Published in final edited form as:

Death Stud. 2015 January ; 39(1): 12–18. doi:10.1080/07481187.2013.846949.

Barriers to Care and Service Satisfaction Following Homicide Loss: Associations With Mental Health Outcomes

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Abstract

Homicide survivors are at increased risk for mental health problems, including depression, posttraumatic stress disorder, and complicated grief. Therefore, improving access to community and mental health resources is critical for this population. The authors sought to examine barriers to accessing services and service satisfaction among 47 homicide survivors. Over half of the sample met criteria for a mental disorder, with depression being the most prevalent problem. Frequently endorsed barriers to care included financial barriers, inadequate information, and health-related problems. However, participants who engaged in services were generally satisfied with those services. Only depression was uniquely associated with worse overall service satisfaction.

Losing a loved one to a violent death is often a devastating experience for the deceased's family and friends, and this devastation may have a rippling effect throughout the larger community in which the death occurred. According to the Centers for Disease Control and Prevention (CDC), nearly 54,000 violent deaths occur annually in the United States resulting in more than \$52 billion in direct and indirect costs associated with medical care and lost productivity (CDC, 2013). Each year, homicide accounts for approximately 17,000 of these violent deaths, but the community and economic impact of homicide loss undoubtedly extends far beyond the direct and indirect costs incurred by each individual death. Although there are no estimates available regarding the economic burden of homicide bereavement, family and close friends of the deceased, here referred to as survivors, likely accrue more medical costs and experience more lost productivity in the years following the homicide given the high rates of poor mental health outcomes associated with homicide loss.

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Specifically, homicide survivors are at increased risk for depression, posttraumatic stress disorder (PTSD), and complicated, or prolonged, grief (Amick-McMullen, Kilpatrick, & Resnick, 1991; Currier, Holland, Coleman, & Neimeyer, 2007; McDevitt-Murphy, Neimeyer, Burke, Williams, & Lawson, 2012; Rheingold, Zinzow, Hawkins, Saunders, & Kilpatrick, 2012; Thompson, Norris, & Ruback, 1998; Zinzow, Rheingold, Hawkins, Saunders, & Kilpatrick, 2009). Although depression, PTSD, and complicated grief (CG) share several features, including loss of interest in activities and feelings of guilt, CG is unique from depression and PTSD in that CG involves sadness that is generally specific to missing the deceased loved one (whereas depression typically involves pervasive sadness) and, unlike PTSD, the primary emotion in CG is sadness rather than fear (Shear, Frank, Houck, & Reynolds, 2005). The adverse economic impact of depression and PTSD due to lost productivity has been well documented (e.g., DuPont et al., 1996; Greenberg et al., 2003), and a growing body of literature suggests that CG is associated with impaired work and social functioning (e.g., Shear et al., 2011). Together, these studies underscore the need to link survivors to community and mental health resources in the wake of homicide in an effort to help survivors not only navigate the challenges associated with acute grief but also aid in preventing long-term consequences associated with poor, bereavement-related mental health outcomes.

Helping survivors engage in various community and mental health resources may act as a buffer against the development of poor mental health outcomes and help promote recovery from mental health problems. Moreover, engagement in community and mental health resources may help facilitate reconnection with personally meaningful activities. Even so, homicide survivors will likely find different resources helpful at different times during the bereavement process. For example, in the weeks and months following a homicide, survivors may benefit from having contact with victim advocates or intensive case management to help link family members to additional resources (e.g., financial entitlements to help pay for crime-related expenses) more so than mental health treatment (e.g., Kelly, Merrill, Shumway, Alvidrez, & Boccelli, 2010; Raphael, Stevens, & Dunsmore, 2006).

There are, however, a number of potential barriers that may prevent homicide survivors from engaging in services. Only a small percentage of survivors may actually use any available services (e.g., Rynearson, 1995), and the cost of interventions, availability of information, and how interventions are offered (e.g., group vs. individual treatment) may all impact survivors' ability and willingness to engage in services (Raphael et al., 2006). Although states are allocated federal funds to provide victims assistance and victims compensation that may help mitigate some of these financial barriers, the application process is often nebulous, and survivors may not be aware that such programs even exist (e.g., Kelly et al., 2010). Survivors living in rural areas may also face additional barriers, including having to travel long distances to access specialized services. Although clinicians and policy makers acknowledge that many of these barriers exist, little is known about the extent to which homicide survivors are likely to encounter different barriers to care.

