondents from rural agencies. Of those at rural agencies, 10 (7.6%) rated the services as inadequate, 62 (947%) rated the services as adequate, and 60 (45.5%) reported not having received the services (see Table 14).

LAP Data: Spoke to Crisis Services by Locality and Agency Size. Results showed 1,411 (61.4%) respondents received crisis services from agencies located in urban settings, and 887 (38.6%) received crisis services from agencies located in rural areas. This was due to most respondents being concentrated in urban areas (see Table 15).

Table 15

Adequacies of DV and Mental Health Services: The Adequacies of Network of Services Provided to the Survivors of Domestic Violence in Pennsylvania–Phase II Study

Adequacy by agency size	Agency size	Total population		Less than adequate		Adequate		Did not receive services	
		n	*%*	*n*	*%*	*n*	*%*	*n*	*%*
Mental health therapy	Small	97	100	10	10.3	48	49.5	39	40.2
	Large	117	100	8	6.8	52	44	57	48.7
Crisis hotline	Small	97	100	6	6.2	57	58.7	34	35.1
	Large	116	100	10	8.6	86	74	20	17.2
Support groups	Small	97	100	8	8.2	39	40	50	51.5
	Large	117	100	8	6.8	54	46	55	47

Adequacy by agency size	Agency size	Total population		Less than adequate		Adequate		Did not receive services	
		n	%	*n*	%	*n*	%	*n*	%
Peer support	Small	97	100	8	8.2	30	31	59	60.8
	Large	117	100	6	5.1	45	38.5	66	56.4
Counseling	Small	96	100	7	7.3	61	63.5	28	29.2
	Large	117	100	5	4.3	65	55.5	47	40.2
Mindfulness/self-care	Small	95	100	10	10.5	42	44	43	45.3
	Large	117	100	7	6	54	46.2	56	47.9

Note. $N = 214$

LAP Data: Received Agency Services by Locality and Agency Size. Of those who went to agencies to receive services, 2,048 (75%) received services from urban agencies and 687 (25%) received services from rural agencies. Additionally, 326 (12%) received services from small agencies, and 2,409 (88%) received services from large agencies. This was due to the agencies' capacity to provide services overall.

Website Mentions of Medication or Psychiatry. When comparing rural and urban agencies that mentioned having psychiatry or medication management, there were no websites that reported having the service (see Table 10).

Agency Provision of Mental Health Therapy. Results showed six (28.6%) of websites that mentioned providing mental health therapy on their websites were urban agencies and five (20%) were rural (see Table 10).

Agency Provision of Nonmental Health Counseling. Results showed 13 (40%) of agencies that mentioned providing nonmental health counseling on their websites were urban and 20 (60%) were rural (see Table 10).

Website Mentions of the Use of Evidence-Based Practices. Results showed of those who report using evidence-based treatments, four (44%) ere urban agencies, and five (56%) were rural agencies (see Table 10).

Website Mentions Mental Health Referrals. As indicated in Table 3, 17 (37%) of agency websites reported providing mental health referrals. Results showed nine (53%) were urban agencies and eight (47%) were rural agencies; 10 (59%) were small agencies and seven (41%) were large agencies (see Table 10).

Crisis Hotline Mentioned. All small urban, large urban, and large rural agencies reported the availability of a crisis hotline. Two small rural agencies reported they did not provide a crisis hotline service (see Table 10).

The null hypothesis was accepted, and the research hypothesis was rejected. In short, clients who received mental health services at urban agencies were not more likely to receive mental health treatment. Overall, there were similar rates of those receiving mental health services at urban and rural agencies with slightly higher rates of people receiving mental health services at rural agencies. Almost all agencies provided crisis services, and no agencies provided psychiatry or medication management services. For counseling services, rates among urban and rural agencies were very similar, with slightly higher rates of service use than for mental health. Website analysis showed more urban agencies use nonmental health counseling than rural agencies. Although few agencies mentioned the use of evidence-based practices on their websites, rates of agencies that mentioned using evidence-based practices were similar for urban and rural agencies. With consistent findings between data sources, it appeared most DV survivors were receiving mental health services at similar rates overall based upon locality. Additionally,

the adequacy of the services results showed most services had similar adequacy rates when comparing urban and rural agencies. The majority of those who received services in all areas rated the services as adequate, with crisis and counseling services having the highest ratings.

Hypothesis 2

There are more mental health services offered at large agencies than at small agencies. The following data came from the Adequacies of Network of Services Provided to the Survivors of Domestic Violence in Pennsylvania–Phase II study:

Mental Health. There were 117 (54.7%) participants who reported receiving mental health services. Of those who reported receiving mental health services, 57 (48.7%) received services from small agencies and 60 (51%) received services from large agencies. Of those who received services at large agencies, 51.39% reported receiving mental health services. Of those who received services from small agencies, 58.8% reported receiving mental health services (see Table 13).

Crisis Hotline. There were 155 (72.4%) participants who received crisis hotline services. Of those who reported receiving crisis services, 62 (40%) received services from small agencies and 93 (60%) received services from large agencies. Of those who received services at large agencies, 95.8% received crisis services and 95.5% of those at small agencies received crisis services (see Table 13).

Support Groups. There were 109 (50.9%) respondents who participated in support groups. Of those who received support groups services, 47 (43%) received services from small agencies and 62 (57%) received services at large agencies. Of those who received services at small agencies, 48.5% received support group services. Of those

who received services at large agencies, 53% received support group services (see Table 13).

Peer Support. There were 88 (41.1%) respondents who participated in peer support. Of those who received peer support services, 38 (43%) received services from small agencies and 50 (57%) received peer support services from large agencies. Of those who received services at small agencies, 39.2% received peer support, and of those who received services at large agencies, 42.7% received peer support (see Table 13).

Counseling. There were 136 (63.8%) participants who received counseling services. Of those who received counseling services, 38 (43%) received counseling services at small agencies and 50 (57%) received counseling services at large agencies. Of those who received services at small agencies, 63.9% received counseling services, and of those who received services at large agencies, 79.5% received counseling (see Table 13).

Mindfulness/Self-Care. There were 113 (53.1%) respondents who received mindfulness and self-care services. Of those who received mindfulness and self-care services, 53 (47%) received services from small agencies and 60 (53%) received services from large agencies. Of those who received services at small agencies, 55.2% reported receiving mindfulness and self-care services, and of those who received services at large agencies, 60 (51.3%) reported receiving mindfulness and self-care services (see Table 13).

