50,000 PEOPLE A DAY: FEDERALLY FUNDED INTIMATE PARTNER VIOLENCE SERVICE PROVISION IN AMERICA

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Abstract

Intimate partner violence is a serious and preventable health problem affecting more than 30 million Americans each year. We use an innovative new research design to describe the frequency and correlates of emergency and crisis intervention services provided by domestic violence programs using safe, non-invasive collection methods. During the 24-hour survey period, 48,350 individuals used the services of primary purpose domestic violence programs, corresponding to a population rate of 16 per 100,000 people. Of these individuals, 14,518 required emergency shelter, 7,989 required transitional housing and 25,843 were provided with non-residential services. Seven times more individuals are served by domestic violence programs than are served in emergency rooms in the US on an average day. The results show unmet demand for services provided by domestic violence programs with 10 percent victims (5,183 requests) seeking services at a domestic violence provider unable to be served daily due to resource constraints. Although DV costs $5.8 billion annually, 70% of which is spent on medical costs, the government only spends $126 million annually. Thus greater funding of domestic violence programs is likely to be a cost-effective investment.

The Senate Judiciary Committee's 1992 report, "Violence Against Women: A Week in the Life of American Women" was a historic event in recognizing the pervasive nature of domestic violence, dating violence, sexual assault, and stalking. That report graphically described 200 incidents of violence that occurred in just one week. Since then, intimate partner violence (IPV)[2] has been recognized by the U.S. Centers for Disease Control (CDC), American Medical Association (AMA), and health care providers as a major public health problem affecting more than 32 million Americans (Tjaden and Thoennes, 2000).[3,4,5] Although fifteen years have passed since the federal recognition of domestic violence, nearly one in four women experiences at least one physical assault by a partner during adulthood.[6] In part this may be because while federal efforts have increased awareness of domestic violence as a serious crime, there has been only limited willingness to treat domestic violence as a public health issue.[7]

Bridging the gap between mainstream criminal justice responses (such as arrest) and the medical response are federally-funded community-based domestic violence programs. These programs to provide a range of services to victims some of which are safety focused (such as shelters and toll-free crisis lines) and some of which are treatment-based (such as counseling services and legal advocacy). These community-based programs play an important role in the public response to intimate partner violence since many victims do not disclose abuse to the police or even to medical professionals. The programs also provide an important referral destination for physicians and other medical professionals who lack the expertise to address the multi-faceted issues many domestic violence victims face.

Existing research on services to domestic violence victims has largely been based on responses in traditional medical setting such as emergency rooms or community health programs. For example, recent studies have demonstrated that two to four percent of all women seen in U.S. hospital emergency departments have acute trauma associated with IPV and another 10 to 12 percent of women have a recent history of intimate partner violence.[8,9,10] Overall, an estimated 73,000 hospitalizations and 1,200 deaths are attributed IPV each year. [11,12] While this research highlights the important intervention role of these medical settings, the majority of reported injuries sustained by IPV victims are less severe.[13] Thus it is likely that many victims of IPV seek services from these community-based domestic violence programs. Moreover, understanding both the structure of these programs and the number of people served could yield important complementary information on interventions in medical settings.

Unfortunately, little is known about these programs, the services they provide or the communities they serve. To the authors' knowledge there have been no large-scale studies of local domestic violence programs and information collected by the programs themselves have

consisted of data that were not always unduplicated and often did not use consistent definitions. Alternative methods that attempt to remedy these problems can be dangerous for victims because they may require disclosure of abuse in unsafe settings or the collection of client-identified information stored in insecure databases.

This study presents the results from a noninvasive and unduplicated count of domestic violence services using the National Census of Domestic Violence Services (NCDVS). The NCDVS uses a "snapshot" approach to estimate the number of individuals served by any organization with the primary purpose of serving victims of IPV and their families. By counting the number of people served by all local domestic violence programs in a single day, it is possible to construct an unduplicated count, as it is generally unlikely that an individual is served by more than one local domestic violence program in a single 24-hour period. This can be done without identifying information about individuals seeking services. The NCDVS thus provides a safe and viable method for local domestic violence programs to provide an unduplicated count of individuals they have served without compromising the safety of their clients.

Based on the responses of domestic violence programs across the US for a 24-hour period, we estimate that 48,350 individuals were served by domestic violence programs during the single day survey period. 22,507 of those served sought some type of housing. In addition to providing in-person services, local programs responded to over 16,000 crisis calls-equivalent to more than 11 calls per minute. These numbers correspond to more than 7 times the implied daily incidence of violence related injuries seen in emergency rooms in the United States.[14]

II. DATA AND METHODS

A. Developing a Sample Frame

Prior to this initiative, there did not exist a complete listing of the community-based programs providing domestic violence services. Thus, to conduct a census of these programs, we first collected a listing of all eligible programs. For the purposes of this study, the community-based programs termed "domestic violence programs" are defined as nonprofit, nongovernmental organizations whose primary mission is to provide services to victims of domestic violence, based on the definition included in the Violence Against Women Act of 2005.[15] The federal funding structure and coordination needs have also led to the emergence of state-level entities. These entities, termed "state coalitions", are federally recognized state-level nonprofit entities that coordinate funding, training, and education to the domestic violence programs. Using the "primary purpose" definition, this study attempted to identify a broad range of local U.S. domestic violence programs through state domestic violence coalitions and via multiple national listservs frequented by domestic violence service providers. Based on programs identified through these means, we include 2,016 domestic violence programs in the sample frame. This is believed to be an almost complete universe of community-based domestic violence programs.

B. Snapshot Approach

The National Census of Domestic Violence Services (NCDVS) provides both a census of programs and program characteristics as well as a measure of the services provided. The survey method that required local domestic violence programs to conduct an unduplicated count of the number of people using their program in a single 24-hour period without providing any identifying information about any individual survivor. The primary assumption for this count to produce an unbiased estimate of service usage is that relatively few people use the residential or

non-residential services of a more than one local domestic violence service provider in a single 24-hour period. This assumption seems reasonable even in the face of a mobile population like IPV survivors.

