Equity Allocation Study

Developed for CPS Unit -Children, Adults & Families -
Department of Human Services and
Crime Victims Assistance Section of the Oregon Department of Justice

Developed by The Planning Group

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And of course the women, children and men of Oregon affected by domestic violence and sexual assault. May your future be violence free.

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Equity Allocation Study

I. Introduction

When government dollars are spent to address societal problems, access and equitable distribution of resources can be hallmarks of perceived good government**.** In Oregon, where communities vary widely not only by population, but by geography and lifestyle, equity is sometimes viewed as an aspect of government's value.

The Department of Human Services, the Department of Justice and the Criminal Justice Services Division of the Oregon State Police each allocate money to fund services to victims of domestic violence and sexual assault. The funding streams have included the federal Family Violence Prevention and Services Act (FVPSA), the Criminal Fines Assessment Account (CFAA/DV and CFAA/SA), the STOP Violence against Women Act (VAWA), the Victims of Crime Act (VOCA), and the Oregon Domestic and Sexual Violence Services fund (ODSVS). Because the dollars are distributed in part to nonprofit organizations throughout the state, equity has been important, but not necessarily easily achieved. The Equity Study was initiated to examine the funding and provision of direct services by nonprofit organizations to victims of domestic violence and sexual assault.

I.A. Equity Study Purpose and Scope of Work

Oregon's domestic violence and sexual assault (DV/SA) services have developed over time in response to community based organizing as well as federally funded initiatives. As a result there has been a vital network of service providers and funders, but centralized or coordinated strategic planning were not features of the system until 2004 when the advisory committees to the several funds embarked on a joint strategic action plan, and staff to the funds began meeting as a work group on a regular basis. This coordinated effort was in response to concerns that some funding decisions were being driven by historical precedent rather than emerging community needs, and that funding inequities were developing among the regions of the state.

Goal of Equity/Allocation Study:

- Review current funding allocation methods.
- Identify core services.
- Identify equitable funding distribution methods.

The strategic plan encompassed several goals:

Goal 1 Strengthen and stabilize funding and services
Goal 2 Coordinate administration
Goal 3 Increase quality of granting and reporting
Goal 4 Support core services and positive outcomes

As part of addressing these goals, the Funding Equity Study was commissioned in July 2005 to review funding methodology and identify core services. The goal of the study was to identify an equitable funding distribution method. In August 2005, The Planning Group was hired to conduct the equity study.

The study design included several components to be completed over a period of 10 months. Phases of work were:

1. Review of **literature and research** related to DV/SA victim profiles and needs, effective service responses, funding of services, and equity in allocation of public resources (see Appendix A for bibliography).
2. Review of **demographic data** for Oregon and its counties.
3. Review of DV/SA **services data**, including shelter use statistics and client contact statistics.
4. Review of **budgetary information** including service provider budgets and history of the distribution of funds to DV/SA providers.
5. **Survey** of nonprofit and governmental DV/SA service providers.
6. **Interviews** with stakeholders (see Appendix B for list of interviewees).
7. Investigation of **methodologies used for allocating funds to DV/SA services in other states.** (See Appendix C.)
8. Data **analysis.**
9. Development and evaluation of **options for equitable funding.**
10. **Recommendations for implementing** an equitable funding method.

To fully understand the development of services in Oregon, it is important to understand the history of the programs and the funding.

II. History of the DV/SA Programs in Oregon

II. A. Programs and Services

The programs that make up domestic violence and sexual assault direct services (other than Legal Aid and prosecutor-based victim assistance) in Oregon are provided by a network of primarily grassroots organizations rather than state agencies or multi-purpose non-profit service agencies. Grassroots organizations are "autonomous (not part of a larger institution or organization), highly volunteer dependent, local and not-for profit." (Wyckoff, 2006) Grassroots organizations require community based resources – money and talent.

Many domestic violence and sexual assault programs emerged from a feminist context in the 60's and 70's, a time of cultural examination punctuated by activist idealism. In the mix of those turbulent decades, women found a new voice, and the result was a feminist movement that awakened awareness of domestic violence and sexual assault in the culture. Across the nation the first programs were located in population centers and university towns, communities whose populations are comparatively well off economically and well educated.(Tiefenthaler, et. al., 2005) The earliest programs in Oregon were developed in Eugene (Rape Relief), Portland (Bradley-Angle House and Rape Relief, now the Portland Women's Crisis Line), Salem (a crisis line, now Mid-Valley Women's Crisis Services) and Medford (Sexual Assault Victims Services now part of Community Works), communities which tend to fit this profile.

Thirteen (13) programs serving six counties were well established by the end of the 1970's. The 1980's brought a proliferation of programs. The Oregon Coalition Against Domestic and Sexual Violence (OCASDV), established in 1979, worked to support rural program development through VISTA (Volunteers in Service to America) which placed stipended volunteers in many rural communities. Additionally, the Coalition and its member programs successfully advocated for the Marriage License "Tax" as a way to provide stable funding, particularly to domestic violence programs. Twenty-one (21) new programs were developed and incorporated in the 1980's bringing the total number of programs in the state to 36. While most of the programs established in the 70's operated in more urban areas, programs developed in the 80's by and large were in the rural and frontier[1] parts of the state. At the end of the 1980's, 23 Oregon counties were served by domestic violence and/or sexual assault programs, nearly quadruple the number of counties served ten years previous.

Growth of Services and Programs

DV/SA services began primarily in the late 70's with services to 6 counties.

By the late 1980's 23 of Oregon's 36 counties had some DV/SA services.

Currently every Oregon county is provided some service.

Programs established more recently, in the 1990's and 2000's, have rounded out service to Oregon counties in providing primarily special focus services, either culturally specific or programmatically specialized.

Currently every county in Oregon is served in some way by nonprofit domestic violence and sexual assault service providers. Twenty-two (22) counties have at least one avenue for service located in the county. Five (5) counties are the headquarters for programs that serve the home county as well as a total of eight other counties typically served through a "satellite" service arrangement. This is well ahead of the national tendency highlighted in Tiefenthaler et. al. where rural communities in most parts of the United States were determined to be "underserved". The following chart outlines program availability by county.[2]

[1] The federal government defines a frontier county as one having a rate of 6 or fewer people per square mile. Rural areas are defined as being 10 or more miles from a population center of at least 30,000 people.
[2] Included in this list are nonprofit service providers that receive some funding administered through the state. This list does NOT include legal services, directly government sponsored programs, or programs that receive no state funding at this time.

TABLE 1: Programs by County[3]

County	Number of programs
BAKER	1
BENTON	1 headquarters + Linn
CLACKAMAS	1 (also part of Tri-county)
CLATSOP	1
COLUMBIA	1
COOS	1
CROOK	Satellite
CURRY	1
DESCHUTES	1 headquarters + Crook, Jefferson
DOUGLAS	1
GILLIAM	Satellite
GRANT	Satellite
HARNEY	1 headquarters + Grant
HOOD RIVER	1
JACKSON	2 programs (1 agency)
JEFFERSON	Satellite
JOSEPHINE	2
KLAMATH	1
LAKE	2
LANE	3
LINCOLN	1
LINN	Satellite
MALHEUR	1
MARION	2
MORROW	Satellite
MULTNOMAH	6 focused
POLK	1
SHERMAN	Satellite
TILLAMOOK	1
UMATILLA	1 headquarters + Morrow
UNION	1
WALLOWA	1
WASCO	1 headquarters + Gilliam, Sherman, Wheeler
WASHINGTON	3 (also part of Tri-County)
WHEELER	Satellite
YAMHILL	1
Tri-County Clackamas, Multnomah, Washington	6 special focus and or culturally specific serving the Tri-county area

[3] In this chart the term "satellite" is used loosely to mean counties served by a program whose headquarters is elsewhere. Crook, Jefferson & Grant do have actual satellite offices that operate full time. Linn has outstationed advocacy at various locations that is not full time. Wheeler, Sherman & Gilliam do not have outstation or satellite presences. The extent to which these counties are served is much looser & less structured than a formal satellite arrangement.

II.B. Funding Streams

Oregon's first DV/SA programs, being primarily grassroots organizations, relied on volunteers and private donations. Governmental funding options specific to DV and/or SA were not available until the establishment of the Marriage License Tax (MLT) funds in 1981. Initially, the intent of the MLT was to stabilize existing programs. Another goal was to aid underserved areas of the state. The organization of counties into the 7 Oregon Coalition Against Domestic and Sexual Violence (OCADSV) regions dates from this period. To distribute MLT money among the disparately sized regions, OCADSV developed a formula with two factors, geography and population.

Funding

Significant additions to the funding available to DV/SA programs occurred in the 1980's and 1990's.

Marriage License Tax monies and VOCA Federal dollars and FVPSA became available in the 80's.

VAWA, CFAA/DV and SA began funding programs in the 1990's.

ODSVS was the most recent substantive fund to be developed and was implemented in the early 2000's.