Mental Health Therapy Adequacy. There were 97 respondents receiving services from small agencies. Of those receiving services from small agencies, 10 (10.3%) rated the services as inadequate, 48 (49.5%) rated the services as adequate, and

39 (40.25%) reported not having received the services. There were 117 respondents receiving services from large agencies. Of those at large agencies, eight (6.8%) rated the services as inadequate, 52 (44.4%) rated the services as adequate, and 57 (48.7%) reported not having received the services (see Table 15).

Crisis Hotline Therapy Adequacy. There were 97 respondents receiving services from small agencies. Of those receiving services from small agencies, six (6.2%) rated the services as inadequate, 57 (58.8%) rated the services as adequate, and 34 (35.1%) reported not having received the services. There were 116 respondents receiving services from rural agencies. Of those receiving services at large agencies, 10 (8.6%) rated the services as inadequate, 86 (74.1%) rated the services as adequate, and 20 (17.2%) reported not having received the services (see Table 15).

Support Groups Therapy Adequacy. There were 97 respondents receiving services from small agencies. Of those receiving services at small agencies, eight (8.2%) rated the services as inadequate, 39 (40.2%) rated the services as adequate, and 50 (51.5%) reported not having received the services. There were 117 respondents receiving services from large agencies. Of those receiving services at large agencies, eight (6.8%) rated the services as inadequate, 54 (46.2%) rated the services as adequate, and 55 (47%) reported not having received the services (see Table 15).

Peer Support Adequacy. There were 97 respondents receiving services from small agencies. Of those receiving services at small agencies, eight (8.2%) rated the services as inadequate, 30 (30.9%) rated the services as adequate, and 59 (60.8%) reported not having received the services. There were 117 respondents receiving services from large agencies. Of those receiving services at large agencies, six (5.1%) rated the

services as inadequate, 45 (38.5%) rated the services as adequate, and 66 (56.4%) reported not having received the services (see Table 15).

Counseling Adequacy. There were 96 respondents receiving services from small agencies. Of those receiving services at small agencies, seven (7.3%) rated the services as inadequate, 61 (63.5%) rated the services as adequate, and 28 (29.2%) reported not having received the services. There were 117 respondents receiving services from large agencies. Of those receiving services at large agencies, five (4.3%) rated the services as inadequate, 65 (55.6%) rated the services as adequate, and 47 (40.2%) reported not having received the services (see Table 15).

Mindfulness/Self-Care Adequacy. There were 95 respondents receiving services from small agencies. Of those receiving services at urban agencies, 10 (10.5%) rated the services as inadequate, 42 (44.2%) rated the services as adequate, and 43 (45.3%) reported not having received the services. There were 117 respondents receiving services from large agencies. Of those receiving services at large agencies, seven (6%) rated the services as inadequate, 54 (46.2%) rated the services as adequate, and 56 (47.9%) reported not having received the services (see Table 15).

LAP Data: Spoke to Crisis Services by Locality and Agency Size. Results from Table 5 showed of those who responded, 337 (14.7%) spoke to crisis services from small agencies, and 1,961 (85.3%) spoke to crisis services from large agencies (see Table 5).

LAP Data: Received Agency Services by Agency Size. Results showed 326 (12%) received services from small agencies, and 2,409 (88%) are from large agencies (see Table 5).

Website Mentions of Medication or Psychiatry. When comparing small and large agencies, none mentioned having psychiatry or medication management (see Table 10).

Agency Provision of Mental Health Therapy. Results showed seven (31.8%) small agencies and four (16.7%) large agencies displayed information on their website about providing mental health therapy (see Table 10).

Agency Provision of Nonmental Health Counseling. As shown in Table 10, 16 (48%) small agencies and 17 (52%) large agencies displayed information on their website about providing nonmental counseling (see Table 10).

Website Mentions of the Use of Evidence-Based Practices. As reported in Table 10, eight (89%) small agencies and one (11%) large agency mentioned using evidence-based practices on their website (see Table 10).

Website Mentions Mental Health Referrals. As indicated in Table 10, 10 (59%) small agencies and seven (41%) large agencies website displayed information on their website about having provided mental health referrals (see Table 10).

Crisis Hotline Mentioned. All websites for small and large urban agencies and large rural agencies reported the availability of a crisis hotline. Two small rural agencies reported they did not provide a crisis hotline service (see Table 10).

The null hypothesis was accepted, and the research hypothesis was rejected. In short, clients who received mental health services at large agencies were not more likely to receive mental health treatment. Findings from the website analysis indicated there were more small agencies that provided mental health treatment at the agency level. Additionally, smaller agencies provided nonmental health counseling at slightly higher

rates than large agencies. There were slightly higher rates of smaller agency websites mentioning the use of evidence-based treatments. All but two small agencies provided crisis services. Findings from the LAP data indicated there were more people overall who received crisis services and agency wide services at larger agencies than small agencies. Results from the Adequacies of Network of Services Provided to the Survivors of Domestic Violence in Pennsylvania–Phase II study indicated that among large and small agencies there were similar rates of those receiving mental health and crisis services. Larger agencies had slightly higher rates of services use for counseling, mindfulness/self-care, support groups, and peer support. All the services that had slightly higher service use also had slightly higher adequacy ratings in all categories.

Hypothesis 3

Barriers to receiving DV and mental health services will differ between rural and urban agencies.

Scheduling as a Barrier. Of the 27 (12.6%) participants who reported scheduling was a barrier for them, 10 (37%) were from urban agencies, and 17 (63%) were from rural agencies. Of those who received services at an urban agency, 12.5% reported scheduling was a barrier to receiving services. Of those who received services at a rural agency, 12.7% reported scheduling was a barrier to receiving services (see Table 16).

Table 16

Barriers to Receiving Services: The Adequacies of Network of Services Provided to the Survivors of Domestic Violence in Pennsylvania–Phase II Study

Barriers	Total population		Urban		Rural		Small		Large	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
To receiving services:										
Scheduling	27	12.6	10	12.5	17	12.7	13	13.4	14	12
Language	3	1.4	1	1.3	2	1.5	0	0	3	2.6
Awareness of programs	60	28	24	30	26.9	9	22	22.7	38	32.5
Transportation/ location	38	17.8	16	20	22	16.4	14	14.4	24	20.5
Wheelchair accessibility	0	0	0	0	0	0	0	0	0	0
Negative impression of services	22	10.3	10	12.5	12	9	6	6.2	16	13.7
To employment:										
Childcare	44	20.6	18	41	26	59	21	47.7	23	52.3
Transportation	65	30.4	30	46.2	35	53.8	25	38.5	40	61.5
Other	26	12.1	14	53.8	12	46.2	15	57.7	11	42.3
Health	25	11.7	7	28	18	72	14	56	11	44

Note. N = 214

Language as a Barrier. There were only three participants who reported language was a barrier for them. One was from an urban agency and two were from rural agencies. Of those receiving services at an urban agency, 1.3% reported language was a barrier and 1.5% reported that language was a barrier at rural agencies (see Table 16).