Even less is known about survivors' satisfaction with the services they receive. Satisfaction with services is likely an important predictor of staying engaged in services and may help providers working with survivors determine whether services being offered are perceived as

helpful. Assessing satisfaction with services may also help indicate the extent to which services are perceived as taxing by survivors. In a sample of 150 family members of homicide victims, Thompson, Norris, and Ruback (1996) found that survivors were generally very dissatisfied with their interactions in the criminal justice system, interactions that can be highly stressful in the context of ongoing criminal investigations and legal proceedings. However, it is not clear whether survivors may be similarly dissatisfied with other services, such as victim advocate and intensive case management services and mental health services. Satisfaction with services may also vary as a function of mental health outcomes. For example, in a sample of 181 urban mental health outpatients, patients with PTSD were generally less satisfied with mental health services than patients without a PTSD diagnosis (Switzer et al., 1999). Thus, better understanding the contribution of bereavement-related psychopathology to survivors' satisfaction with services may better inform how to tailor those services to meet the needs of survivors presenting with mental health problems.

Therefore, a goal of the current study is to explore perceived barriers to care and satisfaction with services among a sample of homicide survivors. An additional goal of this study is to examine whether survivors meeting criteria for different, bereavement-related mental disorders (i.e., depression, PTSD, CG) are more likely to endorse specific barriers to care and report less service satisfaction than survivors without those diagnoses. Lastly, a goal of the current study was to conduct exploratory analyses looking at predictors of overall service satisfaction.

METHOD

Participants

Participants were 47 individuals who lost a loved one to homicide between 2007 and 2009 in the Charleston, SC, tri-county area who agreed to participate in a survey about community resources, access to care, and psychological distress following a homicide loss. The majority of participants were female ($n=37$, 78.7%) and ranged in age from 24 to 74 years ($M=50.84$, $SD=11.11$). Two participants did not report their age. Mean time since the loss was approximately 2 years ($M=25.00$ months, $SD=10.28$). The sample was racially diverse, with most participants identifying as African American ($n=27$, 57.4%) or Caucasian ($n=18$, 38.3%). Of the remaining participants, one identified as Native American (2.1%), and one was missing information regarding racial identity (2.1%). Although nearly a quarter of the sample ($n=11$, 23.4%) did not provide information regarding their annual household income, income level was generally evenly distributed, with 13 (27.7%) participants reporting annual household incomes below \$20,000, 12 (25.5%) reporting household incomes between \$20,000 and \$50,000, and 11 (23.4%) reporting annual household incomes greater than \$50,000.

In terms of participants' relationships to the deceased, most participants ($n=26$, 55.3%) reported that they were parents of the deceased loved one. Other relationship categories represented in the current sample included children ($n=3$, 6.4%), siblings ($n=9$, 19.1%), spouses ($n=3$, 6.4%), a grandparent ($n=1$, 2.1%), and a grandchild ($n=1$, 2.1%) of the homicide victim. A subset of participants reported that they were associated with the same

homicide victim, including one parent and sibling dyad, one parent and spouse dyad, one mother and stepfather dyad, one child and child dyad, and one mother and father dyad.

Measures

Data for the present investigation were collected via a structured telephone survey. Measures included questions about demographic information, structured interviews assessing PTSD and depression, a complicated grief assessment, and questions assessing barriers to care and satisfaction with services. Demographic information, including questions about race and ethnicity, were assessed using standard questions employed by the U.S. Bureau of the Census (1988).