To ensure applicability and usability, the NCDVS survey instrument was developed by a team of researchers and experts in the field of domestic violence service provision. Because this study was the first of its kind and due to the broad scope of the initiative, the census was field tested and participants were provided with detailed trainings regarding definitions of terms and other logistical issues. In May 2006, seven pilot states were selected based on several dimensions including location, size, and programmatic structure. Based on feedback from the May 2006 pilot, some revisions to the survey instrument were made.

On September 13, 2006, the NCDVS survey instrument was distributed publicly. Public distribution included electronic mail to state coalitions as well as to some listserves frequented by local domestic violence service providers. State coalitions were asked to distribute both the survey packet and an information sheet to all local domestic violence programs. State coalitions and local domestic violence programs participated in a one of a series of trainings. These trainings presented a survey instrument and method and discussed the logistical details of implementation. They also allowed local programs to submit any questions or concerns and provided testimonial from pilot participants to encourage participation. The survey was designed to be short and relatively easy to fill out.

On November 2, 2006 at 8am, the survey period began and on November 3, 2006 at 7:59am the survey period ended. Domestic violence programs were then encouraged to submit their counts either online or via fax. Domestic violence programs could then submit their results online, at a site with a form design nearly identical to the paper survey, or they could fax in

results. Reminder emails to state domestic violence coalitions, informing them of which programs had submitted data were sent regularly for 2 weeks following the end of the survey period. In turn, the state coalitions contacted non-responding domestic violence programs and encouraged participation.

C. Response Rates

Of the identified 2,016 domestic violence programs, 1,243 (62%) participated. Table 1 reports the participation rates of local domestic violence programs in each state. Rates do not appear to be strongly associated with state size, population density, or overall population levels. For example, among states with a large population, some had slightly below average participation (e.g. CA, NY) while others had very high participation rates (e.g. IL, PA). Some smaller states appeared to have better participation rates (e.g. NE, NH, RI, VT), though size was not a strong predictor. Analysis of non-responding programs indicates that geography and urbanicity are strong predictors of participation. However, the level to which survey-day service rates and other program-level characteristics may have affected participation in the survey is unknown.

To construct standard errors for survey counts, weights were constructed at the national and state levels because non-respondents may have different characteristics than respondents. To analyze non-response and correlates of service usage, the 2000 U.S. Census county-level data matched to NCDVS survey results based on a linkage between postal zip codes and county codes (FIPS). Because most counties contain only one domestic violence program, the study assigned the population of the corresponding county to the domestic violence program. Standard errors to account for this procedure were then constructed and applied to raw survey sums to account for

errors generated by differential response rates.[16] Population estimates to construct population rates were treated as error free and obtained from the U.S. Census Bureau.

D. Validation of Methods

In order to use safe and noninvasive methods, this census did not use any personally identifying client information and chose to observe only for a 24-hour period to ensure no duplication. In order to empirically support this "snapshot approach" to surveying, two measures were used. First, NCDVS respondents were asked to estimate the number of individuals they serve on a "usual day." This procedure is similar to that used by the U.S. Bureau of Labor Statistics and Census Bureau in the Current Population Survey.[17] Many respondents predicted that they served more individuals on a typical day than on the survey day. This difference is statistically significant ($F(1, 1242) = 240.03$, p-value = 0.00). However, the usual-day estimates are highly correlated with the survey day levels (correlation of 0.77, standard error = 0.01). On average, domestic violence programs reported that they serve about four more people on a usual day than were served on the survey day—approximately 10 percent more than survey day estimates might suggest. While this suggests survey day estimates may be a slight undercount, the data presents a relatively consistent magnitude of around 50,000 individuals served in a 24-hour period by study respondents.

An analysis comparing participants in the May 2006 pilot and the November 2006 national survey day was used to determine how representative and valid the numbers presented might be. Of the 249 domestic violence programs that participated in the pilot, 86 did not participate in the survey, leaving 163 programs participating in both the pilot and nationwide survey, approximately 13 percent of the national sample. The results from the comparison of these two points-in-time show almost no significant difference between the two 24-hour survey

periods, even though the survey days were 6 months apart. The number of women and children sheltered on the survey day were slightly higher than on the pilot day but results were only marginally significant at the 10 percent level. All other differences in average service levels were insignificant between the two days.

E. Limitations

There are some limitations worth noting which impact our ability to capture the full scope of domestic violence services. First, a majority of local domestic violence programs are members of their state domestic violence coalitions. A small number of local domestic violence programs may not be affiliated with state domestic violence coalitions and therefore may not have participated in the count. Programs which serve some IPV victims but do not, as their primary purpose, serve IPV victims may also not have participated in this survey. For example, victims access advocacy and housing through other non-profit groups. While we did not restrict our sample to members of state domestic violence coalitions, to the extent that these programs are not in contact with domestic violence service providers in their state, we tended to omit them.

Second, although dual programs (such as those which serve IPV and sexual assault survivors or those that serve homeless individuals and IPV survivors) were included in these counts, their ability to fully separate IPV and other clients served may be limited by the willingness of survivors to disclose the full extent of their history. If survivors of IPV, for example, prefer to remain in the general homeless population or do not disclose that the perpetrator of their sexual assault was an intimate partner, we may have failed to count these individuals. Such programs account for 37 percent of all domestic violence programs.

Finally, some non-member local domestic violence programs cater to underserved groups (e.g. immigrants, Native American communities, Lesbian/Gay/Bisexual/Transgender) and while attempts were made in the national count to include all local domestic violence programs some groups may not have been aware of the count. In particular, services on Native American reservations and services at military bases are underrepresented in the sample.

III. Domestic Violence Service On a Single Day

Programs are distributed across the country as illustrated in figure 1. While most counties have a program within their boundaries, some rural areas do not. Table 2 presents some summary statistics about programs. Many of the programs are very small. Table 3 shows that most programs have small staffs with more than one-third employing less than 10 and over 70 percent employing fewer than 20. More half of domestic violence programs use fewer than 20 paid staff and volunteers and nearly 20 percent have fewer than 10 paid staff members and volunteers. Programs rely on a large number of volunteers with 20 percent of programs relying on over 40 volunteers. Nearly half of all programs have more than 20 volunteers.