Awareness of Programs as a Barrier. Of the 60 (28%) that reported awareness of services was a barrier, 24 (40%) received services from an urban agency and 36 (60%) received services at a rural agency. Of those who reported receiving services at urban agencies, 30% reported awareness of services was a barrier to receiving services. Of

those who reported receiving services at rural agencies, 26.9% reported awareness of services was a barrier to receiving services (see Table 16).

Transportation/Location as a Barrier. There were 38 (17.8%) people who reported transportation and the location of the facility were barriers to receiving services. Of those who reported experiencing these barriers, 16 were from urban agencies and 22 were from rural. Of those who received services from urban agencies, 22% reported transportation and location were barriers, and of those who received services at rural agencies, 16.4% reported that transportation and location were barriers (see Table 16).

Wheelchair Accessibility as a Barrier. None of the participants reported wheelchair accessibility was a barrier to receiving services at the agency level (see Table 16).

Negative Impressions as a Barrier. There were 22 (10.3%) respondents who reported negative impressions were a barrier to receiving services. Of those 22 respondents, 10 received services from urban agencies and 12 received services from rural agencies. Of those who reported receiving services at urban agencies, 12.5% of respondents reported negative impressions were a barrier. There were 12% of rural respondents that reported negative impressions were a barrier (see Table 16).

Childcare as a Barrier to Employment. There were 44 (20.6%) respondents who reported that childcare was a barrier to employment. As shown on Table 16, 44 of the 135 respondents (20.6%) identified childcare as a barrier to employment. For those who answered childcare was a barrier, 41% were from urban areas and 59% were from rural areas (see Table 16). Of those receiving services at urban agencies, 22.5% reported

childcare was a barrier, and 19.5% of those receiving services at rural agencies reported childcare was a barrier (see Table 16).

Transportation as a Barrier to Employment. Sixty-five (30.4%) respondents identified transportation as a barrier to employment. Among them 46.2% (30) were receiving services at urban agencies and 53.8% (35) were receiving services from rural agencies. Of those receiving services at urban agencies, 37.5% reported transportation was a barrier and 26.1% of those receiving services in rural agencies reported transportation was a barrier (see Table 16).

Health as a Barrier to Employment. There were 25 participants (11.7%) who identified health issues as a barrier to employment. Of those who reported health was a barrier to receiving services, seven (28%) were receiving services from urban agencies and 18 (72%) were receiving services from rural agencies. Of those receiving services from urban agencies, 17.5% reported that health was a barrier. Of those receiving services from rural agencies, 9% reported health was a barrier (see Table 16).

Other Barriers to Employment. Of the 26 (12.1%) who identified having other barriers, 14 (53.8%) were receiving services from urban agencies and 12 (46.2%) were receiving services from rural agencies. Of those who were receiving services at urban agencies, 8.8% reported having other barriers. Additionally, 13.4% of those receiving services from rural agencies reported having other barriers (see Table 16).

Findings showed there were similar rates of those who experienced barriers across agencies, regardless of locality. Respondents identified health and transportation as barriers at slightly higher rates in urban settings. Transportation, childcare, and awareness of programs were the most prominent barriers.

Hypothesis 4

Barriers to receiving DV and mental health services in large and small agencies are also predicted to differ.

Scheduling as a Barrier. Of those who reported scheduling was a barrier, 13 (48%) were receiving services from small agencies and 14 (52%) were receiving services from large agencies. Of those at small agencies, 13.4% identified scheduling services as a barrier and 12% were from large agencies (see Table 16).

Language as a Barrier. There were three respondents who reported language was a barrier, and all of them received services from a large agency (see Table 16).

Awareness of Programs as a Barrier. Of those who reported awareness of programs was a barrier, 22 (37%) received services from small agencies and 38 (63%) received services from large agencies. Of those who received services at small agencies, 22.7% reported awareness of services was a barrier and 32.5% receiving services at large agencies reported awareness of services was a barrier (see Table 16).

Transportation/Location as a Barrier. Of those who reported transportation and location were barriers to receiving services, 14 (37%) were receiving services from small agencies and 24 (63%) were receiving services from large agencies. Of those at small agencies, 14.4% reported transportation was a barrier and 20.5% of respondents receiving services at large agencies reported transportation was a barrier (see Table 16).

Wheelchair Accessibility as a Barrier. None of the respondents identified wheelchair accessibility as a barrier (see Table 16).

Negative Impressions as a Barrier. Of those who reported their negative impression of the agency and DV services as a barrier, six (27.3%) identified themselves

as receiving services from a small agency and 16 (72.7%) reported they were receiving services from a large agency. Of those receiving services at small agencies, 6.2% reported negative impressions were a barrier to receiving services and 13.7% of those receiving services at a large agency reported experiencing this barrier (see Table 16).

Childcare as a Barrier to Employment. Of those who answered childcare was a barrier to receiving services, 47.7% (21) were receiving services from small agencies and 52.3% (23) were receiving services from large agencies (see Table 16). Of those who received services at small agencies, 21.6% reported they found childcare to be a barrier. Of those who received services at large agencies, 19.7% reported they found childcare to be a barrier (see Table 16).

Transportation as a Barrier to Employment. Of those who answered transportation was a barrier to receiving services 38.5% (25) received services from small agencies, and 61.5% (40) received services from large agencies. Of those who received services at small agencies, 25% reported transportation was a barrier. Of those who received services at large agencies, 34% reported transportation was a barrier (see Table 16).

Health as a Barrier to Employment. Of those who answered health was a barrier to receiving services, 57.7% (15) were receiving services from small agencies and 42.3% (11) were receiving services from large agencies. Of those who received services at small agencies, 15.5% reported health was a barrier to employment. Of those who received services at large agencies, 9.4% reported health was a barrier to employment (see Table 16).

Other Barriers to Employment. Of those who reported having other barriers to employment, 14 (56%) were receiving services from small agencies and 11 (44%) were receiving services from large agencies. Of those who received services at small agencies, 14.4% reported they experienced other barriers to employment. Of those who received services at large agencies 9.4% reported experiencing other employment barriers (see Table 16).

Although barriers to receiving services were comparable between small and large agencies in all categories, the areas that had the highest percentage of barriers were transportation, childcare, and awareness of services. Childcare and health were identified as the largest barriers to seeking employment.

Hypothesis 5

There are differences in the demographic characteristics of those seeking services in rural and urban DV agencies.