Major Depressive Episode—The presence of a major depressive episode (MDE) was assessed using the National Women's Study (NWS) Depression Module, a structured interview that targets *DSM-IV* MDE criteria (American Psychiatric Association, 2000). However, functional impairment is not assessed. Participants report whether or not they have ever experienced each MDE symptom with a dichotomous yes/no response. A dichotomous variable reflecting whether the participant met criteria for a MDE within the last six months was then derived based on the *DSM-IV* MDE criteria. This module has been used in previous studies examining mental health correlates of interpersonal violence (e.g., Duncan, Saunders, Kilpatrick, Hanson, & Resnick, 1996; Kilpatrick et al., 2003; Saunders, Kilpatrick, Hanson, Resnick, & Walker, 1999) and demonstrated good reliability in the current sample ($\alpha=.75$).

PTSD—PTSD was assessed with a modified version of the NWS PTSD Module (Kilpatrick, Resnick, Saunders, & Best, 1989). Participants are asked whether or not they experienced each PTSD symptom within the past month using dichotomous yes or no response options. This module assesses each *DSM-IV* criterion with the exception of functional impairment (American Psychiatric Association, 2000) and has shown good convergent validity with the Structured Clinical Interview for *DSM-III-R* (Spitzer, Williams, Gibbon, & First, 1990). Items were used to create a dichotomous variable reflecting whether the participant met criteria for PTSD based on the *DSM-IV* diagnostic criteria. The NWS PTSD Module has been used in previous studies assessing the mental health correlates of trauma exposure (e.g., Galea et al., 2002), and demonstrated excellent reliability in the current sample ($\alpha=.89$).

CG—CG was assessed using the Inventory of Complicated Grief (ICG; Prigerson et al., 1995). The ICG assesses several symptoms of complicated grief, including Criterion A symptoms (separation distress), Criterion B symptoms (e.g., difficulty accepting the death, trusting others, experiencing feelings other than numbness, or feeling as though life were meaningless), and Criterion C (functional impairment). Items are scored on a 5-point scale ranging from 1 (*not at all*) to 5 (*overwhelmingly*), and scores can be used to derive an overall symptom severity score or determine whether an individual meets diagnostic criteria for CG. The ICG demonstrated excellent reliability in the current sample ($\alpha=.91$).

Barriers to Care and Service Satisfaction—Several barriers to care were assessed, including lack of insurance, cost of services, transportation, not knowing who to contact, and limitations due to health. Participants were asked an initial prompt question, “Did any of the following make it difficult for you to schedule or keep appointments for yourself or a child?” and were then read a list of potential barriers to care. Participants responded yes or no to whether each barrier was personally relevant. Satisfaction with criminal justice system and mental health/counseling agencies was assessed with the question, “How satisfied were you with the [agency]?” Participants were asked about satisfaction with criminal justice system agencies including the police department, law enforcement victims' advocates, the prosecuting attorney's office, and prosecuting attorney's office victims' advocates. Participants were also asked about satisfaction with mental health agencies, including a pastoral care agency that provides assistance in emergency situations, an academic medical center clinic providing case management and therapy to victims of crime, other adult mental health services, and a local homicide survivors' support group. Overall satisfaction was assessed with the question, “Overall, how satisfied were you with the way the criminal justice system and other agencies treated you and your family?” Satisfaction was assessed on a 4-point scale ranging from 1 (*very satisfied*) to 4 (*very dissatisfied*).

Procedure

Contact information for 162 family members who lost loved ones to homicide between 2007 and 2009 was provided to project staff by local law enforcement victim advocates offices. In all, 182 homicides occurred in the Charleston tri-county area during this 3-year period. Each family member was mailed information about the study, which included contact information if they were interested in participating in the project. Family members with valid telephone contact information were called and invited to participate in the project. Informed consent was obtained via telephone, and, those survivors that agreed to participate completed a 30-min telephone interview assessing multiple domains, including awareness and use of community resources, barriers to accessing services, satisfaction with services, and mental health outcomes (i.e., MDE, PTSD, and CG). Participants received a \$20 gift card for their participation, and all research procedures were approved by the Institutional Review Board's human participant review committee.