To measure service usage, services were divided into three, mutually-exclusive services: emergency shelter, transitional housing, or non-residential advocacy services. Emergency shelter was defined as any short-term living space provided to victims of IPV in response to an immediate crisis. Transitional housing was defined as temporary housing designed to house victims of IPV for a mid-length period of time, while helping them transition into permanent living arrangements. Non-residential services included both group and individual services provided to any individual not residing in housing provided by the serving program. Services were classified as individual if they were provided to victims of IPV or their friends or families

in a one-on-one setting, including but not limited to one-on-one counseling, safety planning, housing support, and legal services. Group services included a variety of support programs including, but not limited to, support groups for adults or children, job-training programs, and group counseling services.

We estimate that 48,350 individuals were served in a single 24-hour period, not including community education sessions or hotline calls. Table 4 reports unduplicated counts of service usage. This corresponded to a population rate of approximately 16 individuals per 100,000. There was variation by geographic region. In the U.S. Census Northwest Central region (Iowa, Nebraska, Kansas, North Dakota, Minnesota, South Dakota, and Missouri) 27.04 per 100,000 individuals were served, while approximately 11 individuals per 100,000 were served in the Pacific region (Alaska, California, Hawaii, Oregon, and Washington). Urban domestic violence programs served approximately 11 individuals per 100,000 while rural and suburban programs served 24.3 individuals per 100,000.

Similar to results from emergency room studies regarding domestic violence, the individuals using domestic violence program services are primarily women (96 percent of adults served) corresponding to a population rate of 13.5 per 100,000 inhabitants (about 20 women per 100,000 women) in the U.S. Approximately 22.25 per 100,000 children were served by local domestic violence programs during the 24-hour survey period. This was primarily related to the number of children accompanying adults seeking service (on average 1 child per adult requesting emergency shelter and 1.6 children per adult requesting transitional housing).

A. Emergency Shelter

The link between homelessness and domestic violence is both overwhelming and undeniable. A staggering 92% of homeless women have experienced severe physical or sexual abuse at some point in their lives.[18] Survey evidence suggests that domestic violence is directly responsible for homelessness. Fifty percent of homeless women and children are fleeing domestic violence,[19] and 38% of all victims of domestic violence become homeless at some point in their lives.[20] Among cities surveyed by the US Conference of Mayors, 44% identified domestic violence as a primary cause of homelessness.[21]

Some of this is alleviated by the availability of emergency shelters, which can provide temporary, safe living quarters for victims of intimate partner violence. 65 percent of programs provide some form of emergency shelter. We estimate that on a single night 14,518 individuals required emergency shelter. While a given individual may stay several nights, this means that over the course of a year, there will be 5 million stays in shelter beds. Moreover, this rate of service usage requires 4 beds every night for every 100,000 individuals in the community. Unfortunately, some communities, especially rural and socio-economically disadvantaged communities, need many more beds and such emergency beds appear to be scarce.

B. Transitional Housing

Longer term housing is also crucial to the ability of a battered woman and her children to escape an abusive relationship. Victims of domestic violence experience major barriers in obtaining and maintaining housing, and victims most often return to their abusers because they cannot find long-term housing.[22] In addition, evidence suggests that victims are discriminated against, denied access to, and even evicted from public, subsidized, and private housing because of their status as victims of domestic violence or the abuse perpetrated against them.[23] Transitional and long-

term housing options are necessary for many women to move from emergency shelter into permanent housing of their own.

Despite the importance of longer term housing, 22 percent of programs offer emergency but no transitional housing. Shelters in counties with no transitional housing report that women must often return to the shelter because they are unable to secure housing away from their abusers. Shelters with transitional housing report much lower recidivism rates.[24] In fact, the majority of battered women in transitional housing programs state that had these programs not existed, they would have returned to their abusers.[25] When afforded residential stability, homeless persons are considerably less likely to return to emergency shelter.[26]

C. Counseling and Advocacy

In addition to the safety offered from shelter and transitional housing, domestic violence programs offer a range of counseling and advocacy services. These services include individual counseling sessions to address the emotional impact of abuse as well as individual advocacy to help victims safety plan. Group sessions may provide peer-support and strategies from other survivors on addressing the short and long-term effects of domestic violence. Group sessions may also provide critical empowerment skills such as economic self-sufficiency and job training. Local programs also provide services which range from accompaniments to police or medical setting to legal services to assistance in obtaining other public and social services. Such services are typically available to the residents of program-provided housing but also are made available to other non-residential individuals in the community providing a low-cost, safe source of assistance for victims of domestic violence. The provision of such services account for the

majority of individuals served in most programs. In addition to in-person services, many local programs offer crisis lines which help individuals in need but unable to access services in person.

To better measure the distribution of services provided we measure the percent of individuals served through direct service by residential status, hotline calls and community education. This count shows the distribution of service, but duplicates counts of individuals who used more than one service during the survey day (e.g., an individual who used both individual and group counseling). It also allows a quantification of services, which, by their nature, cannot be unduplicated (e.g., hotline calls that are not distinguishable between new and return callers). Service types included: individual services for both residents and non-residents; group services for both residents and non-residents; hotline calls; and, community trainings. Hotline calls included crisis intervention, requests for support by victims, requests for support by friends or family of victims, and other IPV information provided through crisis lines or hotlines. Community training referred to outreach efforts to specific groups or to the general community that increased public awareness about IPV or improved system responses to victims (e.g. law enforcement trainings and volunteer trainings).

The results presented in Table 5. Residential services comprised 22 percent of all services provided. Thirty-five percent of the activities conducted (27 percent in urban and 39 percent in non-urban) were to the broader community in the form of community and public education. There was variation in the distribution of services provided across regions. In some areas, such as the New England (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont) and Mid-Atlantic Regions (New Jersey, New York, and Pennsylvania), most domestic violence programs participating in the study provided between 25 and 30 percent (32 percent in New England and 26 percent in Mid-Atlantic) non-residential advocacy services.

In other areas, such as the South Atlantic region (Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, and West Virginia), half of all services during this 24-hour period were prevention and awareness focused through public and community education.

In addition to in-person services, hotline calls represent an important service by domestic violence programs to provide crisis and intervention services to individuals who require information or services but are unable to come to a shelter in-person. In the 24-hour survey period,16,644 calls were answered—corresponding to more than 11 calls per minute. In addition, the National Domestic Violence Hotline responded to 1,213 calls. The National Domestic Violence Hotline, housed in Texas, is a 24-hour, national toll free hotline. The Hotline provides information, crisis counseling, and referrals in 150 languages. Operators at the Hotline use a sophisticated system to directly connect victims with service providers in their immediate areas, wherever they are across the country.