Age. There were two (0.9%) urban respondents and six (2.8%) rural respondents who were under 20 years old. Of those aged 21–40 years old, 49 (41.5%) were from urban agencies, and 69 (58.5%) were from rural agencies. Of those aged 41–60 years old, 25 (31.6%) respondents were from urban agencies and 54 (68.4%) respondents were from rural agencies. Of those aged 61–80 years old, four (50%) were from urban agencies, and four (50%) were from rural agencies. There was one (100%) respondent who was 81 years or older from a rural agency (see Table 1).

Gender. Of those who identified as men, one (8%) received services from an urban agency, and 12 (92%) received services from a rural agency. Of those who identified as women, 79 (39.9%) received services from urban agencies and 119 (60.1%)

received services from rural agencies. Of those who identified as trans+, four received services from rural agencies and none received services from urban agencies (see Table 1).

Race/Ethnicity. Results showed 42 (29.2%) White respondents received services from urban agencies, and 102 (70.8%) White respondents received services from rural agencies. There were 15 (53.6%) Black/African American respondent who received services from urban agencies and 13 (46.4%) who received services from rural agencies. There were three (37.5%) Latinx respondents who received services from urban agencies and five (62.5%) who received services from rural agencies. Of those who identified as other races or ethnicities, 20 (58.8%) received services from urban agencies, and 14 (41.1%) received services from rural agencies (see Table 1).

Sexual Orientation. Of the 33 individuals who identified as LGBTQ, nine (27.3%) received services from urban agencies and 24 (72.7%) received services from rural agencies. Of the 148 who identified as heterosexual, 58 (39%) received services from urban agencies and 90 (61%) received services from rural agencies (see Table 1).

Level of Education. Of those who received services at an urban agency, eight (%) had less than a high school education, 42 (52.5%) had a high school diploma, and 30 (37.5%) had a college degree or above. For those who received services in a rural area, 16 (11.9%) had less than a high school diploma, 76 (56.7%) had a high school diploma, 41 (30.6%) had a college degree or above, and one respondent declined to answer (see Table 1).

Disabilities. Of those who identified as having a mental health disability, 34 (36.4%) were receiving services from urban agencies and 63 (63.6%) were receiving

services from rural agencies. Of those who identified as having a physical disability, eight (21.6%) were receiving services from urban agencies and 29 (78.4%) were receiving services from rural agencies. Of those who reported having an unidentified disability, three (23%) were receiving services from urban agencies and 10 (77%) were receiving services from rural agencies. Of those who reported that they were blind or had a visual disability, four (36.4%) were receiving services from an urban agency and seven (63.6%) were receiving services from a rural agency (see Table 1).

Employment Status. Of those who had services in an urban environment, 39 (48.8%) were employed, 26 (32.5%) were looking for work, 12 (15%) were not looking for work, and three (3.8%) preferred not to answer. Of those who received services at rural agencies, 57 (42.5%) were employed, 31 (23.1%) were looking for work, 33 (24.6%) were not looking for work, and 13 (9.7%) preferred not to answer (see Table 1).

Current Living Condition. Of those at an urban shelter, 36 (45%) were living at a shelter, eight (10%) were living at a hotel, 24 (30%) were living at an apartment/house, 11 (13.8%) were living in other environments, and one (1.3%) preferred not to answer. Of those living in a rural shelter, 39 (29.1%) were living at the agency/shelter, five (3.7%) were living at a community hotel, 80 (59.7%) were living at an apartment/house, five (3.7%) were living in another environments, and five (3.7%) preferred not to answer (see Table 1).

There were similar rates between urban and rural agencies for respondent age ranges, levels of education, and employment. Rural areas had slightly higher levels of respondents who identified as having mental health and physical disabilities. Additionally, there were higher percentages of men and people who identified as

homosexual and LGBTQ at rural agencies. Urban agencies had more racial minorities including Black/African American, Latinx, and people who identified as other races or ethnicities. There were higher rates in urban settings for respondents living at the shelter, and there were higher rates in rural settings of respondents living in an apartment or at their home.

Hypothesis 6

There are differences in demographic characteristics of those seeking services in large and small DV agencies.

Age. Of those aged 21–40 years, there were 53 (45%) receiving services from large agencies and 65 (55%) receiving services from small agencies. Of those aged 41–60 years old, 35 (4.3%) respondents were receiving services from large agencies, and 44 (55.7%) were receiving services from small agencies (see Table 1).

Gender. Of those who identified as men, eight (62%) respondents received services from small agencies and five (38%) respondents received services from large agencies. Of those who identified as women, 88 (44.4%) respondents received services from small agencies and 110 (55.6%) respondents received services from large agencies. Of those who identified as trans+, one (33.3%) received services from a small agency and two (66.7%) received services from large agencies.

Race/Ethnicity. There were 76 (52.8%) White respondents receiving services from large agencies and 68 (47.2%) receiving services came from small agencies. There were 18 (64.3%) Black/African American respondents receiving services from large agencies and 10 (35.7%) receiving services from small agencies. There were four (50%) Latinx respondents receiving services from large agencies and four (50%) Latinx

respondents receiving services from small agencies. Of those who identified as other races or ethnicities, 19 (55.9%) received services from large agencies and 15 (44.1%) were receiving services from small agencies (see Table 1).

Sexual Orientation. For respondents who identified as LGBTQ, 12 (36.4%) received services from large agencies and 21 (63.6%) received services from small agencies. Of those who identified as heterosexual, 87 (58.8%) received services from large agencies and 61 (41.2%) received services from small agencies. There were 33 respondents who declined to answer this survey item (see Table 1).

Level of Education. Of those who received services at large agencies, 13 (11.1%) had less than a high school education, 67 (57.3%) had a high school diploma, and 37 (31.6%) had a college degree or above. Of those who received services in a rural area, 11 (11.3%) had less than a high school diploma, 51 (52.6%) had a high school diploma, 34 (35.1%) had a college degree or above, and one respondent declined to answer this survey item (see Table 1).

Disabilities. Of those who identified as having a mental health disability, 46 (46.5%) were receiving services from small agencies, and 53 (53.5%) were receiving services from large agencies. Of those who identified as having a physical disability, 24 (65%) were receiving services from small agencies and 13 (35%) were receiving services from large agencies. Of those who identified as having blindness or a visual disability, seven (63.6%) were receiving services from small agencies and four (36.4%) were receiving services from large agencies. Of those who identified as being deaf or hard of hearing, four (40%) were receiving services from small agencies and six (60%) were receiving services from large agencies. Of those who reported they had a disability not

listed, eight (61.5%) were receiving services from small agencies and five (38.5%) were receiving services from large agencies (see Table 2).