Data Analysis

A series of independent samples *t*-tests were used to explore whether homicide survivors meeting criteria for mental disorders including a MDE, PTSD, and CG differ from survivors that do not meet criteria for these disorders in terms of how many barriers to care they endorsed. Chi-square analyses were used to explore whether individuals meeting criteria for different mental disorders were more likely to endorse specific barriers to care than individuals that did not meet criteria for the same disorders. To evaluate whether service satisfaction differs as a function of psychopathology among individuals involved in various community services, a series of independent samples *t*-tests were also used to compare individuals meeting criteria for different mental disorders to those that did not meet criteria for those disorders in terms of mean satisfaction scores. A generalized estimating equation was used to explore the relative contributions of psychopathology and demographic variables (i.e., gender and race) to overall service satisfaction ratings. Because some

participants were associated with the same homicide victim, participants were clustered by association with homicide victims in the equation.

RESULTS

Mental Health Outcomes

More than half of participants in the current study ($n=27$, 57.4%) met criteria for a mental disorder. The most prevalent mental disorder was depression, with nearly half of the sample ($n=23$, 48.9%) meeting criteria for a current MDE. Roughly one-third of the sample met criteria for PTSD ($n=16$, 34.0%), and approximately one-quarter of the sample met criteria for CG ($n=11$, 23.4%). Rates of comorbidity and predictors of mental health outcomes are reported in a separate manuscript (see Rheingold & Williams, 2013).

Barriers to Accessing and Engaging in Services

Of 47 participants in the current study, 94% ($n=44$) provided information regarding perceived barriers to accessing criminal justice system and mental health services. Over half of participants ($n=24$) identified three or more barriers, with participants reporting an average of three barriers ($M=3.59$, $SD=2.80$). The most frequently endorsed barriers were financial barriers, including lack of insurance and the cost of services, not knowing who to contact, and health-related barriers, including feeling too upset and health-related problems. The frequency of endorsement for each barrier is presented in Table 1.

Participants who met criteria for a current MDE reported more barriers to accessing services than participants without a current MDE, $t(42)=-2.23$, $p=.03$. In terms of specific barriers, participants meeting criteria for a current MDE were more likely to endorse not knowing who to contact at different agencies (57.1%) than participants without a current MDE (26.1%), $\chi^2(1)=4.38$, $p=.04$. Participants who met criteria for PTSD did not report more barriers than participants without PTSD, $t(42)=-1.66$, $p=.10$. They were, however, more likely than participants without PTSD to identify their work schedule (50.0% and 10.7%, respectively), $\chi^2(1)=8.38$, $p<.01$; not being able to get time off from work (37.5% and 7.1%, respectively), $\chi^2(1)=6.31$, $p=.01$; and health problems (50.0% and 21.4%, respectively), $\chi^2(1)=3.83$, $p=.05$, as barriers to accessing services. Participants who met criteria for CG did not report more barriers than participants without CG, $t(42)=-.93$, $p>.25$, and were no more likely than participants without CG to endorse specific barriers.

Satisfaction With Services

Although few participants reported that they were not involved in the criminal justice system, the majority of participants reported that they were not involved in mental health or counseling services (see Table 2). However, those participants who were involved in the criminal justice system and/or mental health services generally reported that they were either somewhat or very satisfied with those services. Mean satisfaction scores across four different criminal justice system agencies (i.e., police department, law enforcement victims' advocates, prosecuting attorney's office, and prosecuting attorney's office victims' advocates) were compared among individuals meeting and not meeting criteria for a current MDE, PTSD, and CG. Participants meeting criteria for a current MDE tended to be less

satisfied with the police department ($M=2.68$, $SD=1.04$) than participants that did not meet criteria for a current MDE ($M=2.00$, $SD=1.02$), $t(42)=-2.19$, $p=.03$. No other statistically significant differences emerged in analyses comparing mean criminal justice system satisfaction scores among participants with and without current diagnoses. Because of the small number of participants that reported engaging in mental health services, analyses could not be conducted comparing individuals with and without a current MDE, PTSD, and CG on satisfaction with various mental health services.

Predictors of Overall Service Satisfaction

MDE, PTSD, and CG diagnostic status variables, along with gender and race, were entered as predictors of overall service satisfaction in a generalized estimating equation. Results are presented in Table 3. Meeting criteria for a current MDE was associated with being less satisfied with services. Neither PTSD nor CG was associated with service satisfaction after controlling for depression. Gender was also associated with service satisfaction such that being male was associated with less overall service satisfaction.