Additional government funding became available to programs in 1986 with the federal passage of the Victims of Crime Act (VOCA) authorized in 1984. VOCA funds were a significant infusion of dollars into the system of support for sexual assault and domestic violence. Whereas the MLT funds provide about $500,000 annually, VOCA funds have typically meant between $1 million to $2 million dollars going to services. The federal Family Violence Prevention and Services Act (FVPSA) funding started at roughly the same time as VOCA funds. Other funds, both federal and state, did not generally come into existence until the mid to late 1990's. These included the Violence Against Women Act (VAWA) – 1994, and the Criminal Fine Assessment Accounts, CFAA/DV -1996 and CFAA/SA – 2000 (authorized in 1999). CFAA/DV represents the most significant of these funds, contributing well over one million dollars into the funding pool. (All dollar amounts are annualized unless otherwise indicated.)

VAWA represents a significant contribution of an estimated $700,000 or so. Finally ODSVS, established in 2001, contributes about one million dollars annually as well. This is the latest government funding source to support programs. (More information on these funds is presented on pages 37.) Table 2 outlines the government funding streams along with a funding history from 2000-2005. This table is meant to be illustrative and not precise. The data source was the self-reports of funded programs, and the differing fiscal years of the funds may cause reported amounts to be different from allocated amounts. Reports were made for a July – June fiscal period. Currently, FVPSA, CFAA/DV and CFAA/SA are administered by DHS; VOCA, VAWA[4] and ODSVS are administered by Oregon's Department of Justice.

[4] Department of Justice is just now beginning to monitor VAWA funds. The Criminal Justice Services Division within the Oregon State Police is the administering agent.

Table 2: Short History of Government Funding Sources.
Approximate Annual Amounts and Percentage of Total Funds Available[5]

2000-01	MLT	CFAA/DV	CFAA/SA	FV	SCF OTHER	VOCA				VAWA/OSP	VAWA/ DOJ	TOTALS
TOTAL	$545,839	$1,442,227	$388,881	$698,961	$247,641	$1,929,150				$747,137	$97,288	$6,971,126
percent	**8.12%**	**21.45%**	**5.78%**	**10.40%**	**3.68%**	**28.69%**				**11.11%**	**14.45%**	
2001-02	MLT	CFAA/DV	CFAA/SA	FV	SCF OTHER	VOCA		DOJ CIVIL	DOJ CAP	VAWA/OSP		
TOTAL	$632,838	$1,329,449	$335,244	$1,024,237	$399,899	$1,664,739		$432,203	$528,862	$708,921		$7,056,394
Percent	**10.33%**	**21.70%**	**5.47%**	**16.72%**	**6.53%**	**27.17%**		**7.05%**	**8.63%**	**11.57%**		
2002-03	MLT	CFAA/DV	CFAA/SA	FVPSA	OTHER DHS	VOCA	ODSVS	CIVIL LEGAL	CAPITOL	VAWA		
Totals	$628,629	$1,429,877	$352,463	$1,137,198	$328,695	$1,754,997	$1,676,632	$322,793	$529,135	$769,153		$8,929,574
Percent	**7.60%**	**17.29%**	**4.26%**	**13.75%**	**3.97%**	**21.22%**	**20.27%**	**3.90%**	**6.40%**	**9.30%**		
2003-04	MLT	CFAA/DV	CFAA/SA	FVPSA		VOCA	ODSVS			VAWA		
	$570,191	$1,333,407	$331,734	$1,141,818		$2,027,416	$1,230,610			$772,157		$7,407,333
	7.70%	**18.00%**	**4.48%**	**15.41%**		**27.37%**	**16.61%**			**10.42%**		
2004-05	MLT	CFAA/DV	CFAA/SA	FVPSA		VOCA	ODSVS			VAWA		
Totals	$561,311	$1,227,750	$276,146	$1,161,388		$1,947,975	$948,342			$776,266		$6,899,179
	8.14%	**17.80%**	**4.00%**	**16.83%**		**28.23%**	**13.75%**			**11.25%**		

[5] Several of these funding sources including VOCA, ODSVS and VAWA utilize competitive grants as well as RFP's to distribute funds. For instance, approximately 50% of VOCA funds go to competitive project grants. Please see page 8 for explanation of information sources.

Although the funds administered by DHS have focused on the grassroots private nonprofit agencies, the VOCA, VAWA and ODSVS have supported a broader spectrum of DV/SA services that includes, but is not limited to, those offered by the grassroots providers. For example, in addition to DV/SA services, VOCA funds crime victim advocates in prosecutor based victim assistance and child abuse intervention centers across Oregon. VAWA supports projects that promote collaboration between DV organizations and law enforcement agencies, prosecutors and courts. And ODSVS provides money for legal services.

In addition to these primary sources, funds are available through the Attorney General's Sexual Assault Task Force (Rape Prevention Education – RPE grants) and through the Oregon Coalition Against Domestic and Sexual Violence tax check-off program and services to victims of sexual offenses. These funds were established in the '80's and '90's, represent less than $400,000 annually, and are very specifically targeted. The RPE grants are long-term grants to 12 programs for specific prevention activities. The OCADSV grants may be limited to member programs and programs serving victims of sex offenses.

Programs also receive funding through local sources such as United Way, foundation grants, local government and fundraising. However, over half of DV/SA programs funded by all government resources rely on those resources to fund 40% or more of program operating budgets. Nearly one-quarter rely on these funds for 50% or more of program budget.[6]

The following timeline in Table 3 gives a sense of the emergence of services/programs in Oregon as well and the establishment of funding sources.

Table 3: TimeLine

Program	Date[7]	# in each decade	Funding Source	County Served
	1970's	13programs, 6 counties		
Sexual Assault Victims Services	1972 Merged with Dunn House in Sept 83 to form Crisis Intervention Services: CIS merged with others to become Community Works in 1996			Jackson
Bradley-Angle, Inc.	1975			Tri-County area
PWCL	1975			Tri-County area
Clatsop Women's Resource Center	1976			Clatsop
DVRC	1977			Washington
Womenspace	1977			Eugene
Dunn House	1977 (see SAVS above)			Jackson
Mid-Valley WCS	1978 (Begun as a crisis line in 1973)			Marion
V of A Home Free	Began operating as DV program in late 70's early 80's			Tri-County area

[6] From 2004-2005 data as reported by programs to DHS.

[7] Dates below are incorporation dates (501(c)(3) as listed with the IRS unless otherwise indicated.

Program	Date	# in each decade	Funding Source	County Served
1970's				
West Women's & Children's Shelter	Began operating in late 70's early 80's initially for homeless women, then more specifically DV. Started under Burnside Community Council then moved to the Salvation Army somewhere between 1987 or 89			Tri-County area
YWCA Yolanda House	Began operating DV services in late 70's but had been serving women generally for a longer period.			Tri-County area
Raphael House	1978			Tri-County area
OCADSV	1979			
	1979		**VISTA**	
1980's		21 providers 17 counties		
Columbia Women's Resource Center	1980			Columbia
Women's Crisis Support Team	1980			Josephine
Helping Hands	1980			Hood River
Domestic Violence Services	1980 (Task Force 1977)			Union +
	1981		**MLT 1981**	
Battered Persons' Advocacy	1981			Douglas
CARDV	1981			Linn/Benton
Women's Safety & Resource Center	1981			Coos
Henderson House	1982 (c3)			Yamhill
COBRA	1982	-		Deschutes +
Haven	1982			Wasco
My Sister's Place (Women's VIP); before that Lincoln Shelter & Services	1982 (c3)			Lincoln
Project DOVE	1983			Malheur
HHOPE	1983			Harney
Shelter from the Storm	1985 (started as Union Co Task Force on DV)			Union
Canyon Crisis Center	1985			Marion +
Clackamas Women's Services	1985			Clackamas, Tri-county
Lake County Crisis Center	1985 (originally affiliated with Klamath)			Lake

Program	Date	# in each decade	Funding Source	County Served
1980's				
Women's Crisis Center	1986			Tillamook
Community Advocates	1986			Tri-county
	1986		**VOCA**	
Klamath Crisis Center	1988			Klamath
Siuslaw AWC	1989			Lane
1990's		9 providers 4 counties		
May Day, Inc.	1991			Baker
SARC	1991 (Established earlier according to history available on Website)			Washington
SASS	1992			Lane
Oasis Shelter Home	1994			Curry
S.A.B.L.E. House	1994			Polk
	1994		**VAWA 1994**	
Safe Harbors	1995			Wallowa
	1996		**CFAA/DV 1996**	
	1999/2000		**CFAA/SA 1999**	
Illinois Valley	2001			Josephine
SAWERA	1998			Washington, Tri-county
Catholic Charities: El Programa	Funded 1999			Tri-County
2000's		4 providers		
Native American Family Healing Circle	Funded 2000			Tri-county
Russian Oregon Social Services/EMO	Funded 2000			Tri-county
IRCO/RIFS	Funded 2001		**ODSVS 2001**	Tri-county
Breaking Free	2003			Lane

All together these funding sources provide a minimal but critical level of DV and SA services. As the level of resources has increased, providers have been able to address DV and SA issues in communities more effectively and with more consistency. However, programs throughout the state still struggle on very limited budgets to address the needs of women, men, and their families who experience sexual and domestic violence. Many programs work with determination and creativity, but wonder if their counties are receiving an equitable level of support. Furthermore, not having sufficient resources sometimes results in people wondering if they are being treated fairly.