Employment Status. Of those receiving services at small agencies, 51 (52.6%) were employed, 22 (22.7%) were looking for work, 20 (20.6%) were not looking for work, and four (4.1%) preferred not to answer. Of those who received services at large agencies, 45 (38.5%) were employed, 35 (29.9%) were looking for work, 20 (21.4%) were not looking for work, and 12 (10.3%) preferred not to answer (see Table 1).

Current Living Condition. Of those who received services at a small agency, 28 (28.9%) were living at an agency shelter, four (4.1%) were living at a community hotel, 57 (58.8%) were living at an apartment/house, five (5.2%) reported other housing accommodations, and three (3.1%) preferred not to answer. Of those who received services at a large agency, 47 (40.2%) were living at an agency shelter, nine (7.7%) were living at a community hotel, 47 (40.2%) were living at an apartment/house, 11 (9.4%) reported living in another environment, and three (2.6%) reported they preferred not to answer (see Table 1).

The most common DV survivor respondents in this survey were White, heterosexual women with a high school diploma, living at their home or apartment. Importantly, this was not reflective of all DV survivors and may only be reflective of those who obtain services. Although minority groups may be impacted by DV at higher rates, past research has shown that racial minorities are less likely to seek services than White DV survivors (Crowe, 2015; Gerken, 2022; Kulkarni, 2019; Mengo et al., 2022; Sabri et al., 2015; Trevillion et al., 2016). There were similar percentage rates in all categories between large and small agencies.

Chapter 5: Analysis, Interpretation, and Synthesis

This chapter provides an interpretation, analysis, and synthesis of the results addressing the four research questions posed. In this chapter, I discuss patterns among findings and supporting literature, along with the study's limitations and the generalization of findings.

Discussion

Although there were few significant differences among respondents by agency size and locality, some patterns emerged. Across all three data sets I analyzed, there was an overall trend demonstrating that domestic violence (DV) survivors were not receiving mental health services at a level commensurate with their mental health needs. The following section summarizes these results and their implications for each of the four research questions.

Research Question 1: Is There a Difference in DV Survivors' Utilization of Mental Health Services Between Urban and Rural Pennsylvania?

Based on the findings from each of the three data sources, there were no major differences in use of mental health services based on agency location. This could be due to the small sample size for several of the comparisons. Findings from an examination of agency websites revealed none of the agencies provided psychiatric or medication management. From these data, it is apparent DV survivors were likely not receiving adequate treatment at the DV agency level for psychiatric illness, despite there being high rates of posttraumatic stress disorder (PTSD), depression, and anxiety among DV survivors (Coker et al., 2000; Golding, 1999; Lucea et al., 2013; National Coalition Against Domestic Violence, 2023; Pill et al., 2017). The website analysis revealed there

were similar numbers of evidence-based practice providers between urban and rural agencies, and a small number of agencies provided evidence-based behavioral treatments to address some mental health disorders. Most of the agencies that provided counseling provided nonmental health and more immediate crisis counseling. Although these services help to address immediate crises, they are not equivalent to the long-term counseling generally required to address mental health diagnoses and treatments. Apart from one rural agency, all urban and rural agencies provided crisis services. Additionally, fewer than one third of both rural and urban agencies made mental health referrals to outside agencies.

Data from the Lethality Assessment Program (LAP) revealed less than half of all respondents in all areas reported used crisis services. Although there were no significant differences among agency size or location in DV service use, large urban agencies had the most use at 37%, and small rural agencies had the least use at 32%. In short, a majority of DV survivors did not contact police or access DV services.

Findings from the Adequacies of Network of Services Provided to the Survivors of Domestic Violence in Pennsylvania—Phase II study showed of those who responded, slightly more than half (51.4%) reported receiving mental health therapy. If the sample was representative of the greater population, then, as with police and DV service utilization, many survivors were not receiving mental health services.

Research Question 2: Is There a Difference in DV Survivors' Utilization of Mental Health Services Between Large and Small Agencies in Pennsylvania?

The website analysis provided interesting findings and valuable insight into DV survivors mental health utilization. One area that showed statistical significance was the

mention of evidence-based practices for mental health. Significantly more rural agencies identified evidence-based psychiatric service availability on their websites than urban agencies. This difference could be due to larger agencies referring more patients seeking mental health services to other agencies and smaller agencies requiring more comprehensive services due to having less access to resources or connections in the local community. This is an area that should be explored in future research. Although there was a statistical difference in the provision of mental health service availability, it is important to note both the small and large agencies had few website mentions of evidence-based practices to treat diagnoses such as PTSD, depression, and anxiety. Treatment for these mental health conditions might not be provided at the agency level in many DV agencies, and outside mental health agencies might be used for treating these conditions instead. This is an interesting and important finding, as past research has shown many mental health professionals reported having minimal training and feelings of low competence when treating DV survivors (Gauthier & Levendosky, 1996; Honig & Fendell, 2000; Murray & Graves, 2013; Nyame et al., 2013; Rose et al., 2011; Trevillion et al., 2016; Wingfield & Blocker, 1998).

The website analysis revealed no statistical differences between the use of mental health services at large and small agencies. This overall finding was consistent with the finding that less than a third of all websites indicated the agencies provided mental health therapists. The Adequacies of Network of Services Provided to the Survivors of Domestic Violence in Pennsylvania–Phase II study had similar findings with most respondents not receiving mental health counseling coming from large agencies.

More than half of the agencies, both large and small, reported providing some type of counseling, including “empowerment counseling” and “DV counseling.” Future research should examine the availability of mental health professionals with specialized training in treating DV survivors across agency size and locality.

The website analysis also revealed all but one small rural agency mentioned the use of crisis services. The LAP data showed similar rates of crisis service use between small and large agencies. Findings from data from the Adequacies of Network of Services Provided to the Survivors of Domestic Violence in Pennsylvania–Phase II study and LAP were similar with most of the agencies providing crisis services.

Research Question 3: What are the Barriers to Receiving DV and Mental Health Services Based on Locality and Agency Size?

Childcare and transportation were both identified as major barriers for DV survivors in both urban and rural agencies. There were nonsignificant, but slightly higher, percentages of barriers in all categories for those living in rural areas compared to those living in urban areas. This finding was consistent with the existing literature and might be attributed to finances and other resources that are available to those living in more rural areas. Interestingly, the opposite was true when it came to larger agencies. Inconsistent with the current literature, those who received services at larger agencies reported they had slightly higher rates of barriers across the board than respondents receiving services at smaller agencies. Comparing both agency size and locality, the slight differences were not substantive enough to draw any major conclusions. The findings do, however, support the conclusion that at all levels there are major barriers to receiving services for

DV survivors. These barriers include transportation and childcare, perhaps due to large statewide transportation and childcare shortages.