III. Understanding Unmet Requests for Service

In addition to services, we measure requests for services that went unmet due to lack of resources. This count might include duplicate counts of individuals because someone may have contacted more than one local domestic violence program during the survey period to request assistance. Unmet requests were defined as any request for service that a domestic violence program was unable to meet due to resource constraints (e.g., inadequate space, staff, or money). This count included individuals who were referred to other community organizations due to the initial respondent program's resource constraints.

As reported in Table 6, a total of 5,157 requests for service — 1.74 per 100,000

individuals in the U.S. — could not be met due to lack of resources. In the Mountain region, 1.16 individuals per 100,000 requesting emergency shelter had to be turned away or referred elsewhere due to space constraints. In non-urban areas, 2.17 individuals per 100,000 were unable to be served, which is in contrast to the national average of 1.75 per 100,000.

This count is likely to be a serious undercount of unmet requests for several reasons. First, many programs do not "turn away" any individuals seeking services and may instead spend time seeking alternative services or arrangements for these individuals. As such, many programs did not classify individuals that they did not serve as unmet requests. Second, many programs may not be able to provide the service requested by the individual but will offer another service instead. For example, if a woman requests shelter but the program does not have any available beds they may provide her safety-planning and crisis management. In this case, the program may not count her as an unmet request although she would have preferred shelter and that request remained unmet. Third, there was a general cultural aversion to classifying any individual as un-served, largely because domestic violence programs are often places of last resort. As a result, many programs were particularly unwilling to classify requests as unmet and were displeased about the nature of this question.

To better understand what factors are associated with higher levels of service requests and higher rates of unmet requests, we estimate a simple linear regression estimating the relation between service and turn-away rates on one hand and observable programmatic and geographic factors. These results presented in Table 7 highlight factors that are correlated with service usage. The first four columns measure the relationship between total number of individuals served and the various program and area characteristics. Column (1) of Table 7 presents simple correlation with information collected in the survey. Predictably, it appears that both staff size and budget

size are positively associated with number of individuals served. The increase in number of individuals served appears to increase relatively steadily with respect to both budget and staff size. Column (2) adds controls for median family income, unemployment rate, and male-female labor force participation ratio. Controlling for these economic factors renders the budgetary levels insignificant. This is likely because larger budget areas are associated with a host of program specific variables. Column (3) adds demographic control variables such as percent black and percent immigrant, which do not have a significant relationship to service levels. The specification in column (3) also includes the male and female marriage rates which are significant and are opposite in sign. Male and female marriage rates obviously correlated, but the correlation coefficient is 0.55. As reported in Table 7, a higher fraction of married men appears to be negatively associated with service levels while a higher fraction of married women appears to be positively associated with service levels. Column (4) also includes controls for poverty levels, none of which are significantly associated with service levels.

Columns (5) through (8) report similar specifications with the outcome of number if individuals turned away. Using the specification in column (8), it appears that larger programs (i.e. those programs with larger staff sizes) have higher turn-away rates. In addition, it appears that suburban areas have higher turn-away rates than urban areas. This may be due to the limited availability of outside options although this does not appear to be the case for rural areas. Poor areas appear to have more unmet requests as do areas that are predominantly black or Native American. It appears the service provision is substantially more constrained in poor and minority communities.

IV. CONCLUSIONS

In 2004, 1,159 women and 385 men were killed by intimate partners.[27] While much of IPV is non-fatal, the frequency and danger to its victims make it an ongoing public health concern. Because only about one in seven of all domestic assaults come to the attention of the police, expanding the use of public health tools to measure the extent and response to domestic violence is crucial to effective intervention.[28] While many studies have studied the interaction between traditional medical settings and domestic violence services, this study represents the first attempt to highlights the important complementary role that local domestic violence programs play in the provision of care to victims of domestic violence.

This study presents results from the National Census on Domestic Violence Services (NCDVS). Results indicate that 48,350 individuals were served during a single 24-hour period. These estimates are larger than the numbers of individuals seeking emergency medical care, and correspond to at least 7 times the number of violence-related injuries treated in US emergency rooms daily.[29] While the NCDVS is advantageous because it is a noninvasive new method of measuring the magnitude and distribution of emergency and crisis services provided to victims of IPV, it provides only limited information about the level of intimate partner abuse. Although little is known about individuals who use crisis services, even less is known about individuals who do not seek the services of domestic violence programs and the selection parameters that govern the decision to use services. Thus, the NCVDS presents a measure of domestic violence service usage that is likely to be correlated with incidence levels, but still provides only limited insight into the true, potentially higher, incidence of IPV.

The NCDVS does provide new and important information about the usage and unmet demand for IPV services. The existing data can be used to determine the demand for specific types of services and the need to expand capacity in certain types of service provision. Ongoing

data collection in the form of an annual NCDVS will enable a more detailed examination of both the spatial and temporal correlates of service usage and the relationship between this usage and other measures of IPV. Future annual estimates generated from additional years of data collected through the NCDVS may allow researchers and decision-makers to measure the effectiveness and quantify the social cost of unmet requests.

This study helps highlight the extensive service network for victims of domestic violence. Understanding the structure of these programs which are at the intersection of safety services and social services provides an important source of information on the interventions necessary to effectively serve victims of domestic violence. The most concerning results from this survey is that 5,183 requests for service went unfulfilled due to lack of resources in a single day. Given the dire nature of domestic violence victims' circumstances as they seek safety, this inability to provide crisis services may be dangerous if not deadly. It is hoped that this and future surveys will provide insight into the level and nature of services required by victims of intimate partner violence and help ensure sufficient resources to effectively respond to the needs of these victims.