II.C. Funding Patterns

To allocate funds to service providers, government sources have used a wide variety of approaches and formulae. Some funds have used a population/geography formula like the MLT formula. Others have relied on competitive means to fund programs. As a result of these different funding approaches, per capita funding can be disparate even when county populations are similar.[8] The following table gives examples that illustrate this point.

Table 4: Examples of Funding in Population Comparable Counties

County	Population	Annual Amount Funded	Per capita funded	Land area
WALLOWA	7,130	$ 117,496	$ 16.48	3,145.34
LAKE	7,505	$ 113,459	$ 15.12	8,135.75
HOOD RIVER	21,180	$ 125,864	$ 5.94	522.35
CURRY	21,190	$ 99,496	$ 4.70	1,627.38
COOS	62,695	$ 190,951	$ 3.05	1,600.48
KLAMATH	65,055	$ 205,965	$ 3.17	5,944.19
LINN/BENTON[9]	189,985	$ 262,091	$ 1.38	2,968.64
JACKSON	194,515	$ 307,407	$ 1.58	2,785.19
MARION	302,135	$ 247,673	$ 0.82	1,183.95
LANE	336,085	$ 577,166	$ 1.72	4,554.00

Currently, the most heavily government funded programs receive 21 times the per capita funding when compared to those that receive the least.

III. Definitions of Domestic Violence and Sexual Assault

For the purpose of this study, the following definitions will be used.

Sexual assault is forced oral, vaginal, or anal sex, whether the act was completed or attempted without completion. This definition was used as part of the Intimate Partner Violence study referenced below. The State Attorney General's Task Force on Sexual

[8] Per capita is calculated on the basis of total county population.
[9] These two counties are combined for this analysis as one program serves both counties

Assault defines "sexual assault" as any nonconsensual sexual act, "A sexual act is nonconsensual if it is inflicted upon a person unable to grant consent OR is unwanted and compelled through the use of physical force, manipulation, coercion, threats, or intimidation."

Domestic violence includes physical abuse and/or sexual abuse committed by a spouse, former spouse, current or former boyfriend or girlfriend. The term "Intimate Partner Violence" is beginning to replace the term "domestic violence," but the Center for Disease Control (CDC) indicates that the terms are interchangeable. ("Costs of Intimate Partner Violence Against Women in the United States", National Center for Injury Prevention and Control, part of the Centers for Disease Control and Prevention.)

Physical assault has been defined in the study "Intimate Partner Violence in Oregon: Findings from the Oregon Women's Health and Safety Survey" as a range of behaviors intended to cause physical harm from hitting and shoving, to shooting and stabbing.

The Equity Study recognizes that more broad definitions of abuse exist including definitions that take into account various types of control and coercive behavior, incorporating non-physical psychological abuse and verbal abuse. (Moore-Parmley, Angela 2004)

IV. Equity Considered and Defined

The concept of "equity" speaks to people's sense of fair division of resources but equity is sometimes a slippery concept. It is easy to understand the equity of dividing a pie into eight equal parts for eight people, but when the eight people include a young athlete, an overweight senior, a toddler, a pie enthusiast who missed dinner, a person who doesn't particularly like pie, and three people with moderate appetites who just finished eating dinner, "equal parts" no longer seem equitable. Then the question of how big a piece each person needs and/or wants seems equitable. Furthermore, varying the size of pie slices seems virtuous because it is effective, efficient and nobody really values wasting food.

Perspectives on Equity

"Equal means that core staff are the same. Core staff needs to cover hotline, shelter and advocacy." *Service provider.*

""Equity" is everyone has enough money to exist. A guarantee." *Service provider*

For this equity study two sources of information helped inform the definition of equity. The literature review included experiences from other states as well as scholarly papers which analyzed a theoretical construct of equitable distribution of scarce resources. For example, in "Equity, Equality, or Need?" Elizabeth Mannix et al posit that a definition of equity might depend on an organization's goals and whether the resource being distributed serves as a reward for past behavior, an incentive for future behavior, or an allocation to meet a service need. Similarly, examples from programs in other states reflected diverse approaches to equity. In some cases equity was accomplished solely by competitive proposal practices, while other programs utilized complex formulae to insure equitable distribution of scarce resources.

Additional sources of perspective to inform the definition of equity were the interviews conducted with people across Oregon, and survey information from DV/SA services

providers. For most interviewees and for some survey respondents, the concept of equity was rooted in the needs of people. This weighing of needs became an evident aspect of people's response to the question, "How would you define equity?" One respondent stated that equity would be served in the ideal if all providers were "getting what we need for our populations in the areas we serve." However, a number of factors affected need –

- Size of population
- Physical isolation of population
- Presence of culturally specific populations
- Level of community support for DV/SA services in terms of resources provided
- Level of local government support in terms of resources provided

Specifically, interviewees offered these perspectives on equity:

- Parity is receiving resources in **proportion to size of population** in need.
- Equity reflects **geography, population and effectiveness of services** provided.
- Equity requires some **service level in every county**.
- Equity encompasses **efficient use of government dollars**, e.g. a minimum level of services in every community, but with centralized offices.
- Equity requires not only a rational distribution of resources, but a **voice in determining the process of distribution**. (For example, one person said equity was, "a voice for (nine) Native tribes to effect change at all levels of the system so that Native women as individuals or as members of tribes do not get discriminated against whether they live on or off a reservation.")
- Equity is everyone (providers) having **enough money to exist**, a guarantee.

Based on findings, the study adopted a definition of equity that is grounded in meeting victims' needs:

Equity is an allocation of state resources that assures meaningful access to DV/SA services for DV/SA victims in all of Oregon's 36 counties.

Implicit to this definition are the concepts of 1) stability of a service provider network, 2) meaningful access even at minimal service levels, 3) culturally appropriate services for culturally specific populations, 4) appropriate services for special circumstances such as seniors or people with disabilities, 5) effectiveness of services provided, and 6) open and transparent decision making regarding allocations so that healthy public dialogue is facilitated. To further define what equitable allocation of funds would look like, the study examined the demographics of the state, the needs of DV/SA victims, and the services provided to victims.

V. Oregon's DV/SA Services

As mentioned earlier, the DV/SA service structure involves a network of nonprofit primarily grassroots service providers. These are joined by local law enforcement,

district attorneys' offices, county prosecutor based victim assistance programs, and legal aid. Both sexual assault and domestic violence service networks are either utilizing or beginning to utilize multi-disciplinary teams to further enhance services to victims/survivors. For example, community based Sexual Assault Response Teams, exist or are being planned for in 29 counties. These teams are to "ensure an effective, consistent, comprehensive and collaborative response to sexual assault that prioritizes the needs of sexual assault victims and brings responsible persons to justice." (from the Attorney General's Sexual Assault Task Force website, http://www.oregonsatf.org/SART/)

The following is an outline of major providers and the roles they play in assisting victims/survivors.

- ***Nonprofit organizations:***
  - **Emergency intervention**
  - **Shelter and safety**
  - **Counseling**
  - **Advocacy**
  - **Support**
  - **Prevention**

- ***Law Enforcement***
  - **Intervention**
  - **Arrest**

- ***District Attorneys***
  - **Prosecution**

- ***Prosecutor-Based Victim Assistance***
  - **Advocacy**
  - **Support**
  - **Notification of victim rights**