Research Question 4: What are the Differences in Demographic Characteristics of Those Seeking Mental Health Services at DV Agencies Based on Locality and Agency Size?

Although socioeconomic status might not be a factor in DV incident rates, it might be a factor in a survivor's ability to find resources so that obtaining shelter is not necessary. This finding was also consistent with the literature where the average respondent had a high school diploma as their highest level of education. Although education level did not dictate lower income in any single instance, there was evidence that, on average, those with higher educational attainment made more money overall across their lifetime.

Although men and people who identified as LBGTQ participated in this survey, by a large margin, respondents were straight women. This was also reflective of the literature showing women were the predominant users of DV services. According to past literature, women were victims of DV at a higher rate than men, and men were likely to seek services due to social stigmas. Survivors who identified as LBGTQ also may not have sought service due to fears around services not being LBGTQ-affirming. Similar to the other findings, there were no major differences between participation rates at urban and rural agencies across client demographics.

Limitations

There are limitations to this study's generalizability. Although this study was reflective of the participants and services in Pennsylvania at the time it was conducted,

the study needs to be replicated to determine whether these findings will be stable across time and whether they are generalizable to other states and nationally aggregated data.

The second limitation is the relatively small sample size. In all categories, because the response rates were low from some localities, the statistical power to find differences may not have reached significance. Indeed, there were comparisons with relatively large differences that were not statistically significant. Post hoc power analyses confirmed these speculations. Because of the low statistical power, the nonsignificant results for several of the comparisons makes it difficult to have confidence in these result's replication or generalization. This study should be replicated, and future research should increase the sample size to confirm that there are indeed no significant differences among size and location of agencies that serve DV survivors. Despite the small sample size, the nonsignificant findings substantively replicated those of previous studies, adding a measure of confidence in the current results.

Limitations of the Adequacies of Network of Services Provided to the Survivors of Domestic Violence in Pennsylvania–Phase II Study

All the data in this study were derived from secondary sources. Additionally, all secondary data were self-reported. As stated by Thyer (2010), self-report data always pose a risk of being a threat to the validity of the study due to the risk of social-desirability bias. Due to DV and mental health being stigmatized in society, there was a risk that answers would reflect such a bias. Additionally, in some sections of the data, there were missing data due to clients not answering sections. The missing data may have skewed the results.

Another limitation to using secondary data is, although the data provide valid answers to the questions, they do so indirectly, leaving potential gaps in the coherence of the data and more questions that should be answered in future research. The data from this study were collected exclusively from DV survivors across the Commonwealth of Pennsylvania that had already received services. The data do not provide answers from those currently receiving services. Additionally, data did not account for those receiving mental health services at non-DV agencies across the Commonwealth of Pennsylvania.

Limitations of the LAP

The data from the LAP provided a deeper understanding of the rates at which survivors received DV services outside of the agency environment. However, LAP did not query mental health services apart from crisis services. These data alone did not provide full or comprehensive answers to the questions posed and those generated by this study.

Limitations of Website Analysis

Due to the nature of the content analysis, there is a possibility the website analysis data may have been limited as a result of the assumption that if the agency did not mention the provision of a service on the website, it was not offered. These agencies may have been providing services that were not mentioned. Additionally, both the interrater and researcher had a background in treating mental health and with DV survivors and, therefore, may have had different interpretations of the website analysis than DV survivors without this level of education and expertise. It may have been advantageous to have additional interraters without this background to increase the generalizability of the findings.

As previously mentioned, a limitation of this study is the sample size was very small. Only 46 agency websites were available for evaluation. As Rubin and Babbie (2016) stated, the main disadvantage of having the small sample size was it led to higher variability, which, in turn weakened the reliability of the results. Nonetheless, the study examined all agency websites across the state and, therefore, was representative of the population of Pennsylvania DV agencies.

Discussion of the Findings

Previous literature suggested DV survivors suffered from mental health and physical health disabilities at higher rates than the general population (Bell & Goodman, 2001; Devries et al., 2013; Golding, 1999; Goodman et al., 2016; Logan et al., 2002; National Coalition Against Domestic Violence, 2023; Stubbs & Szoeke, 2022; Trevillion et al., 2012). Results from this study showed similar findings with 46% of respondents reporting having a mental health disability. Notably, findings showed there were higher rates of respondents in rural areas who reported having a mental health disability than in urban areas. This could have been due to increased barriers for people living in rural areas including access to services, transportation, and cultural factors. The stigma around DV in rural areas and concerns around a lack of anonymity may have been factors in these findings. The LAP data and Adequacies of the Network of Services Provided to the Survivors of Domestic Violence in Pennsylvania–Phase II study data showed, of those who had police encounters, approximately 3,563 of the DV survivors who went to agencies for services had mental health disorders, and approximately 15,736 of the survivors who had police encounters had mental health disorders and did not obtain services. Therefore, a large portion of the population was not requesting or receiving

these services from the agencies in this study. It was unknown whether that group was receiving mental health services at outside mental health agencies.

Data from the Adequacies of the Network of Services Provided to the Survivors of Domestic Violence in Pennsylvania–Phase II study suggested about half of all respondents received mental health treatment with similar rates across agency locality and agency size. The website analysis, however, differed with only 24% of all agencies indicating they provided mental health therapy. The difference may have been due to survey respondents not understanding whether they were receiving mental health therapy or nonmental health counseling services. Additionally, this could have been because agency websites were not accurately portraying the services offered. The website analysis found only 20% of all agencies mentioned the use of evidence-based medical practices. That data could indicate many of the survivors were not receiving treatment for their mental health disorders and, therefore, would need their mental health disorders to be addressed outside of the DV agency at local mental health treatment facilities. For this reason, it is important for mental health providers at non-DV agencies to obtain training in treating those who suffer from DV and co-occurring disorders including depression, anxiety, and PTSD.

Most websites mentioned use of nonmental health counseling, including terms like “domestic violence counseling” and “empowerment counseling,” which websites stated were used to help empower DV survivors to make changes and for crisis stabilization. Many of the agencies reported using peer supports and nonmental health counselors to engage in these interventions. Although these interventions may have

decreased diagnoses and incidence of such treatable disorders as depression, anxiety, and PTSD symptoms, they were not evidence-based treatments for treating these disorders.

All agencies, apart from two small, rural agencies, had crisis services. This was consistent across all data sources and was consistent with the literature. The findings from this study showed most DV survivors who sought services had contact with the crisis hotline. This was their main portal for obtaining additional access and services. The crisis hotline was often the first entry point for ensuring that those with mental health disabilities obtained referrals for mental health treatment at the agency-level or at community-based agencies. Findings also showed, of those who received services, the majority found the services were adequate.