DISCUSSION

Homicide loss can take a tremendous toll on survivors, who will likely become involved with and need assistance from a variety of community-based agencies following a homicide-related death. To our knowledge, this is the first study to examine a broad spectrum of perceived barriers to care, service satisfaction, and their associations with mental health outcomes in a sample of homicide survivors. It is notable that one out of every two survivors met criteria for a mental health problem. The rate of MDEs observed in this sample of homicide survivors was much higher than the rate observed among homicidally-bereaved adolescents (Rheingold et al., 2012) but comparable to estimates of depression reported in other adult samples of homicide survivors (e.g., McDevitt-Murphy et al., 2012). On the other hand, the rate of current PTSD observed in this sample was much higher than estimates based on other samples of adult homicide survivors but more consistent with lifetime estimates reflected in studies of adult homicide bereavement (e.g., Amick-McMullen et al., 1991; McDevitt-Murphy et al., 2012). In contrast, the rate of CG observed in this study was lower than rates observed in other studies (e.g., McDevitt-Murphy et al., 2012).

Despite the high prevalence of poor mental health outcomes in this sample, an overwhelming majority of survivors reported that they were not engaged in mental health or counseling services. Commonly endorsed barriers to accessing and engaging in these and criminal justice system services included financial barriers, lack of information regarding services, and health-related barriers. Health-related barriers were more likely to be endorsed by survivors meeting diagnostic criteria for PTSD, which is consistent with research suggesting that PTSD is strongly associated with poor health (e.g., Friedman & Schnurr, 1995). Overall, survivors who were engaged in services were generally satisfied with those services, including services provided by the police department, which stands in contrast to prior research among homicide survivors (Thompson et al., 1996). However, these results suggest that, relative to other forms of bereavement-related mental health problems,

depression may hold a place of prominence in terms of understanding barriers to care and satisfaction with services. Survivors meeting criteria for a current MDE endorsed more barriers to care than survivors without a current MDE, and, when modeled simultaneously with PTSD and CG, meeting criteria for a MDE was uniquely associated with worse overall service satisfaction.

These findings support previous research suggesting that, when modeled with PTSD and CG, depression is uniquely predictive of worse mental health functioning among homicide survivors (Williams, Burke, McDevitt-Murphy, & Neimeyer, 2012). Perhaps survivors with depression are more likely to perceive negative interactions with professional staff at these various agencies given that depression is known to be associated with attentional bias to negative stimuli (e.g., Gotlib, Krasnoperova, Yue, & Joormann, 2004). For instance, in a mixed trauma sample, Williams, McDevitt-Murphy, Fields, Flood, and Weathers (2011) found that those individuals meeting criteria for major depressive disorder were likely to report less trust in health care personnel than well-adjusted individuals that did not meet criteria for any psychiatric disorder, including PTSD. Individuals with PTSD, however, did not differ from their well adjusted peers in terms of trust in health care personnel. So, because of the nature by which depressed individuals may be more likely to attend to negative stimuli in interpersonal interactions, they may be less satisfied with services overall.

In terms of clinical implications, these results underscore the need to help survivors reduce barriers to engaging in services by improving knowledge about how to access services. Indeed, nearly 40% of survivors reported that they did not know who to contact to set up appointments. So, agencies serving homicide survivors may need to expand the availability of information by using novel approaches to reach survivors throughout the community. For example, web-based media may be a useful way to provide information to survivors about resources available in the local community and provide useful information about the course of bereavement after violent loss. Because many survivors will typically have contact with police departments well before they have contact with other community agencies, helping local police departments provide information regarding local services may also help reduce barriers associated with lack of information. Moreover, active outreach to survivors (e.g., attempting to contact survivors and arrange home visits or visits elsewhere in the community) may help reduce the burden on survivors to try and find information about area resources at a time when they are likely experiencing intense emotional pain following the loss (e.g., Aldrich & Kallivayalil, 2013).