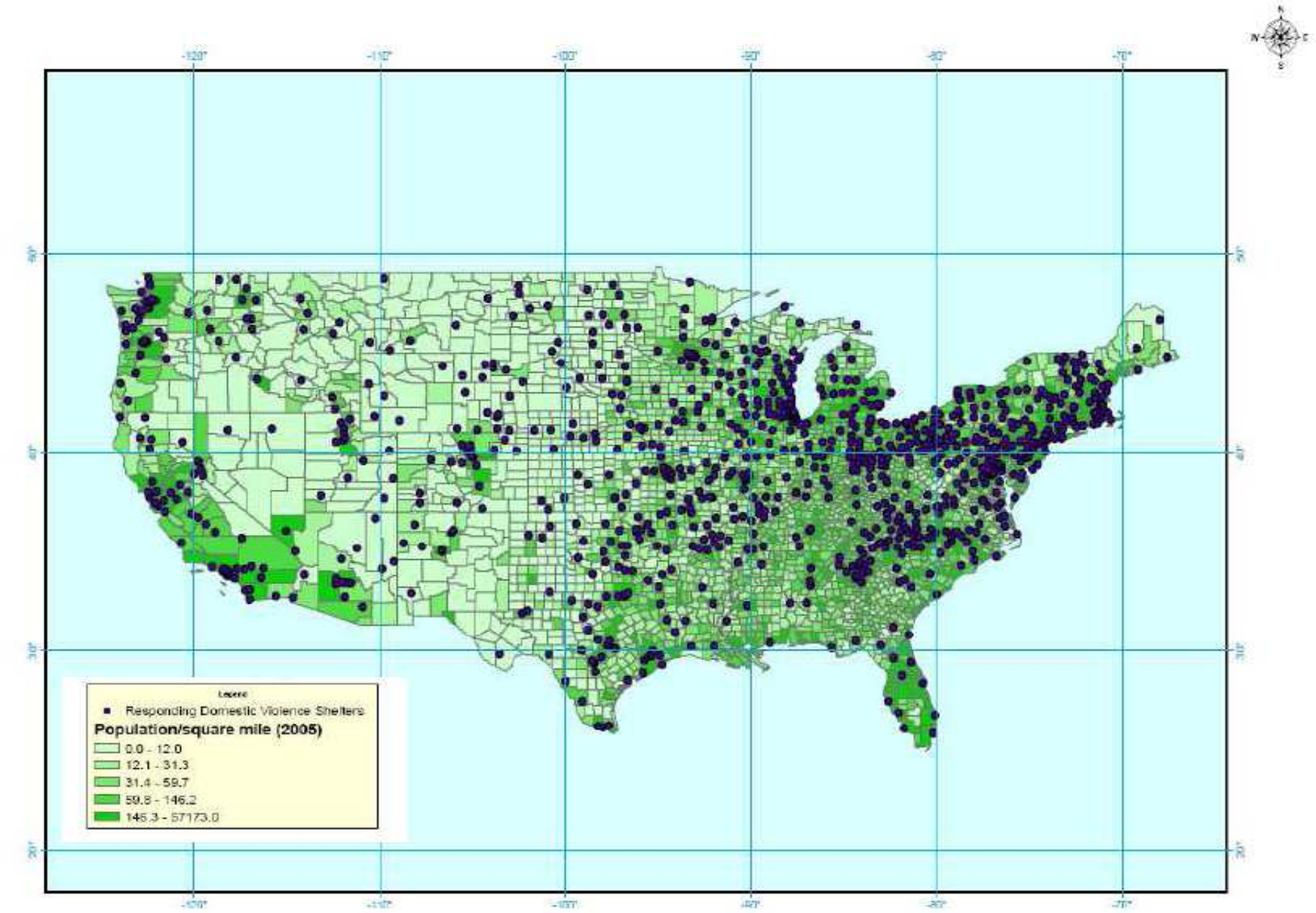

Figure1. Domestic Violence Service Providers across America by Population Density

Table 1. Number of Programs and Participation Rates by State

State	Number of Responding programs	Number of Primary Purpose DV Programs	Participation Rate	State	Number of Responding programs	Number of Primary Purpose DV Programs	Participation Rate
AK	16	20	80%	NC	51	90	57%
AL	12	19	63%	ND	18	21	86%
AR	22	29	76%	NE	22	22	100%
AZ	23	34	68%	NH	12	12	100%
CA	54	121	45%	NJ	23	28	82%
CO	28	46	61%	NM	10	32	31%
CT	9	18	50%	NV	8	15	53%
DC	6	9	67%	NY	44	129	34%
DE	4	9	44%	OH	68	90	76%
FL	28	41	68%	OK	29	30	97%
GA	27	48	56%	OR	19	45	42%
HI	8	18	44%	PA	61	61	100%
IA	21	22	95%	PR	6	10	60%
ID	7	25	28%	RI	7	7	100%
IL	54	54	100%	SC	12	13	92%
IN	22	44	50%	SD	19	24	79%
KS	16	34	47%	TN	17	47	36%
KY	13	13	100%	TX	71	123	58%
LA	6	20	30%	UT	15	16	94%
MA	21	52	40%	VA	45	46	98%
MD	19	20	95%	VI	2	2	100%
ME	9	9	100%	VT	15	15	100%
MI	32	66	48%	WA	38	45	84%
MN	26	89	29%	WI	47	88	53%
MO	56	67	84%	WV	14	14	100%
MS	5	12	42%	WY	12	24	50%
MT	14	28	50%	TOTAL	558	967	58%

Notes: Estimates based on 1,243 participating programs except for urbanicity which is based on responses from 1,199 programs. Population estimates are based on census estimates and treated as error-free. Standard errors constructed based on analysis of non-responding program community characteristics. Total count of program based on reports from State Coalitions

Table 2. Summary Statistics for Primary Purpose Domestic Violence Programs and their Communities