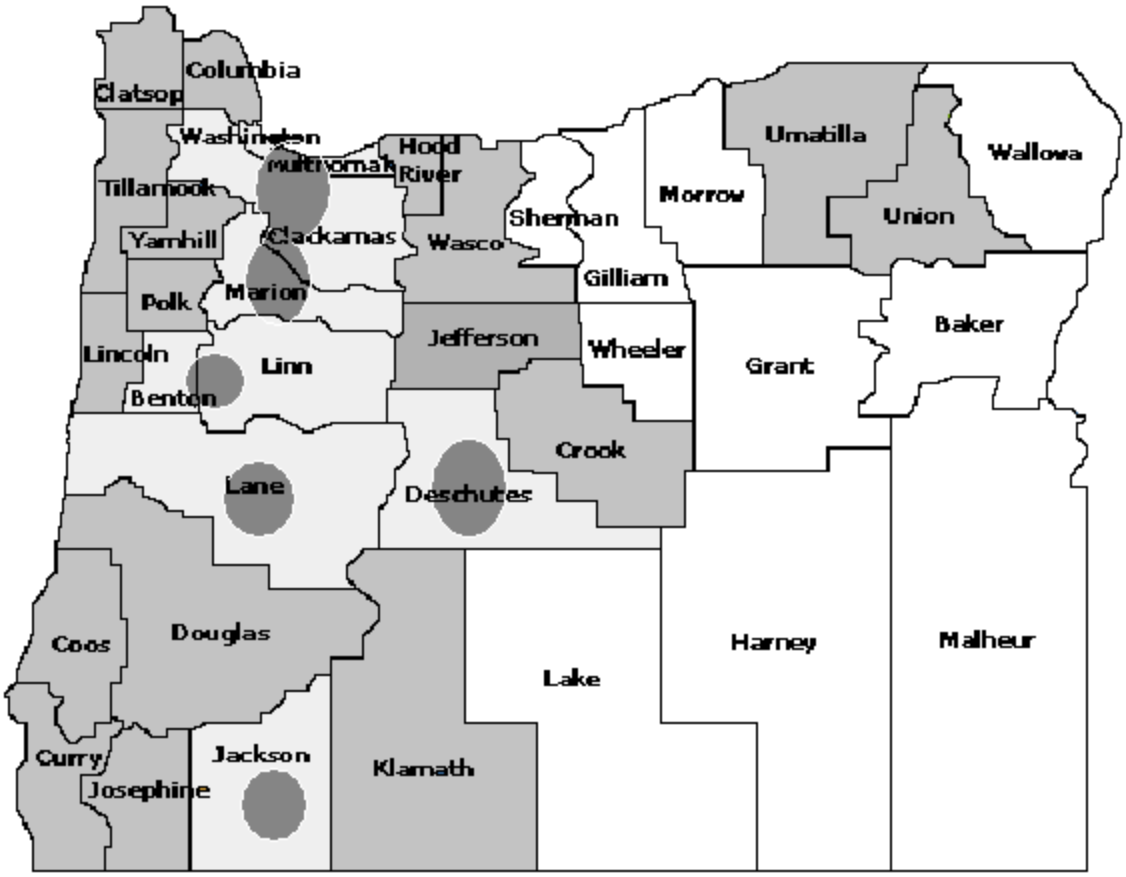
- ***Legal Assistance***
  - **Legal intervention and support**

VI. Oregon's Demographics

Oregon's geography is a mix of ocean coast, mountain ranges, high desert, rain forest and fertile valleys. It is a stunning landscape and home for a citizenry that is passionate about both the land and the lifestyles the land defines. However, geography dictates population patterns that over the years have presented Oregon with political and social challenges. A large percentage of Oregon, 55%, is publicly owned and sparsely populated. Conversely, 50 % of population lives on 4% of land mass (Clackamas, Multnomah, Marion and Washington Counties = 4,248 sq.mi.). The majority of the state's population lives along the I-5 corridor, although central Oregon is one of the state's fastest growing

areas. Map 1 shows Oregon's population distribution, while Map 2 shows land ownership.[10]

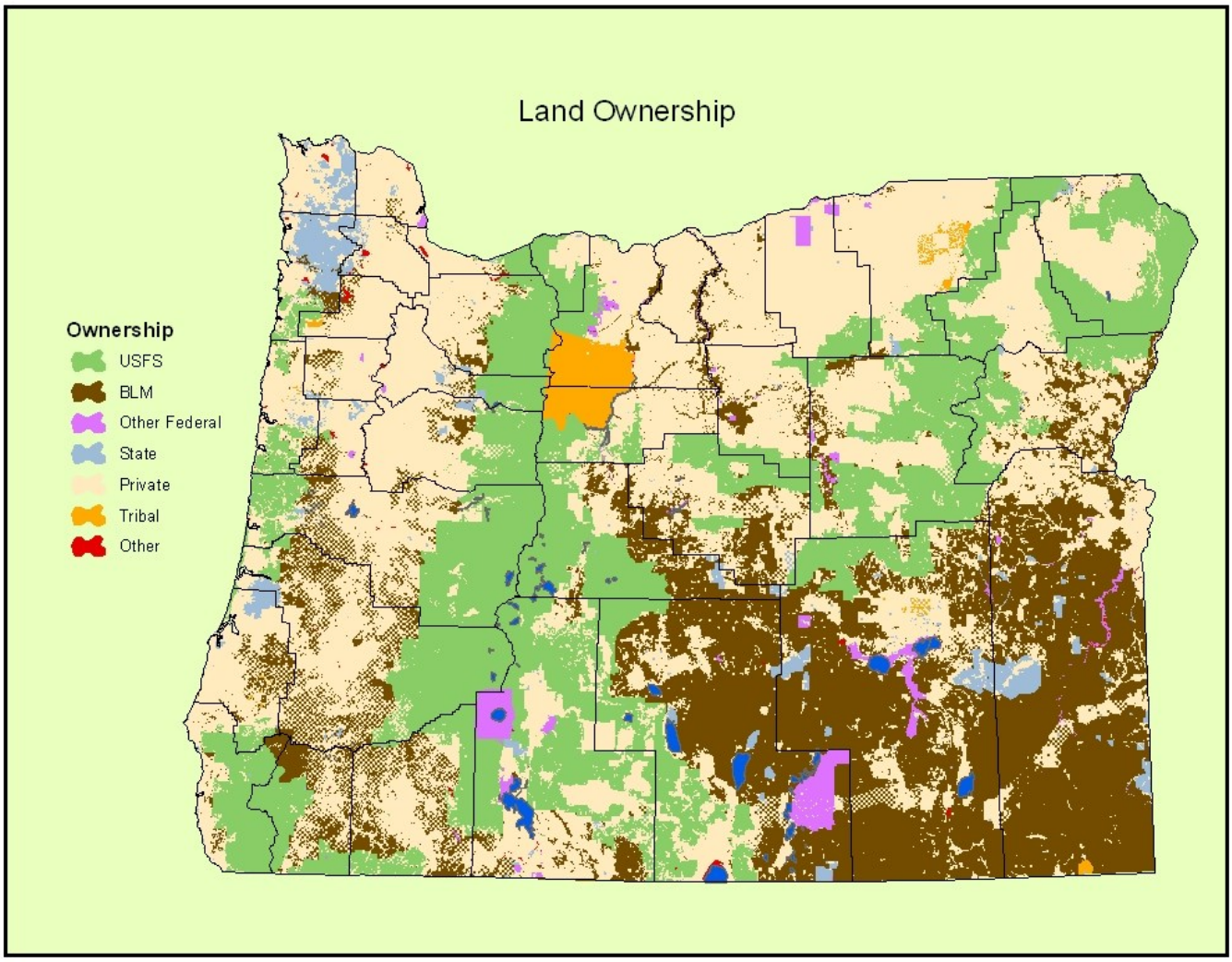
Map 1: Population distribution



	Dark grey circles	Urban areas	50,000 or more people
	Light Grey	Rural w/ urban	
	Grey	Rural	10 miles or > from pop. Center of 30,000
	White	Frontier	6 or < per sq. mile

[10] Demographic data from U.S. Census QuickFacts 2004

Map 2: Land Ownership



The disparity in population density between Oregon's most and least populous counties is huge. Multnomah County has a population of approximately 654,000 living on 464 square miles, for a density of 1410 people/per sq. mile, while 10 counties, Harney, Wheeler, Lake, Gilliam, Grant, Sherman, Wallowa, Morrow, Baker, and Malheur are designated by the federal government as frontier counties because they have six or fewer people per square mile. The total population of the 10 frontier counties is only 14% of Multnomah County's population. Furthermore, the problems of population and density are compounded by economic factors. By state designation, 16 of Oregon's 36 counties are economically severely distressed with an additional 9 counties being distressed. ("2005 Distressed Areas and Associated Index Values", www.econ.state.or.us/distlist.htm) All of the frontier counties are among these counties. This demographic picture is significant because it has been difficult for economically distressed rural and frontier counties to fund DV/SA victim programs, and yet they serve isolated populations whose access to services is hindered by geography.

Oregon is a State of contrasts.

55% of land mass is publicly owned.

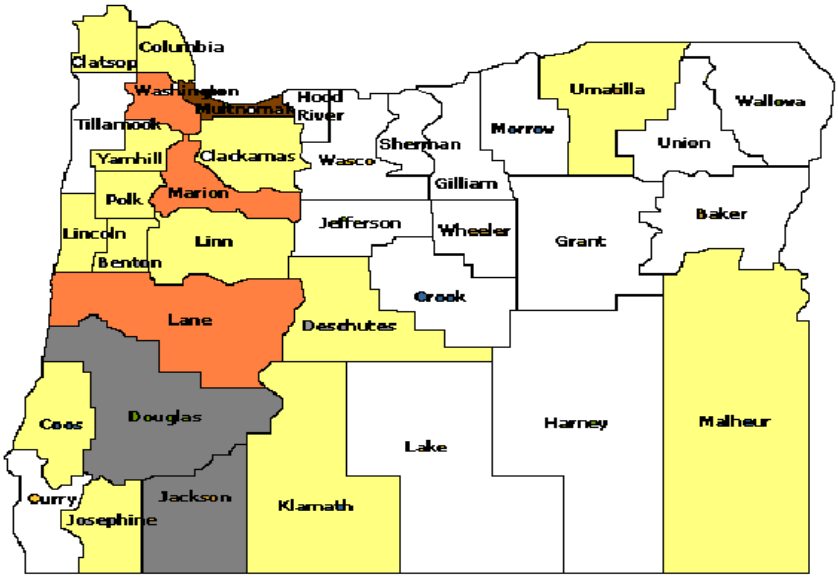
Density ranges from 1,410 people per sq. mi. to .7 people per sq. mil.

