The Impact of COVID-19 Restrictions on Victim Advocacy Agency Utilization Across Pennsylvania

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Abstract
This brief report highlights the impact of the COVID-19 restrictions on the utilization of Victim Advocacy Agencies’ (VAAs’) services across Pennsylvania, using VAA utilization data from 2019–2020. VAA utilization data in this report were collected from 2019–2020 by the Pennsylvania Coalition Against Rape (PCAR). VAA utilization data were anchored to COVID-19 restriction timelines, defined by the Pennsylvania Office of the Governor. For each month, a percent change in VAA utilization (e.g., Jan 2020 utilization compared to Jan 2019 utilization) was calculated. A one-way ANOVA was run to assess whether the association between restriction phase and percent change in overall VAA utilization from 2019 to 2020 was statistically significant. A substantial decrease in VAA utilization was observed once lockdown restrictions were enacted, as well as a sustained decrease in utilization between 2019 and 2020. When restrictions were eased, an increase in service utilization was noted. This pattern of findings held for the three variables assessed: hotline utilization, new client, and medical accompaniments for FRES per month. The one-way ANOVA confirmed a statistically significant decrease in overall VAA utilization when comparing the most severe COVID-19 related restrictions to both pre-COVID and less severe restrictions. A variety of barriers (e.g., financial instability, loss of childcare, technology access, chronic physical proximity to abuser, hospital visitation restrictions, fears of contracting the virus) may result in decreased utilization of VAA services. Future research should investigate the relevance of potential causal mechanisms behind VAA utilization to help inform intervention approaches.

Keywords COVID-19 · Sexual assault · Domestic violence · Victim advocacy · Utilization of care

Introduction
In March 2020, many countries enacted lockdown measures to slow the spread of COVID-19. While necessary to curb illness and death, the repercussions of these measures resulted in stress, financial instability, and limited resources, all of which can increase risk for violence in the home (Jarnoecke & Flanagan, 2020). Early data has confirmed that interpersonal violence including sexual assault and domestic violence, has increased during the COVID-19 pandemic (Campbell, 2020; Gosangi et al., 2020). This brief report focuses on another potential consequence of lockdowns: decreased utilization of victim advocacy services for victims of interpersonal violence.

Victim advocacy agencies (VAA) that provide support to victims of sexual assault and domestic violence offer services such as counseling, legal and medical advocacy, shelter, and connection to community resources. Having support following interpersonal violence can lead to positive healing trajectories for victims (Howard et al., 2003; Sylaska & Edwards, 2014; Trabold et al., 2020; Ullman, 1996). Agencies also support 24/7 crisis hotlines which can be a first point of contact between victim and VAA. Hotlines provide crisis counseling and connection to advocacy services.

Many VAAs that traditionally provide face-to-face services shifted to remote or telehealth services once COVID-19 lockdown measures were enacted. These changes had the potential to either increase or decrease utilization of VAA during the
lockdowns. Service utilization could increase through tel- 
ehalth by decreasing barriers associated with travel (Fryer et al., 2020). Alternatively, concerns about privacy when the 
abuser resides with the victim, or hospital policies limiting 
victim advocates’ ability to accompany sexual assault victims 
during examinations, may result in decreased service utiliza-
tion (Barbara et al., 2020; Jarnecke & Flanagan, 2020).

Limited evidence from Europe has reported decreased 
utilization of VAAs during the initial lockdowns (Bar-
bara et al., 2020). The United States has reported mixed 
results for domestic violence-related police and hotline calls 
through April 2020, with some cities showing call-related 
signals of increased domestic violence concerns and others 
seeing no change or decreases in domestic violence-related 
calls (Lee, 2020; Tolan, 2020). Sexual Assault Nurse Exam-
iners (SANEs), nurses trained to provide Forensic Rape Exams (FRE), have reported decreases in FREs performed 
during the lockdown periods of March and April 2020 
compared to the year prior (Stahl, 2020). It is important to 
understand how VAA utilization is impacted by pandemic-
related restrictions so solutions can be developed to prevent 
decreased access or utilization of services when measures 
must be taken that limit face-to-face interaction. The pur-
pose of this brief report is to highlight the impact of the 
COVID-19 restrictions on the utilization of VAAs across 
Pennsylvania using VAA utilization data from 2019–2020.

Methods

Data in this report were collected from 2019–2020 by the 
Pennsylvania Coalition Against Rape (PCAR). PCAR pro-
vides funding, training, and support for VAAs that serve 
those who experience sexual assault across the Common-
wealth of Pennsylvania. PCAR-supported VAAs are either 
sexual-assault specific agencies or dual agencies; those that 
serve individuals who experience sexual assault and/or 
domestic violence. VAAs that only serve victims of domes-
tic violence are not affiliated with PCAR and therefore were 
not included in this study. PCAR collects aggregate, de-
dentified data from its affiliated agencies to examine service 
utilization. As these data are aggregate and not identifiable, 
PCAR was able to provide the authors with 2019–2020 uti-
лизation data to analyze the impact of COVID-19 on VAA 
utilization. Analysis of these data were deemed exempt by 
the university’s Institutional Review Board.