Although this study helps address an important gap in the literature on homicide bereavement, notably by examining perceived barriers to accessing services and satisfaction with services received postloss, this study is not without limitations. First, the small sample size may have limited our ability to detect important associations between our variables of interest and limited the analyses that could be performed. Second, there may be important barriers to care that were not assessed in this study. For example, professionals' personal characteristics, including perceived sensitivity and compassion, language, and cultural background may all emerge as (or even reduce) barriers to care (Raphael et al., 2006), and future studies should assess the extent to which to which these variables help or hinder

survivors' attempts to engage in services. Third, less than half of eligible survivors in the Charleston tri-county area actually participated in this study, so the extent to which these results may generalize to other survivors in the area is not clear. More broadly, it is not clear how well these results would generalize to the experiences of homicide survivors outside of an urban environment in the southeastern United States.

To help survivors engage in services and improve satisfaction with those services, future research is needed to better understand the prevalence of different barriers and predictors of service satisfaction in a more nationally representative sample of homicide survivors. Nevertheless, these preliminary results provide encouragement in that those barriers that were identified can potentially be overcome, and most survivors were generally satisfied with those services they received.

Acknowledgments

This research was supported by Grant Number 2009-VF-GX-K009, awarded by the Office for Victims of Crime, Office of Justice Programs, U.S. Department of Justice. The opinions, findings, and conclusions or recommendations expressed in this article are those of the contributors and do not necessarily represent the official position or policies of the U.S. Department of Justice. Preparation of this article was supported by the National Institute of Mental Health Training Grant T32 MH18869-26.

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TABLE 1

Barriers to Accessing Services

Did the following make it difficult to schedule or keep appointments for yourself or a child?	n (%)
No insurance	14 (31.8)
Cost of services	16 (36.4)
Transportation	8 (18.2)
Waitlist	6 (13.6)
Not knowing who to contact	18 (40.9)
Services too far from home	7 (15.9)
Work schedule	11 (25.0)
Didn't think appointment was necessary	8 (18.2)
School schedule	0 (0.0)
Hours clinic was open	7 (15.9)
Could not get time off from work	8 (18.2)
Had questions about the referral but did not know who to ask	11 (25.0)
Feeling too upset	18 (40.9)
Information not provided clearly enough	12 (27.3)
Health got in the way	14 (31.8)
Illness	5 (11.4)
Alcohol or drugs	1 (2.3)
Pain	2 (4.5)
Fatigue	2 (4.5)
Mental health	4 (9.1)

Note: n = 44 for all analyses.

TABLE 2

Satisfaction With Services

Service	Mean satisfaction rating M (SD)	Not involved with agency n (%)
Police department	2.34 (1.08)	0 (0.0)
Law enforcement victims' advocates	1.45 (.75)	12 (26.7)
Prosecuting attorney's office	2.22 (1.27)	7 (16.3)
Prosecuting attorney's office victims' advocates	1.56 (.98)	10 (23.8)
Local chaplaincy crisis service	2.43 (.98)	35 (83.3)
Local victims of crime intensive case management services	1.55 (1.04)	30 (73.2)
Local victims of crime specialty mental health clinic	1.90 (1.10)	31 (75.6)
Adult mental health services	1.25 (.46)	33 (80.5)
Homicide survivors support group	1.54 (.66)	26 (66.7)

Note: Valid *ns* for analyses range from 39 to 45. Satisfaction ratings were only obtained from individuals that reported using services.

TABLE 3

Generalized Estimating Equation With Mental Health Outcomes Predicting Overall Service Satisfaction

Variable	B	SE	Wald χ^2	95% CI
PTSD	-.01	.39	.00	-.78, .75
Depression	.86	.26	10.99**	.35, 1.37
CG	.09	.24	.13	-.39, .56
Gender	-.91	.23	15.35**	-1.36, -.45
Race	.39	.33	1.38	-1.03, .26

Note: Because all but one participant with valid information regarding race reported being either Caucasian or African American, the race variable was collapsed in to a dichotomous variable representing Caucasian survivors and racial minority survivors. PTSD = post-traumatic stress disorder; CI = confidence interval.

*
 $p < .05$.

**
 $p < .01$.