More populated counties have concentrated numbers of people in need. Sometimes these numbers exceed the populations of Oregon's least populous counties.

Less densely populated areas may have a greater percentage of county population in need.

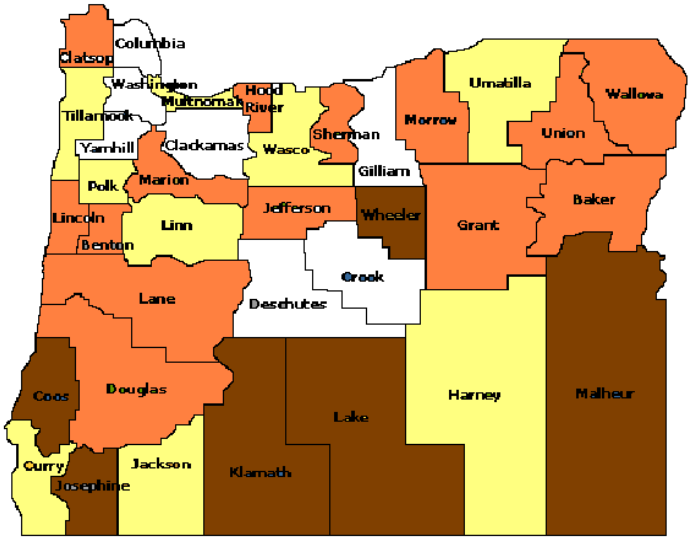
One approach to assessing county needs is to identify risk factors associated with DV/SA, and then look at the prevalence of those risk factors in county population. In the literature review conducted as part of this study, poverty is consistently found to be a socio-economic risk factor for abuse (other factors account for access barriers and will be discussed later.) The poverty data for Oregon illustrates the contrasts among Oregon counties due to population size and economic health. Counties can have high rates of poverty and yet their low income population accounts for only a small portion of the state's low income population. For example, more than 20% of Oregonians living in poverty live in Multnomah County – the largest number of Oregon residents living in poverty live in that county. However, six counties (Coos, Josephine, Klamath, Lake, Malheur and Wheeler) have more than 15% of their county populations living in poverty, but these people represent less than 6% of the state's poverty population. Maps 3 and 4 illustrate how sheer numbers affect some counties, while high percentages affect others.

Map 3: People in Poverty – Greatest Numbers



	20% or more, Multnomah
	>6%-15%
	3% - 6%
	1% - 2%
	1% or Less

Map 4: County Populations in Poverty - % of population



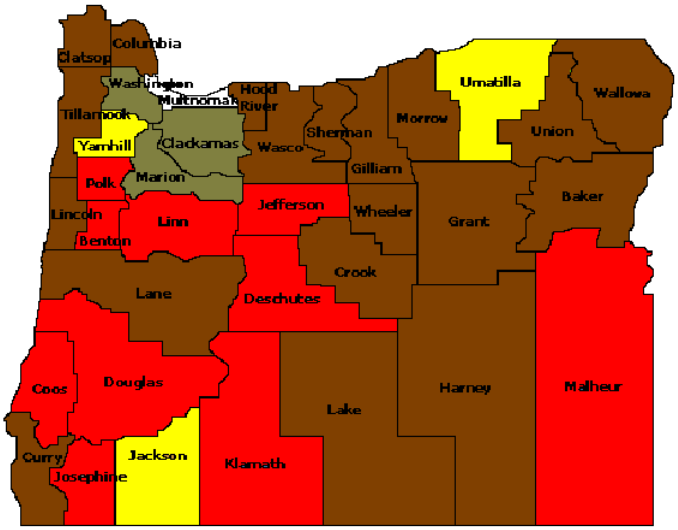
	15% or more
	13% - <15%
	11%-<13%
	Less than 10%

Considerable research has been conducted to determine whether ethnicity/race and/or being a non-English speaker are socio-economic factors for abuse. Generally, the literature search found that, with the exception of Native Americans, race/ethnicity are not factors that put an individual at greater risk of being a victim of DV/SA except when combined with poverty. However, these are factors in victims' ability to access needed services. Similarly, for victims who speak a language other than English or do not speak English well, access to services can be difficult. Yet when one looks at demographic data to assess which counties might be impacted by these access issues, the great disparity in population size among counties is a defining dynamic.

The following maps show data about ethnic population (see map 4 and 5), Hispanic/Latino population (see map 6 and 7), and populations whose primary language is not English (see map 8 and 9). Some of Oregon's rural and frontier counties such as Malheur, Marion and Hood River, have high proportions of Hispanic/Latinos and/or non-English speakers, but these populations are still a small proportion of all Hispanic/Latinos or non-English speakers in the state as a whole. Achieving equity among counties characterized by such wide differences is Oregon's challenge.

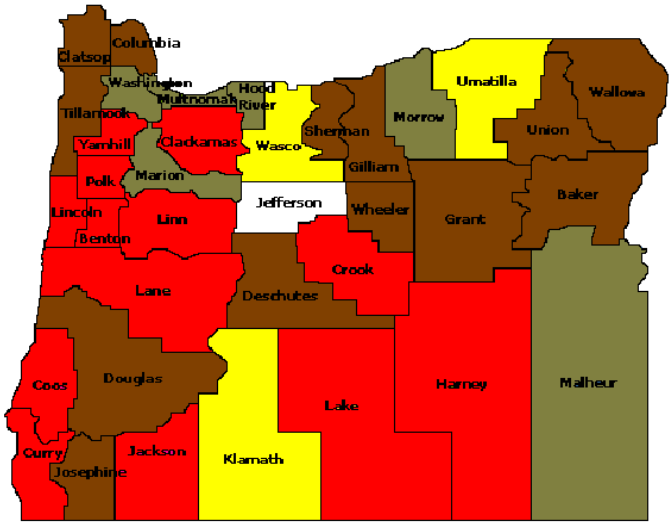
Finally, there is some evidence that developmentally delayed women and women suffering from mental illness are particularly at-risk for DV/SA. And there is increasing concern in Oregon about elder abuse as a form of DV. Although these populations have well-established service systems to address many of their needs, ensuring access to appropriate DV/SA services will require collaboration between DV/SA networks and senior and/or mental health agencies.

Map 4: Ethnic Population: Greatest Numbers



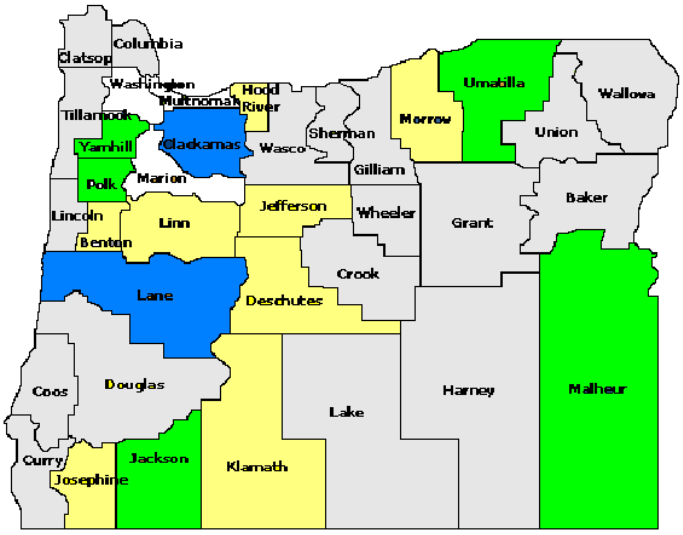
	More than 25%, Multnomah
	5%-20%
	>2%-4%
	1% - 2%
	Less than 1%

Map 5: Ethnic Population – County Populations - % of county



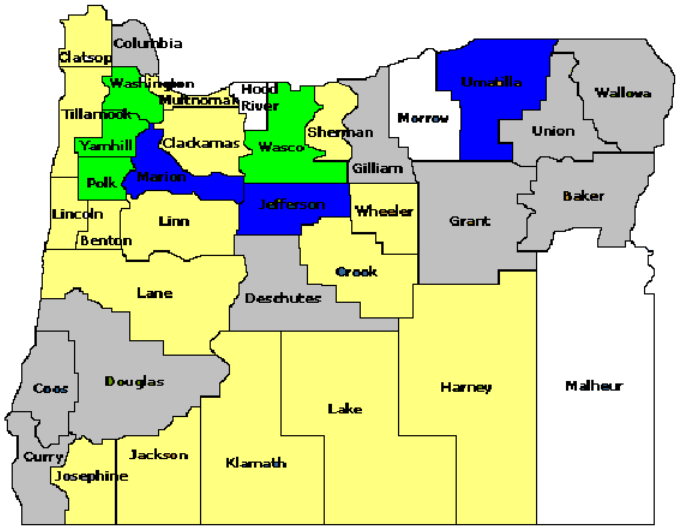
	More than 30%, Jefferson
	>19% - 25%
	12%-19%
	>7% - 9%
	2%-7%