Findings from the Adequacies of the Network of Services Provided to the Survivors of Domestic Violence in Pennsylvania–Phase II study showed there were three main barriers to DV survivors receiving services. The first barrier was transportation. This was a barrier across all agency localities (i.e., urban and rural) and sizes (i.e., small and large). Past literature has shown that transportation can be a major barrier to DV survivors obtaining services in rural areas (Hanley & MacPhail, 2023; Owen & Carrington, 2015). This study expanded that finding and demonstrated that it was true in both rural and urban agencies. Additionally, across all agency types, childcare was listed as a major barrier for DV survivors which corroborated past research (Archer-Kuhn et al., 2023; Maguire-Jack et al., 2022). For women to be able to obtain employment and be able to access services of all types, affordable childcare was a necessity.

The last major barrier that was reported across all agency types was awareness of services. If people do not know about the service, then they will not actively try to obtain

them. Unfortunately, the website analysis showed most websites were unclear, and it was challenging to find needed information about mental health services provided. By prompting interagency collaborations and increased advertising, women will be able to access the needed services.

Findings showed special considerations for certain populations. Most of those who received services who identified as LBGTQ received DV services from rural agencies. This finding was surprising, as most often it was hypothesized that those who are from minority groups obtained services from urban agencies. Additionally, most of those from the LGBTQ community reported coming from large agencies. This might have been due to more service availability specific to LGBTQ individuals at large agencies than at small agencies. Additionally, although many of the agencies were in rural counties, they might have been in more urban parts of that counties and, therefore, attracted higher numbers of LGBTQ individuals. Additionally, there were more men who received DV services at rural agencies. Similar to past findings, more racial minority groups received services at both small and large urban than at rural agencies. This was most likely due to racial minority groups being concentrated in urban areas. Nonetheless, there were racial minorities in rural areas that responded to the survey. It is important for both urban and rural agencies to be culturally competent to provide services to minority groups at these agencies.

Summary

In summary, I used secondary data in the form of surveys about DV users and inspection of websites to help me understand mental health service use across the Commonwealth of Pennsylvania. There were some areas of statistical significance,

including the use of evidence-based practices when comparing small and large agencies. Although many of the findings did not reach statistical significance between groups, the results overall provided important insight into the mental health services being provided at the agency level. The overarching themes that emerged were (a) many DV agencies were not providing mental health services to DV survivors at the agency level and (b) there were specific barriers to service use, perhaps due to the social stigma connected to the receiving of services. The next chapter explores recommendations for future research and expands upon these topics.

Chapter 6: Conclusions and Recommendations

This study explored the mental health service use of domestic violence (DV) survivors across the Commonwealth of Pennsylvania by examining the differences in use of mental health services by DV survivors by agency locality and size and the barriers to accessing those services. The purpose of the study was to help build a more comprehensive understanding of these issues to inform policy, practice, and training. The larger goal was to provide a deeper understanding of service use to better help DV survivors and the mental health professionals who provide services to them.

Recommendations for Future Research

In this section, I discuss this study's implications for social work practice, policy, leadership, and education. I also discuss some of the implications this study has for future research.

Implications for Social Work Practice

An important implication of the results of this study for social work practitioners and health personnel working in social service agencies is the need to screen all DV survivors for a mental health diagnosis when they come to the agency seeking DV services. Awareness of this increased risk of mental health disabilities and the need for mental health treatment among DV survivors is critical to finding ways to keep them safe. Social workers need to provide survivors seeking services with appropriate safety planning services and referral information. Additionally, due to the high rates of women with mental health disorders having experienced DV, survivors should be screened for mental health disorders, especially those seeking services at non-DV agencies that provide mental health treatment.

The survivors in this study reported childcare, transportation, and awareness of services were the main barriers to both obtaining services and employment. As a result, to increase DV survivors' ability to become healthy and more self-reliant, there should be increased efforts to help supply survivors with regularly available transportation and affordable childcare. Increased effort should be placed into advertising and expanding community awareness of services.

Implications for Social Policy

To advocate for new policies and to amend existing policies, it is important for social workers to be cognizant about DV laws and policies. Social workers should keep in mind acts such as the Violence Against Women Act that provide funding to DV agencies. The high rates of individuals with mental health disorders receiving DV services can justify the application for these funds. Increased funding from such funding sources can be used to help train mental health professionals and increase the use of evidence-based treatments. As a result, it is imperative for social workers to be aware of these public policies and to advocate for the welfare of their clients who have mental health disabilities.

Implications for Social Work Education

The findings from this research emphasize the importance of teaching social work students and mental health professionals about the cooccurrence DV and mental health diagnoses. It is important for social work educators to develop curriculum and teaching models that expose social work students to better understanding DV to increase professional competence and confidence. This study also provided important evidence for agencies to advocate for increased funding to go toward training inhouse and outside

mental health providers in their local communities. Such funding will increase the continuity of care and interagency collaboration.

Implications for Social Work Leadership

The findings from this research could help guide leadership to advocate for changes in policy by enhancing knowledge of the factors that impact service use, along with overall service availability. Leaders can use these findings to help determine how they want to allocate the funding of services. By enhancing knowledge of the factors that impact mental health service use, DV agency leaders and staff will be better equipped to meet the needs of their clientele. Additionally, this research could help to provide leaders in the social work field with greater understanding of some of the cultural implications which may impact client service utilization and quality of care. Understanding client demographics and barriers to obtaining services will enhance leaders' cultural competency and, in turn, help leaders to provide quality care and engage in informed decision making.

Implications for Future Research

There are several important implications for social work research from the findings of the present study. Given the limitation of a relatively small sample size for many of the comparisons, future studies should obtain larger sample sizes by collecting data from more agencies located across the United States. This would improve the generalizability of the findings. Further research studies are needed to assess mental health agencies' and DV survivors' use of mental health treatment. Future research should also be done to increase understanding around ways to address previously

identified barriers to receiving services, including transportation, affordable childcare, and awareness of services.

Additionally, there should be increased research on the creation of websites that are more user friendly for those who are in crisis. Many people used websites as their first contact with the agency to understand service availability. By creating more user-friendly websites that are clear to understand, DV survivors may feel more empowered to use those services. This would include exploring usability, using a common language, and ensuring DV survivors understand what they learn from the website content versus what is provided by a mental health professional. Website analysis in the mental health and DV fields can be used better to understand human behavior in general.

Future research would also benefit from a deeper look into how many DV survivors are receiving mental health therapy at mental health agencies in both rural and urban areas to determine if the gaps identified in this study are being fulfilled. Additionally, a more in-depth look into whether DV survivors are receiving mental health treatment from mental health professionals outside of the DV agencies would be imperative in answering this question.