Data Collection

Victim Advocacy Agencies

Data were collected from the 49 VAAs that cover all 67 
counties in Pennsylvania for sexual assault-related services.

Of those centers, 33 are considered “dual centers”, provid-
ing services to both victims of domestic violence and sexual 
assault. Data from the dual centers included data from indi-
viduals experiencing sexual assault and/or domestic violence 
whereas the sexual assault-specific agencies provide data 
from individuals experiencing sexual assault.

Variables

Utilization

The number of hotline calls per month includes number of 
unique calls to each VAA’s crisis hotline per month. The 
number of new clients per month includes all clients receiv-
ing services for the first time at a VAA. A client is any child 
or adult victim as well as any family members who receive 
services. Number of FREs per month includes when a vic-
tim advocate joins a victim at the hospital and a FRE is 
performed.

COVID-19 Restrictions

Timelines of COVID-related restrictions were defined by 
the Pennsylvania Office of the Governor (Commonwealth 
of Pennsylvania, 2020). Counties transitioned into phases at 
differing time points depending on levels of virus transmis-
sion. The restrictions were defined in phases: Red, Yellow, 
Green, and Targeted Restrictions. The Red Phase was the 
most restrictive with stay-at-home orders in place, followed 
by the Yellow Phase which included aggressive mitigation 
but allowed schools and certain business to open at reduced 
capacity. The Green Phase was the least restrictive, allow-
ning for greater capacity for gatherings and an increase in the 
types of businesses that could open, although at reduced 
capacity. The Targeted Restrictions were in response to a 
Fall surge in COVID-19 cases and were focused on school 
closures in areas with high COVID-19 transmission, limit-
ing travel, and mandating teleworking in all circumstances 
where possible. Table 1 provides detailed definitions and 
time frames for each restriction level.

Analysis

Percent change was calculated between months during the 
initial COVID-19 restrictions and between corresponding 
months for 2019 and 2020 (i.e., June 2019 and June 2020). 
Of note, annually on July 1st, PCAR reclassifies all continu-
ing clients as new clients. Thus, the July 2019 and 2020 new 
client data is inflated with both continuing clients and new 
clients.
A one-way ANOVA with two levels on the independent variable (restriction phase: Pre-COVID/Green/Targeted, Red/Yellow) was conducted to examine percent change in utilization from 2019 to 2020. There were a limited amount of data represented by this dataset as there were only 36 datapoints representing percent change for each month (e.g., Jan 2020 hotline calls compared to Jan 2019 hotline calls) across the three types of VAA utilization (i.e., hotline calls, new clients, medical accompaniments for FREs per month). Therefore, a decision was made to collapse Pre-COVID, Green Phase, and Targeted Restriction Phases of the pandemic into one group, and Red Phase and Yellow Phase into another group. Functionally, phases of the pandemic were dichotomized into least restrictive (e.g., Pre-COVID/Green Phase/Targeted Restrictions Phases) and most restrictive (e.g., Red/Yellow Phases) and compare the percent change in utilization of Victim Advocacy Agencies’ (VAAs’) services from 2019 to 2020 across these two levels of restrictions. In addition to dichotomizing the restriction phase, we collapsed data across hotline calls, medical accompaniments, and new client percent change values to create an overall utilization value to provide more stable statistical estimates of association.

### Results

Findings represent data from the 49 VAAs across Pennsylvania from 2019 to 2020. Figure 1 represents the number of hotline calls per month. There was a 37% drop in calls from March to April 2020 when restrictions began. During April and May 2020 hotline utilization was 30% and 36% lower than April and May 2019, respectively. As restrictions eased in June 2020, hotline utilization increased 34%, with only 10% fewer calls compared to June 2019. The average number of hotline calls per month in 2020 across all months was 7% lower than 2019 levels. Similar findings were noted for the number of new clients per month (see Fig. 2); the number of new clients dropped 58% from March to April 2020. The number of new clients per month were 33%, 72%, and 62% lower compared to the corresponding 2019 months of March, April, and May, respectively. While new clients increased by 54% in June 2020, utilization was still 31% lower compared to June 2019. The average number of new clients per month across all months in 2020 was 23% lower than 2019 levels. Figure 3 represents the number of medical accompaniments for FREs per month. There was a 50% drop
in medical accompaniments from March to April 2020. Medical accompaniments for FREs in March, April, and May 2020 were 57%, 83%, and 79% lower compared to their corresponding months in 2019, respectively. While medical accompaniments increased by 63% in June 2020, they were still 54% lower than in June 2019. The average number of medical accompaniments for FREs across all months in 2020 was 47% lower than 2019 levels.