Map 6: Latino/Hispanic Population: Greatest Numbers



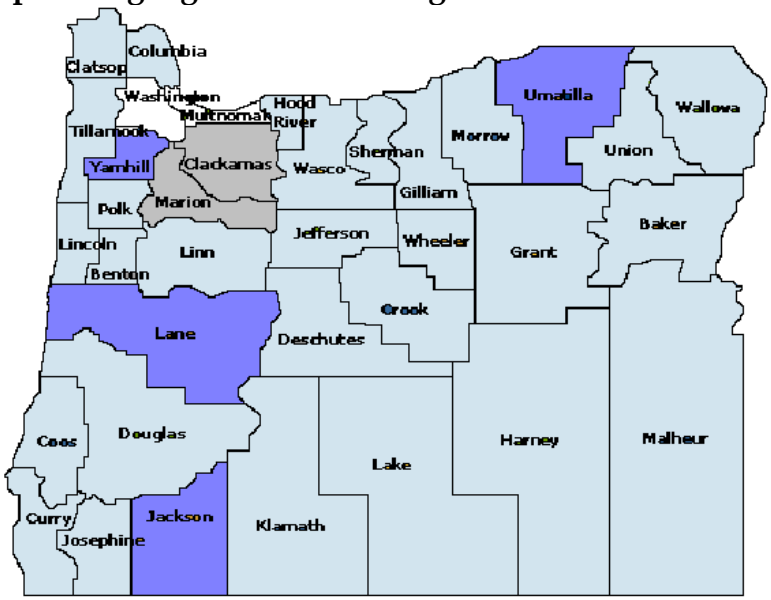
	17% or more of total population, Multnomah, Washington, Marion
	5%-6.5%
	2% – 4.5%
	1%-<2%
	< 1%

Map 7: Latino/Hispanic Population – County populations - % of county



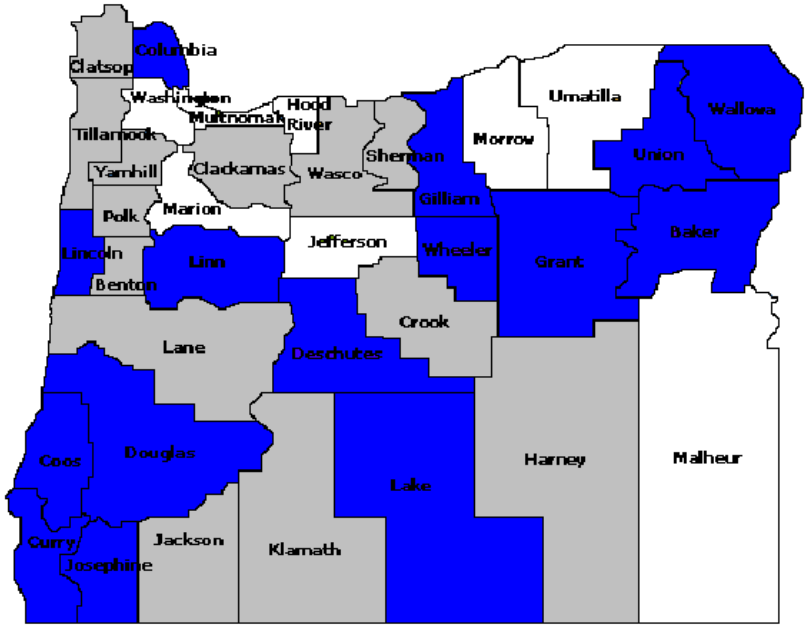
	24% or more, Hood River, Morrow, Malheur
	13%-18%
	>8%-12%
	4%-8%
	<4%

Map 8: Language Other than English – Greatest Numbers



	20% or more Multnomah, Washington
	7%-14%
	2%-6.5%
	< 2%

Map 9: Language Other than English – County populations - % of county



	> 16%
	6%-12%
	<6%

VII. Prevalence of DV/SA in Oregon and the Need for Services

Oregon counties have striking contrasts, but over the past two decades Oregon has built a network of DV/SA services across the state, including strong, effective programs in rural and frontier areas. This is to Oregon's credit because other states have patterns of funding urban areas and leaving rural areas underserved (Tiefenthaler, et al.). Still, equitable funding of DV/SA victim services benefits from examination of need for services statewide. The Planning Group looked at DV/SA prevalence data and then, based on data, developed a model for a level of service that could assure a basic access for victims.

Sources of information to assess the prevalence of DV and SA in Oregon include law enforcement data, research conducted by the Center for Disease Control and Prevention, and research conducted by the Oregon Health Division. Law enforcement data depends on victims reporting crimes, and DV and SA crimes are widely considered to be under-reported.

Public health surveys, although vulnerable to problems of sampling low income, isolated, homeless, ethnic, and non-English speaking populations, are seen as credible by service providers in Oregon. These surveys reveal DV/SA as severe problems in our society. The National Violence Against Women Survey found, for example, that 1 in 6 women experiences rape at some time in her life, while 25% of women and 7.5% of men have been victims of domestic violence in their lifetime.[11]

For the equity study, The Planning Group focused on four sources for prevalence data:

- Findings from the 1995-96 National Violence Against Women Survey (NVAWS) conducted by Patricia Tjaden and Nancy Thoennes
- Findings from the 2001-2002 Oregon Women's Health and Safety Survey (Intimate Partner Violence) conducted by the Oregon Health Division
- 1998 Oregon Domestic Violence Needs Assessment: A Report to the Oregon Governor's Council on Domestic Violence
- Findings from the 2004 Oregon Behavioral Risk Factor Surveillance Survey (BRFSS)

Table 5 below presents sexual assault prevalence data from two surveys applied to Oregon's 2005 (U.S. Census data) population of women ages 18 and older.

TABLE 5: PREVALENCE OF SEXUAL ASSAULT

Study / Survey	Age Surveyed (women)	Findings: Sexual Assault experienced in a 12 month period	Findings Applied to Oregon 2005 populations estimates
NVAW	18 years & older	.3 % of women	4,207
BRFSS	18 years & older	.85% of women	11,919

[11] Tjaden, Patricia, and Thoennes, Nancy. NVAW studies (2)

Table 6 shows findings from four studies on the prevalence of domestic violence, applied to Oregon's 2005 population estimates for women.

TABLE 6: PREVALENCE OF DOMESTIC VIOLENCE

Study / Survey	Age Surveyed	Findings: DV (physical assault) experienced in a 12 month period	Findings Applied to Oregon 2005 populations estimates
1998 Needs Assess.	18-64 yr. olds	13.3% of women	152,241
OR IPV Study	20-55 years old	3 % of women	34,340
NVAW	18 years & older	1.5% of women	21,035
BRFSS	18 years & older	1.3% of women	18,230

Table 7 shows findings from two studies on the prevalence of intimate partner rape, applied to Oregon's 2005 population estimates for women.

TABLE 7: PREVALENCE OF INTIMATE PARTNER RAPE

Study / Survey	Age Surveyed	Findings: Sexual Assault by Intimate Partner experienced in a 12 month period	Findings Applied to Oregon 2005 populations estimates
1998 Needs Assess.	18-64 yr. olds	7.5% of women	85,850
OR IPV Study	20-55 years old	1 % of women	11,447

To more clearly determine the level of need in counties throughout Oregon, The Planning Group chose prevalence rates from the Intimate Partner Violence study for domestic violence (3% of women), and the BRFSS for sexual assault (.85% of women) and applied those rates to individual counties. Both the IPV study and the BRFSS data were surveys conducted on Oregon residents and are considered credible data sources for DV/SA providers in Oregon.[12]

Once the yearly prevalence rate of new victims was established for each county, it was divided by 12 to estimate the number of new victims per month. The staff service ratio of 1:10 for DV victims and 1:8 for SA victims was then applied.[13] Only staffing levels for direct service positions, i.e. advocacy and crisis intervention, were considered. Table 8, below, shows need (i.e. number of DV and SA victims) and staff level.

[12] The IPV survey used questions from 4 existing instruments each of which had been tested and successfully administered nation-wide and in Canada. See also Vest, et al. and Thompson, et al. regarding BRFSS.

[13] The staff service ratios were based on information gathered on the survey of providers and are consistent with the Council On Accreditation Beta Version of Accreditation Standards, and Child Welfare standards for caseloads.