For this study, the level of lethality among DV survivors was not examined. It would be beneficial for future research to include this when answering questions about service use. Rankings of lethality levels are accounted for within the Lethality Assessment Program (LAP) dataset.

Finally, additional research should be conducted to increase the understanding of barriers to receiving services for racial minorities, LGBTQ, and men when trying to access mental health services for DV. Other groups including immigrants and those with

various physical and mental health challenges and disabilities should be studied more fully to determine their utilization rates of mental health services for DV and to address any possible barriers or inadequacies within the current system.

Conclusions

The findings from this study revealed there were few differences between large and small agency sizes or between urban and rural localities. The findings indicated there were gaps in DV survivors' attainment of mental health services. If DV agencies are unable to provide evidence-based mental health treatment for mental health disorders, increased funding used for access and training for those who are working in mental health agencies to increase cultural and professional competence are imperative. Teaching mental health clinicians about DV from a feminist and ecological perspective could help to increase feelings of competence in those who are providing long-term treatment. Additionally, smaller and more rural agencies could benefit from increased help addressing access to services by removing childcare and transportation barriers.

This study added to the knowledge base of the relationship between DV and mental health as it relates to service utilization. This study found most of the DV survivors had a mental health disability but may not have been receiving treatment at the DV agency level to address these disorders. Additionally, most services received were nonmental health services. These disheartening findings challenge service providers and policy makers alike to address the critical relationship between mental health and DV. This challenge must be met at the DV agency level. This research has implications for social work education policy, practice, and research.

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Appendix A

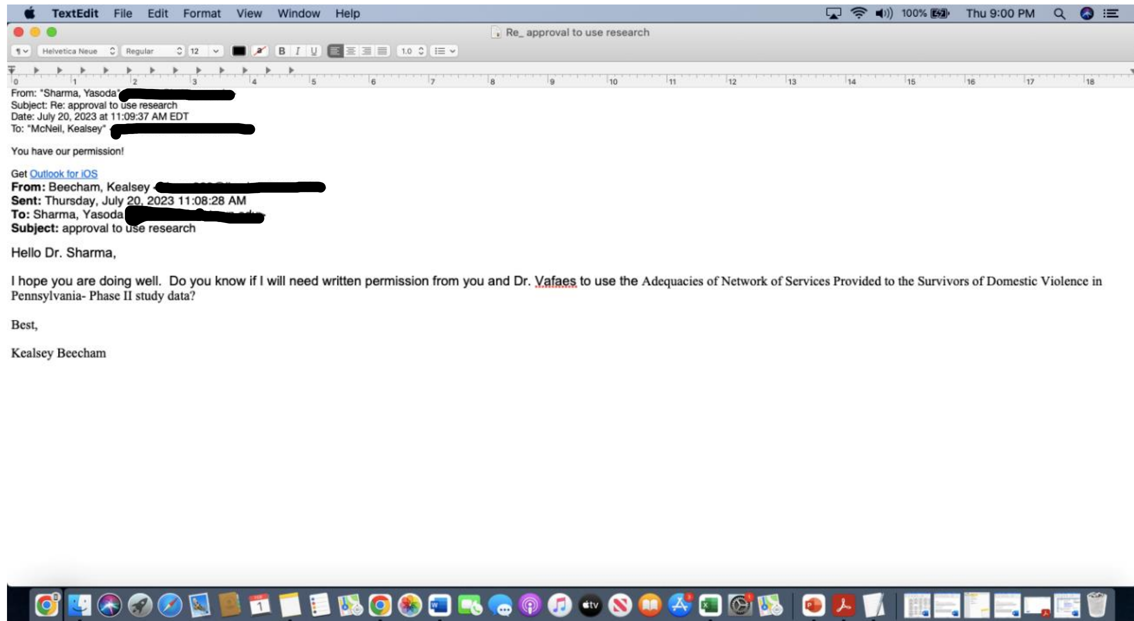
Definitions of Key Terminology

Domestic violence–Domestic violence (DV) was defined as a pattern of abusive behavior where one intimate partner had control or power over the others. This can be sexual, physical, emotional, psychological, economic, threats, or technological action. It included any behavior which was intended to manipulate, intimidate, frighten, isolate, threaten, blame, coerce, hurt, wound, or injure another person (U.S. Department of Justice, 2022).

Mental health service–According to the American Psychological Association (2023), mental health services included "any interventions—assessment, diagnosis, treatment, or counseling" (p. 1). Under the umbrella of mental health services, DV agencies often included crisis services, mental health counseling, group therapy, peer support groups, substance abuse treatment, and safety planning in individual, family, and group settings.

Utilization–According to the Oxford Learners Dictionary (2023), utilization can be defined as "the act of using something for a practical purpose." In the context of this study, utilization was used in terms of social determinants of health, which included factors that impact the need for care, the propensity to use services, and the barriers that impact service use (National Academies of Sciences et al., 2018).

Appendix B



From: "Sharma, Yasoda"
Subject: Re: approval to use research
Date: July 20, 2023 at 11:09:37 AM EDT
To: "McNeil, Kealsey"

You have our permission!

Get Outlook for iOS
From: Beecham, Kealsey
Sent: Thursday, July 20, 2023 11:08:28 AM
To: Sharma, Yasoda
Subject: approval to use research

Hello Dr. Sharma,

I hope you are doing well. Do you know if I will need written permission from you and Dr. Vafaes to use the Adequacies of Network of Services Provided to the Survivors of Domestic Violence in Pennsylvania- Phase II study data?

Best,

Kealsey Beecham

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Appendix C

INSTITUTIONAL REVIEW BOARD
110 Old Main, PO Box 730, Kutztown, PA 19530
(484)-646-4167

DATE:	October 2, 2023
TO:	Kealsey McNeil Dr. Yosada Sharma Department of Social Work
FROM:	Jeffrey Werner, Chairperson Institutional Review Board
STUDY TITLE:	Comparison of the Utilization of Mental Health Services in Rural and Urban Domestic Violence Agencies in Pennsylvania
IRB NUMBER:	IRB07092023
SUBMISSION TYPE:	Initial Application
REVIEW TYPE:	Exempt
EXEMPT CATEGORY:	4
ACTION:	Approved
APPROVAL DATE:	October 2, 2023

The Kutztown University IRB has approved the initial application for your research study. Your research study has been assigned the IRB Number 07092023. This number must be referred to in any future communications with the IRB.

In addition, the following language must be added to the consent form, "This research has been approved by the Kutztown University IRB – approval #07092023."

Research approved as Exempt will have no expiration date. However, any revisions/changes to the research protocol affecting human subjects may affect the original determination of exemption and therefore must be submitted for review and subsequent determination.