Results of the one-way ANOVA revealed a significant effect of restriction phase on percent change in overall utilization of VAA services from 2019 to 2020, $F(1, 34) = 6.59$, $p < 0.001$, $\eta^2 = 0.36$, with larger percent changes from 2019 to 2020 during Red and Yellow Phase restrictions ($M(SD) = -60.33$ (22.42)) than pre-COVID, Green Phase, and Targeted Restrictions Phases ($M(SD) = -14.60$ (23.41)).

Discussion

To our knowledge, this is the first study to examine VAA utilization throughout the COVID-19 pandemic in the U.S. The findings reveal a statistically significant decrease in VAA utilization that corresponds to the initiation of the most severe lockdown restrictions (i.e., Red and Yellow Phases) between 2019 and 2020. The difference in utilization during the Red and Yellow Phase restrictions between 2019 and 2020 is troubling, as decreased utilization does not necessarily reflect decreased violence (Gosangi et al., 2020). Early COVID-19 data shows that interpersonal violence is still occurring (Campbell, 2020; Gosangi et al., 2020; Lee, 2020; Tolan, 2020). Increased injuries due to interpersonal violence have been seen during the pandemic compared to interpersonal violence related injuries in 2019 (Gosangi et al., 2020). Given the prevalence of interpersonal violence during COVID-19, the deviation in service utilization seen in this study is likely associated with additional and substantial barriers to seeking and accessing care during COVID-19.

Fear of leaving the home or pandemic-related stress such as financial instability, health concerns, and loss of childcare, can make it challenging to prioritize accessing help. While VAAs offer services through phone or video, those needing help may not have the technology required to receive that care (Saunders, 2020). Many victims of violence live with...
their abuser, making it hard to find safe space or time away from an abuser to receive phone counseling. Hospital visitor restrictions can prevent advocates from providing accom-paniment during FREs. Fear of contracting COVID-19 may prevent victims from seeking care at hospitals. Across the U.S. there was a 42% drop in overall Emergency Department visits from March to April 2020 compared to March to April 2019 (Hartnett et al., 2020).

The percentage change between 2019 and 2020 during Green and Targeted Restriction Phases were smaller in magnitude compared to the change during Red and Yellow Phases. This may reflect the notion that individuals and systems (e.g., survivors, hospitals, and advocates) began to adjust to new ways of operating in a world of COVID-19-related restrictions. Research is needed to understand factors that drive decreased utilization of VAAs in a pandemic, especially as rates of violence are stable, if not increased (Campbell, 2020; Gosangi et al., 2020). By understanding these factors, system changes, such as ensuring equitable access to telehealth platforms for VAAs and their clients or increased funding for VAAs to offer a robust 24/7 counseling and advocacy response, can be implemented when public health or other restrictions in utilization occur. In situations where a victim is isolated at home with an abuser, developing a safety plan on how to reach the victim (e.g., identifying the best time or method to reach a victim, storing the contact as a non-descript name on your phone, have a trusted friend relay messages to the victim from the VAA) or utilizing text message-based counseling may decrease some barriers. Because lockdown measures have varied throughout the pandemic, a continued analysis of VAA data paired with COVID-19 epidemiologic data can provide a more nuanced understanding of how rising or falling COVID-19 case counts and tightening or easing of restrictions may impact victim advocacy utilization.

A few limitations of this study are worth noting. The first is a potential problem endemic to many administrative databases; namely, the variability in the quality of the data collected across a variety of different agencies. There is reason, however, to expect that these data are reliable, given the fluctuation observed from month-to-month both pre- and post-COVID, as well as the fact that these data are utilized by the governing body (i.e., PCAR) to determine funding allocations to VAAs, leaving a standing incentive
to accurately report the data. Another limitation is that this study was not able to include data from stand-alone domestic violence agencies, which prevented a more complete picture of utilization for those experiencing interpersonal violence. Including PCAR data with singular domestic violence agencies and comparing to other states that had differing levels of virus circulation and restrictions would allow for enhanced understanding of the impact of COVID-19 cases and mitigation efforts on VAA utilization.

Purposeful funding for VAAs is needed to support the promotion of effective methods to reach victims of violence during restrictions in the provision of care. Funding could support telehealth, additional staff to create a robust 24/7 response to provide counseling during non-business hours, social media outreach campaigns, or even provide cellphones or wireless internet cards to decrease technology barriers. Encouraging hospitals to access telehealth or develop protocols to safely allow victim advocates to provide accompaniments to FREs can increase victims’ connection to advocacy services. Ongoing communication to victims of violence that services are still available and victim advocates will continue to be a safe space for support is warranted to increase awareness of services. Finally, high-quality multi-faceted data collection on the quality of service-provision through VAAs will further the field’s ability to detect challenges in service-provision and test potential solutions so that VAA services can be continuously accessible to all, especially in future public health emergencies.

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