Table 8: Estimated Need for Direct Service Staff[14]

	Total Pop	Total population of women 18-64	DV /IPV@ 3% yearly	DV Staff FTE	SA @ .85 yearly	SA Staff FTE		Total potential direct staff FTE
OREGON	**3,631,440**	1,144,666	34,340		9,730			
BAKER	16,500	4,818	145	1.20	41	0.43		1.63
BENTON	82,835	29,032	871	7.26	247	2.57		9.83
CLACKAMAS	361,300	115,780	3,473	28.94	984	10.25		39.20
CLATSOP	36,640	11,415	342	2.85	97	1.01		3.86
COLUMBIA	46,220	14,392	432	3.60	122	1.27		4.87
COOS	62,695	18,956	569	4.74	161	1.68		6.42
CROOK	22,775	6,769	203	1.69	58	0.60		2.29
CURRY	21,190	5,921	178	1.48	50	0.52		2.00
DESCHUTES	143,490	45,838	1,375	11.46	390	4.06		15.52
DOUGLAS	102,905	30,876	926	7.72	262	2.73		10.45
GILLIAM	1,890	540	16	0.13	5	0.05		0.18
GRANT	7,685	2,274	68	0.57	19	0.20		0.77
HARNEY	7,660	2,238	67	0.56	19	0.20		0.76
HOOD RIVER	21,180	6,249	187	1.56	53	0.55		2.12
JACKSON	194,515	60,621	1,819	15.16	515	5.37		20.52
JEFFERSON	20,600	5,867	176	1.47	50	0.52		1.99
JOSEPHINE	79,645	23,926	718	5.98	203	2.12		8.10
KLAMATH	65,055	19,465	584	4.87	165	1.72		6.59
LAKE	7,505	2,205	66	0.55	19	0.20		0.75
LANE	336,085	109,521	3,286	27.38	931	9.70		37.08
LINCOLN	44,405	13,805	414	3.45	117	1.22		4.67
LINN	107,150	32,286	969	8.07	274	2.86		10.93
MALHEUR	31,800	8,184	246	2.05	70	0.72		2.77
MARION	302,135	89,620	2,689	22.40	762	7.94		30.34
MORROW	11,945	3,480	104	0.87	30	0.31		1.18
MULTNOMAH	692,825	230,535	6,916	57.63	1,960	20.41		78.05
POLK	65,670	20,725	622	5.18	176	1.84		7.02
SHERMAN	1,880	524	16	0.13	4	0.05		0.18
TILLAMOOK	25,205	7,338	220	1.83	62	0.65		2.48
UMATILLA	72,395	20,858	626	5.21	177	1.85		7.06
UNION	24,950	7,803	234	1.95	66	0.69		2.64
WALLOWA	7,130	2,106	63	0.53	18	0.19		0.71
WASCO	23,935	7,081	212	1.77	60	0.63		2.40
WASHINGTON	489,785	155,430	4,663	38.86	1,321	13.76		52.62
WHEELER	1,550	425	13	0.11	4	0.04		0.14
YAMHILL	90,310	27,772	833	6.94	236	2.46		9.40
TOTAL	3,631,440	1,144,673	34,340	286	9,730	101.35		387.52
Average	100,873	31,796	954	8	270	2.82		10.76
"Model" (see page 40 for application)	30,000	9453	284	Rounded 2.25	69	Rounded .75		Rounded 3

[14]Limited to direct advocacy/crisis staff and does not include support, administration or other essential staff. Data from U.S. Census QuickFacts 2005. Staffing is based on incidence distributed over a 12 month period.

As Table 8 illustrates, Oregon needs about 388 direct service staff to address the needs of approximately 34,340 new DV victims, and 9730 new SA victims each year. The specific services are discussed in the following section.

VIII. Core Services and Service Costs

A task of the equity study has been to identify DV/SA services, determine which of these are core services, and ascertain costs. In examining services the Planning Group used data from the provider survey as well as information from the literature search.

VIII. A. Services

Services to victims/survivors of domestic violence and sexual assault have some parallels and some differences. Domestic violence victims/survivors often come to shelters and crisis services after an acute battering incident or when threatened with violence. Approximately 50% of these women have children with them. Besides the potential need for immediate safe shelter, DV victims/survivors can need help accessing basic needs (food, permanent housing) and legal advocacy (especially related to restraining orders and custody of children). Support groups and peer counseling help women understand the cycle of abuse and issues related to getting out of abusive relationships.

Perspectives on Service Resources

"Rural communities don't have the luxury of specialization. We don't have separate staff for each problem." *Rural service provider*

Children accompanying their mothers to shelter also have service needs. On a practical level, child care is needed when mothers have appointments. School attendance might be negotiated and school needs bridged. In addition, children need support and counseling for issues around observing abuse.

Sexual assault victims/survivors may seek services immediately after the rape or assault or s/he may be seeking service months or years after the event, when something or someone has triggered memories of the assault. Immediate crisis response can include peer counseling, support, advocacy, and accompaniment to the hospital and police. Subsequent assistance can include legal advocacy (accompaniment to court) and peer counseling. Help to victim/survivors who have experienced an assault in the past tends to focus on counseling and support. Emergency shelter, while a potential component of service to victims of sexual assault, is not a typical feature of service as is evidenced in program service statistics.

Perspectives on Service Resources

"No one anywhere in the state is floating in money. Still, the numbers of victims we deal with here are astronomical." *Urban service provider.*

For both DV and SA survivors, services may relate to meeting basic needs – food for instance, or safe transportation. Alternatively, services may be very client specific such as dealing with immigration issues.

Although intervention is the current primary focus of both DV and SA services, prevention is critical to the service network also. Prevention can be with victim/survivors to ensure against re-occurrence of abuse, but prevention includes education of the larger society and of specific

populations within a community to reduce or eliminate domestic violence and sexual assault as risks to women.

Different constellations of service may be considered "core" when viewed from a client perspective. And it would be ideal for every organization to be in a position to provide this panoply of services, but it may not be practical. The medical system provides an analogy in that all patients (usually) get weighed, measured, blood pressure and temperature taken, and interviewed by nurses, but not every patient gets blood tests, prescriptions, etc. etc. Some are even referred to specialists. Thus not every medical practice is expected to provide every service that may be "core" from a patient's perspective. Furthermore, doctors may do "prevention" in counseling patients on health issues, but not prevention in the broadest community sense.

Perspectives on Service Resources

"In my area there aren't a lot of people, but there is huge isolation, and services -- not just DV/SA, but ALL services -- are limited." *Frontier county service provider*

Similarly, for the DV/SA system, there should be consistent services that every victim/survivor should expect to receive in response to their initial call for help or their subsequent need for service (which may even be an ongoing need for assistance). And, there should be a basic level consistently available from county to county. But it may be too much to expect every service provider to provide "specialist" services as well as generalist services. The service system can and should be expected to respond with sensitivity to every victim/survivor client and their needs, and effectively link the woman to services (if possible) even if not able to provide a direct response or intervention on every need. Volume of clients with specific, specialized needs might be a factor in the level of response a single agency can provide. This seems more likely in population centers where the volume of people in need of specialized services would be greater.

The following lists (alphabetically) services that may be provided to victim/survivors of domestic violence and sexual assault. These are then generally characterized as a core service (essential to be offered by DV/SA providers throughout the state), an essential but secondary or supplemental service, and a third level of optional or discretionary service. In other words, the state should be obligated to fund the first level of service throughout the state, and while the second and third level of service is important and perhaps vital, the first level should be provided everywhere before the second and third levels are funded to any significant degree. Funding core service means funding direct service SA/DV staff, and if possible, attendant infrastructure costs. (Infrastructure in this case means cost of office, supplies and some administration.) Some core services could be provided perhaps on a state-wide or localized basis.