	All Programs (1,243 Nationwide)	Excluding top 1% of Programs
Panel A: Program Characteristics		
Served (Emergency Shelter, Transitional Housing, Non-Residential Services per 100,000 inhabitants in service areas)	5.597 (53.257)	2.606 (4.538)
Unable to Serve Due to Lack of Resources (per 100,000 inhabitants in service areas)	1.0587 (19.504)	0.265 (1.131)
Fraction of programs employing less than 10 paid staff	0.3469 (0.476)	0.350 (0.477)
Fraction of programs employing more than 40 paid staff	0.088 (0.284)	0.085 (0.280)
Fraction of programs with fewer than 10 volunteers	0.335 (0.472)	0.337 (0.473)
Fraction of programs with greater than 40 volunteers	0.195 (0.396)	0.192 (0.394)
Fraction of programs with annual budget >$500,000	0.456 (0.498)	0.454 (0.433)
Fraction of programs with annual budget <$25,000	0.435 (0.495)	0.439 (0.495)
Panel B. Community-Level Characteristics (Defined as Service Area of Reporting Programs)		
Fraction of programs in rural areas	0.212 (0.273)	0.213 (0.273)
Unemployment Rate	0.181 (0.285)	0.177 (0.282)
Male-Female Labor Force Participation Ratio	1.151 (0.18)	1.151 (0.164)
Fraction of population that is African-American	0.089 (0.158)	0.088 (0.157)
Fraction of population that is Native American	0.022 (0.084)	0.022 (0.084)
Fraction of population that are Immigrants	0.067 (0.091)	0.067 (0.091)
Male Marriage Rate	0.677 (0.182)	0.680 (0.179)
Female Marriage Rate	0.633 (0.093)	0.634 (0.088)
Median Family Income	45,700 (15,424)	45,768 (14,685)
Fraction of households with family income < $25,000	0.223 (0.135)	0.223 (0.134)
Fraction of households with family income > $100,000	0.216 (0.278)	0.213 (0.275)

Notes for Table 2: Panel A estimates based on 1,243 participating programs in National Census of Domestic Violence Programs. For some questions on 1,189 programs responded. Programs excluded in top 1% means are those programs in counties with the highest budgets. Standard errors constructed based on analysis of non-responding program community characteristics. Panel B estimates are based on data from the 2000 US Census. Standard deviations are reported in parentheses.

Table 3. Employment and Volunteer Sizes in Primary Purpose Domestic Violence Programs

		Percent of programs with				
		less than 10 Volunteers	10-20 Volunteers	21-40 Volunteers	>40 Volunteers	
Percent of programs with	less than 10 paid staff	0.18	0.11	0.05	0.02	0.36
	10-20 paid staff	0.13	0.11	0.06	0.06	0.36
	21-40 paid staff	0.03	0.06	0.04	0.06	0.19
	>40 paid staff	0.01	0.01	0.02	0.06	0.09
		0.35	0.28	0.17	0.20	1.00 (N=1189)

Notes: Estimates based on 1,243 participating programs except for urbanicity which is based on responses from 1,189 programs. Population estimates are based on census estimates and treated as error-free.

Table 4. Number of Individuals provided with Domestic Violence Services on a Single Day

	Total Served	Emergency Shelter	Transitional Housing	Non-Residential Services
Nationwide	48,350	14,518	7,989	25,843
Per Capita Provision	16.15	4.85	2.67	8.63
(per 100,000 in habitants)	(3.32)	(1.78)	(1.55)	(2.01)
By Urbanicity per 100,000 inhabitants in Urban or Not-Urban Areas (respectively)				
Urban	10.89	3.17	2.22	5.51
	(2.11)	(1.23)	(2.23)	(2.51)
Not-Urban	24.31	7.38	3.30	13.63
(Rural or Suburban)	(3.00)	(2.43)	(2.35)	(3.23)
By Gender (Adults Only) per 100,000 inhabitants				
Total Adults Served	14.05	3.35	1.45	9.26
	(3.02)	(1.13)	(1.43)	(2.31)
Women	13.52	3.33	1.44	8.75
	(3.11)	(1.32)	(1.15)	(2.65)
Men	0.08	0.02	0.01	0.71
	(0.06)	(0.08)	(0.03)	(0.05)
Services for Children				
Number of Children Served	22.25	8.97	5.98	7.30
(per 100,000 children)	(2.16)	(1.46)	(1.05)	(1.25)
Average Number of Children	0.60	1.02	1.57	0.30
per Adult	(0.16)	(0.99)	(1.01)	(0.18)
Regional Estimates reported per 100,000 inhabitants in region				
New England	18.01	3.68	4.68	9.65
	(2.15)	(1.69)	(1.55)	(2.32)
Middle Atlantic	14.21	3.40	2.33	8.49
	(1.99)	(1.88)	(1.55)	(2.61)
East North Central	17.76	5.12	3.31	9.33
	(2.81)	(1.92)	(1.55)	(2.65)
West North Central	27.04	9.05	2.36	15.63
	(2.22)	(2.18)	(1.55)	(2.82)
South Atlantic	15.54	4.93	2.02	8.59
	(2.01)	(1.77)	(1.55)	(2.17)
East South Central	13.40	4.08	1.57	7.74
	(2.57)	(1.03)	(1.55)	(2.12)
West South Central	17.04	5.56	2.86	8.61
	(2.16)	(1.55)	(1.55)	(2.52)
Mountain	17.52	7.12	3.43	6.97
	(1.89)	(1.38)	(1.55)	(2.76)
Pacific	10.95	2.95	2.31	5.69
	(1.70)	(1.41)	(1.55)	(2.75)

Notes: Estimates based on 1,243 participating programs except for urbanicity which is based on responses from 1,199 programs. Population estimates are based on census estimates and treated as error-free. Standard errors constructed based on analysis of non-responding program community characteristics. Regions are based on U.S. Bureau of Census. There are 9 census divisions and 4 census region. Region 1 is the Northeast and is divided into 2 divisions. Division 1 is New England, and includes Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. Division 2 is Mid-Atlantic, and includes New Jersey, New York, and Pennsylvania. Region 2 is the Midwest and is divided into 2 divisions. Division 3 is East North Central and includes Indiana, Illinois, Michigan, Ohio, and Wisconsin. Division 4 is West North Central and includes Iowa, Nebraska, Kansas, North Dakota, Minnesota, South Dakota, and Missouri. Region 3 is the South and is divided into 3

divisions. Division 5 is South Atlantic, and includes Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, and West Virginia. Division 6 is East South Central and includes Alabama, Kentucky, Mississippi, and Tennessee. Division 7 is West South Central and includes Arkansas, Louisiana, Oklahoma, and Texas. Region 4 is the West and is divided into 2 divisions. Division 8 is Mountain and includes Arizona, Colorado, Idaho, New Mexico, Montana, Utah, Nevada, and Wyoming. Division 9 is Pacific and includes Alaska, California, Hawaii, Oregon, and Washington. Regional sums do not include federal territories.

Table 5. Distribution of services provided

	In-Person Residential		In-Person Non-Residential		Not in Person or Not-Direct Service	
	Individual Service	Group Service	Individual Service	Group Service	Hotline Calls	Community Education
Nationwide	18,964	6,696	26,587	6,883	15,715	40,215
% of Services Provided	0.16	0.06	0.23	0.06	0.14	0.35
By Geographic Region						
New England	0.14	0.05	0.26	0.06	0.15	0.34
Middle Atlantic	0.12	0.04	0.22	0.04	0.14	0.43
East North Central	0.17	0.07	0.19	0.07	0.15	0.35
West North Central	0.20	0.05	0.25	0.05	0.16	0.28
South Atlantic	0.13	0.05	0.16	0.05	0.11	0.50
East South Central	0.24	0.06	0.21	0.06	0.12	0.32
West South Central	0.15	0.06	0.41	0.09	0.10	0.19
Mountain	0.22	0.08	0.15	0.06	0.17	0.32
Pacific	0.22	0.09	0.26	0.07	0.19	0.18
By Urbanicity						
Urban	0.20	0.07	0.21	0.08	0.16	0.27
Not-Urban (rural or Suburban)	0.15	0.05	0.24	0.05	0.12	0.39

Notes: Estimates based on 1,244 participating programs except for urbanicity which is based on responses from 1,199 programs. Population estimates are based on census estimates and treated as error-free. Regions are based on U.S. Bureau of Census. There are 9 census divisions and 4 census regions. Region 1 is the Northeast and is divided into 2 divisions. Division 1 is New England and includes Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. Division 2 is Mid-Atlantic and includes New Jersey, New York, and Pennsylvania. Region 2 is the Midwest and is divided into 2 divisions. Division 3 is East North Central and includes Indiana, Illinois, Michigan, Ohio, and Wisconsin. Division 4 is West North Central and includes Iowa, Nebraska, Kansas, North Dakota, Minnesota, South Dakota, and Missouri. Region 3 is the South and is divided into 3 divisions. Division 5 is South Atlantic and includes Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, and West Virginia. Division 6 is East South Central and includes Alabama, Kentucky, Mississippi, and Tennessee. Division 7 is West South Central and includes Arkansas, Louisiana, Oklahoma, and Texas. Region 4 is the West and is divided into 2 divisions. Division 8 is Mountain and includes Arizona, Colorado, Idaho, New Mexico, Montana, Utah, Nevada, and Wyoming. Division 9 is Pacific and includes Alaska, California, Hawaii, Oregon, and Washington. Regional sums do not include federal territories. Rows may not sum to one due to rounding errors.

Table 6. Unmet Demand for Domestic Violence Services

	Total Served	Emergency Shelter	Transitional Housing	Non-Residential Services
Nationwide	5,183	1,752	1,432	1,999
Per Capita Provision	1.74	5.91	4.83	6.74
(per 1,000,000 in habitants)	(0.36)	(3.15)	(1.25)	(2.89)
By Urbanicity				
Urban	13.76	5.40	3.17	5.19
	(2.52)	(2.36)	(1.15)	(2.32)
Not-Urban	21.71	5.66	7.26	8.80
	(3.36)	(2.43)	(3.55)	(3.01)
By Gender (Adults Only) per 100,000 inhabitants				
Total Adults Served	1.39	0.40	0.31	0.68
	(0.25)	(0.20)	(0.18)	(0.20)
Women	1.33	0.39	0.29	0.65
	(0.31)	(2.16)	(1.43)	(3.09)
Men	0.06	0.02	0.01	0.03
	(0.03)	(0.05)	(0.00)	(0.02)
By Age				
Number of Children Served	2.69	1.08	0.95	0.66
(per 100,000 children)	(0.36)	(0.23)	(0.31)	(0.23)
Average Number of Children per Adult	1.55	2.7	3.06	1.03
	(0.95)	(1.32)	(1.01)	(0.18)
Regional Estimates reported per 100,000 inhabitants in region				
New England	1.55	0.73	0.45	0.37
	(0.36)	(0.22)	(0.12)	(0.28)
Middle Atlantic	1.48	0.26	0.19	1.02
	(0.37)	(37.80)	(0.13)	(0.22)
East North Central	1.63	0.55	0.51	0.57
	(0.37)	(0.26)	(0.18)	(0.23)
West North Central	3.03	1.23	0.54	1.26
	(0.33)	(0.32)	(0.24)	(0.31)
South Atlantic	1.68	0.42	0.65	0.61
	(0.30)	(0.22)	(0.26)	(0.21)
East South Central	0.86	0.38	0.00	0.48
	(0.28)	(0.17)	0.00	(0.27)
West South Central	2.17	0.69	0.43	1.05
	(0.32)	(0.22)	(0.22)	(0.23)
Mountain	1.66	1.16	0.27	0.23
	(0.30)	(0.32)	(0.12)	(0.25)
Pacific	1.58	0.56	0.69	0.34
	(0.22)	(0.24)	(0.17)	(0.20)

Notes: Unmet demand is measured by programs calculation of "unable to serve due to lack of resources." Estimates based on 1,244 participating programs except for urbanicity which is based on responses from 1,199 programs. Population estimates are based on census estimates and treated as error-free. Standard errors are reported in parentheses. Regions are based on U.S. Bureau of Census. There are 9 census divisions and 4 census region. Region 1 is the Northeast and is divided into 2 divisions. Division 1 is New England and includes Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont. Division 2 is Mid-Atlantic and includes New Jersey, New York, and Pennsylvania. Region 2 is the Midwest and is divided into 2 divisions. Division 3 is East North Central and includes Indiana, Illinois, Michigan, Ohio, and Wisconsin. Division 4 is West North Central and includes Iowa, Nebraska, Kansas, North Dakota, Minnesota, South Dakota, and Missouri. Region 3 is the South and is divided into 3 divisions. Division 5 is South Atlantic and includes Delaware, District of Columbia, Florida,

Georgia, Maryland, North Carolina, South Carolina, Virginia, and West Virginia. Division 6 is East South Central and includes Alabama, Kentucky, Mississippi, and Tennessee. Division 7 is West South Central and includes Arkansas, Louisiana, Oklahoma, and Texas. Region 4 is the West and is divided into 2 divisions. Division 8 is Mountain and includes Arizona, Colorado, Idaho, New Mexico, Montana, Utah, Nevada, and Wyoming. Division 9 is Pacific and includes Alaska, California, Hawaii, Oregon, and Washington. Regional sums do not include federal territories.

Table 7. Linear Estimates of the Correlates of Service Provision and Turn-Away Rates

Dependent Variable Mean	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
	Log(Served)				Log(Unable to Serve)			
Medium Staff Program	0.2639***	0.2312**	0.2019**	0.1980**	-0.1857	-0.3296	-0.3583	-0.3189
=1 for programs employing < 10 paid staff	(0.0950)	(0.0961)	(0.0922)	(0.0916)	(0.2248)	(0.2354)	(0.2351)	(0.2367)
Large Staff Program	0.8680***	0.9133***	0.7862***	0.7594***	0.1430	0.1763	0.1665	0.1433
=1 for programs employing 21-40 paid staff	(0.1307)	(0.1367)	(0.1322)	(0.1319)	(0.2833)	(0.3098)	(0.3091)	(0.3144)
Very Large Staff Program	1.3701***	1.2454***	1.2298***	1.2097***	0.6071*	0.4588	0.4240	0.3934
=1 for programs employing > 40 paid staff	(0.1656)	(0.1730)	(0.1654)	(0.1644)	(0.3355)	(0.3513)	(0.3523)	(0.3539)
Medium Volunteer Program	-0.1099	-0.0312	0.0192	0.0193	0.1247	0.2088	0.3151	0.3249
=1 for programs engaging < 10 volunteers	(0.0888)	(0.0905)	(0.0867)	(0.0861)	(0.1949)	(0.2079)	(0.2076)	(0.2081)
Large Volunteer Program	-0.0469	0.0561	0.0887	0.0864	0.0781	0.0598	0.1910	0.1778
=1 for programs engaging 21-40 volunteers	(0.1024)	(0.1054)	(0.1010)	(0.1007)	(0.2294)	(0.2473)	(0.2472)	(0.2483)
Very Large Staff Program	-0.0900	0.0938	0.1586	0.1566	0.1690	0.4015	0.5342*	0.5484*
=1 for programs engaging > 40 volunteers	(0.1088)	(0.1144)	(0.1098)	(0.1094)	(0.2563)	(0.2818)	(0.2840)	(0.2861)
High Budget Programs	0.2094	0.3891**	0.5331***	0.5430***	-0.0487	-0.0828	-0.1292	-0.1056
=1 for programs with budgets >$500,000	(0.1893)	(0.1929)	(0.1870)	(0.1859)	(0.3993)	(0.4266)	(0.4219)	(0.4252)
Fraction of population living in rural areas		0.9838***	1.2605***	1.2501***	0.6073*	0.7656**	1.1775***	1.1188**
		(0.1433)	(0.1683)	(0.1693)	(0.3228)	(0.3492)	(0.4268)	(0.4387)
Unemployment Rate		5.2391***	0.4075	-1.5549		6.3123**	-1.3769	-3.6464
		(1.0254)	(1.1432)	(1.2443)		(2.7194)	(3.3481)	(3.6833)
Male-Female Labor Force Participation Rate		0.6510***	1.0634***	0.9951***		0.2828	-0.2301	-0.2706
		(0.2301)	(0.2688)	(0.2755)		(0.4818)	(0.6232)	(0.6358)
Fraction of population that is African-American			0.5588*	0.4018			0.4529	0.4093
			(0.2983)	(0.3111)			(0.6419)	(0.6634)
Fraction of population that is Native American			1.1448**	0.9176*			2.3536*	2.2502
			(0.5019)	(0.5055)			(1.3588)	(1.3636)
Fraction of population that are Immigrants			-0.8487	-0.7852			-0.0284	0.0008
			(0.7992)	(0.8032)			(2.0092)	(2.0235)

Male Marriage Rate			-1.6181*	-1.2381			-4.3628**	-4.0104**
			(0.8725)	(0.8778)			(1.9620)	(2.0057)
Female Marriage Rate			-3.1160***	-3.0695***			-0.3066	-0.3326
			(0.9756)	(1.0156)			(2.0873)	(2.2184)
Fraction of Low Income Families (Annual Income below $25,000)				-4.5145**				5.2557
				(1.8307)				(4.1610)
Fraction of Low-Middle Income Families (Annual Income $25-50,000)				-3.8110***				2.2227
				(1.0439)				(3.4647)
Fraction of Middle Income Families (Annual Income $50-100,000)				-2.7269***				2.3115
				(0.9777)				(3.0077)
State Fixed Effects	Y	Y	Y	Y	Y	Y	Y	Y
Program Level Control Variables [a]	Y	Y	Y	Y	Y	Y	Y	Y
Economic Controls [b]	N	Y	Y	Y	N	Y	Y	Y
Demographic controls [c]	N	N	Y	Y	N	N	Y	Y
Household Controls [d]	N	N	N	Y	N	N	N	Y
Observations	1068	929	929	928	364	309	309	309
R-squared	0.2283	0.2960	0.3685	0.3807	0.2292	0.2898	0.3419	0.3489

Notes: Standard errors clustered at the state level are reported in parentheses. The dependent variable in columns (1)-(4) is the number of people served in-person, which includes emergency shelter, transitional housing, and non-residential services. The dependent variable in columns (5)-(8) is the number of requests for service that went unmet due to lack of resources. All regressions include state fixed effects.

a. Program level controls include a full set of staff size indicator variables (<10, 10-20, 21-40, >40), a full set of volunteers size indicator variables (<10, 10-20, 21-40, >40), budget size (<$25,000, $25-50,000, $50-100,000, $100-500,000, $500,000).

b. Economic controls include unemployment rate and male-female labor force participation rate, and GDP.

c. Demographic Controls include fraction of the population that is African-American, Native American, Asia, Pacific Island, or other as well as controls for the fraction of the population that are immigrants, male marriage rate and female marriage rate.

d. Household controls include median family income, family of families with income less than $25,000, $25-50,000, $50-100,000, and greater than $100,000.

REFERENCES AND NOTES

[1] Radha Iyengar is a Robert Wood Johnson Health Policy Scholar at Harvard University. Lindsay Sabik is a graduate student in the Harvard School of Public Health. Cindy Southworth, Sarah Tucker, and Cynthia Frasier work at the National Network to End Domestic Violence. Please direct all correspondence to riyengar@rwj.harvard.edu

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