Table 9: DV/SA Services Defined and Categorized

Core	Service	Definition
C	Accompani-ment to hospital	Acting as an informed and supportive companion for services delivered in the health care system
C	Advocacy – Direct Service Advocacy	Continuum of services ranging from actively assisting and/or intervening for an individual client in access to service(s) to formal partnerships or agreements with other providers to expedite assistance to a specific group of individuals. May include accompaniment to appointments to support the voice of the client. In the case of children, may include actively speaking on behalf of the child. Goal is to insure victims' interests are represented and their rights upheld. Advocacy may be in the arena of legal, medical or social services or other client needs.
C	Counseling	Counseling involves providing information on the dynamics of domestic violence or sexual assault, doing an assessment of risk, and engaging in other supportive activities as appropriate. Listening not problem solving. May be provided in the context of "case management".
C	Crisis line	24 hour phone access to peer crisis counseling and services. AKA hotline
C	Crisis response	Addressing a specific crisis in the aftermath of an assault or in responding to a person's immediate need for support (i.e., survivors experiencing PTSD)
C[15]	Culturally specific services	Services provided to specific marginalized populations that address DV/SA in a culturally appropriate way.
C	Danger assessment &safety planning	The development of a plan for security that includes a lethality assessment, documentation of abuser patterns and an escape plan.
C:DV	Emergency shelter	Shelter home or shelter facility: a place of temporary refuge, offered on a 24-hour, seven-day per week basis to victims of domestic violence and their children. Safe house: a place of temporary refuge, offered on an as needed basis to victims of domestic violence and their families (in the home of a trained volunteer) Motel vouchers: a place of temporary refuge, offered on an as needed basis to victims of domestic violence and their families (in a hotel/motel room paid for and arranged by a DV/SA program)
C	I and R	Assessing problems and providing appropriate resources and phone numbers/addresses for the client to contact herself
C:DV	Peer support	Education, information, listening, etc. provided by a volunteer or staff person trained in the dynamics of domestic violence and/or sexual assault.
C:DV	(Emergency) Services to children:	Continuum of services provided as part of a response to crisis ranging from child care to supervision to play therapy.
C:SA	Support groups	Regular or drop-in "counseling" groups supervised by trained volunteers or professional staff with an emphasis on peer support.
C	Transportation: Emergency	Transporting victims/clients to/from a) safe location, or immediately after the crisis.
Secondary	**Service**	**Definition**
S/O	Advocacy – Systems Advocacy	Educating policy-makers and other decision makers to change existing laws, rules and procedures so that victims' interests are represented and their rights upheld on a system-wide basis.
S	Case management	The provision of an individual needs assessment, development of an individualized service plan, a written safety plan, and the coordination of appropriate services and follow-up. May or may not include counseling and/or advocacy.
S	Community Education	1. Presentation to the general public, both in person and through the media, of information on the incidence and dynamics of domestic violence or sexual assault 2. Training of professionals
S	Financial assistance support	Providing credit counseling, housing assistance, help w/ filing for CV Comp. Or providing a loan or grant for individual assistance.

[15] In meeting emergency and core service needs.

Secondary	Service	Definition
S	Follow-up	Activities initiated by the service provider that maintain supportive contact for a specific period of time with a former client or after the initial crisis. Follow-up can assess current status of the client and any additional needs for service
S	Legal Assistance	A continuum of services ranging from providing information on legal resources to in-person support through legal proceedings to legal representation in court proceedings.
S	Mental health counseling	Providing clinical services with appropriately trained professionals
S	Outreach	Efforts to reach potential victims/survivors. I.e., presentations to a specific population group who may be at-risk of abuse, flyers posted in women's rest-rooms, etc.
S	Prevention	Activities related to education or other efforts that prevent sexual assault and/or domestic violence or reduce the consequences of violence.
S	Services to children: Support	Continuum of services ranging from providing childcare for women in shelter, to regular programs for children to therapeutic individual/group counseling.[16] Services are part of an ongoing services plan.
S	Transitional housing	Temporary housing beyond emergency or short-term shelter. Usually for a period of up to 2 years.
S	Transportation: non-emergency	Transporting victims/clients to/from appointments and other services.
Optional or discretionary	**Service**	**Definition**
O	A/D treatment	Providing clinical services related to alcohol and/or drug addiction.
O	Batterer/perpetrator programs	Individual and/or group counseling specific to educating and changing batterer behavior.
O	Job training	Specialized program to provide job skills and/or placement in a job site.
O	Parenting groups	Regular or drop-in groups with an emphasis on children's issues and developmentally appropriate parenting practices. For adults.
O	Permanent housing	Housing wherein the housing provider and tenant have a typical landlord/tenant relationship and a lease is involved but support services are present.
O	Supervised parenting time	Providing staff to be present when there is visitation between non-residential parent and children.
O	Support groups	Regular or drop-in "counseling" groups supervised by trained volunteers or professional staff with an emphasis on peer support.

A comprehensive set of intervention services would include core, support and discretionary services listed above. Prevention would include primary prevention via society-wide education and prevention that is individually focused. Infrastructure elements that an organization/program might be expected to engage in would include services coordination, systems advocacy, multi-language translations of materials and ongoing training and education in culturally specific and culturally appropriate processes.

Another way to look at this is to see what staffing would be needed for each element. The following services list identifies how the service relates to SA and/or DV service provision and what staff would be needed to provide the service (note we are not discussing the number of staff at this point, just type of staff).

[16] Some specific children's program services could include: Academic support – school enrollment, on-site education, tutoring; Recreation – play groups, field trips, special events; Skills development – conflict resolution, communication, safety planning; Counseling – art therapy, individual counseling, family counseling.

Table 10: Staffing for DV/SA Services

Service[17]	SA[18]	DV	Both	Staffing
Accompaniment to hospital			C	Direct service staff or volunteer
Advocacy – Direct Service Advocacy			C	Direct service staff or volunteer
Counseling			C	Direct service staff or volunteer for peer counseling.
Crisis line			C	Direct service staff or volunteer
Crisis response			C	Direct service staff or volunteer
Culturally specific services to meet needs			C	While all staff should be trained in culturally appropriate response, some organizations may have culturally specific staffing.
Danger assessment & safety planning			C	Direct service staff or volunteer
Emergency shelter		CDV		Some programs may need 24-hr staffing.
I and R			C	Direct service staff or volunteer
Peer support		C/SDV		Direct service staff or volunteer
Services to children: Emergency			C	Children's program staff.
Support groups	C			Direct service staff Counselor trained staff
Transportation Emergency			C	
Advocacy – Systems Advocacy			S/O	Management level staff and/or direct service staff
Case management			S	Direct service staff or volunteer
Community Education			S	Outreach/education staff
Financial assistance or support			S	
Follow-up			S	Direct service staff or volunteer
Legal Assistance			S	Direct service staff or volunteer. May be lawyer, paralegal, or specially trained staff.
Mental health counseling			S	Direct service staff Master's level counselor trained staff
Outreach			S	Outreach/education staff
Prevention			S	Outreach/education staff
Transitional housing			S	
A/D treatment			O	Direct service staff Master's level counselor trained staff
Batterer/perpetrator programs			O	Master's level counselor trained staff
Job training			O	
Parenting groups			O	Direct service staff or volunteer trained in effective parenting skills.
Permanent housing			O	
Supervised parenting time			O	Direct service staff or volunteer
Support groups		ODV		Direct service staff or volunteer Masters level counselor trained staff or volunteers.

[17] C= core; S=secondary or supplemental, 0= optional or discretionary
[18] As outlined in ODSVS Grant application for 2005

It takes staff to provide services, either paid staff or volunteer staff. If an organization utilizes volunteer staff, a volunteer coordinator is necessary. Rural and frontier programs tend to have smaller staffs and urban programs larger staffs which could be expected given population differences. Essential staff for all programs includes sexual assault and/or domestic violence advocates and an Executive Director or primary program director. Most programs have at least one SA and/or DV advocate and many have two or more of these staff positions.

Core positions and staffing configurations are different in rural and urban programs. There is an average of 4.13 FTE (full-time equivalent staff) in rural programs and 17.3 FTE in urban programs. This most likely reflects the sheer volume difference in clients seeking service and the staffing of shelter programs 24-7.

The following chart compares staffing in typical rural and urban programs and whether that staff is related to core or secondary service provision or infrastructure/management.

Table 11: Comparisons of Staffing in Urban and Rural Programs[19]

	C=Core, S=Secondary O=Option I/M=Infrastructure/ Management	**Urban FTE**	**Rural FTE**
Director/ED	I/M	1	1
Advocates (DV/SA)	C	3-4	1-2
Youth/Children	C/S	1	1
Outreach/Education	S	1-2	1
Cultural Specialist	C	2	<1
Administrative support	I	1.5	<.5
Shelter staff specific	C	1.5	<1
Other advocates or liaisons	C/S	1.3	.5
Volunteer Coordinator	C	<1	.8
Sexual Assault Specific Advocate (in dual purpose programs)	C	<1	.8

Other positions:

		Urban FTE	Rural FTE
Rural Outreach	S/I	<.5	.5
Transitional Staff	S	2	
Support groups spec.	C if SA, O if DV	.25	

Important, but not as uniformly important in staffing a community agency, are the following positions: Children's program staff, cultural specialist, emergency shelter staff, prevention/community education/outreach, and volunteer coordinators. Additional staff in

[19] Organized using data from provider surveys, previously completed salary/staffing surveys and grant application information.

specialized areas might be considered core depending on the staffing configuration of the organization and its size.

Administrative support, development director, specialist advocates or liaisons are also important staffing components but seem to be less vital to the core operation of a DV/SA agency.

Based on current practice, an approach to staffing a SA and/or DV agency would thus probably include the following staff functions: Executive Director, DV/SA direct service staff, children's program staff, cultural specialist or culturally specific advocate, and volunteer coordinator. The functions could be accomplished with a range of staff FTE depending in part on county population, but a minimal average would be 4.5 FTE.

VIII.B. Service Costs

What does it take financially to provide services? There are several ways to look at the cost of services. One way is to take a staffing approach, which requires defining a staffing level and cost. If a potential minimal (full) agency staff is 4.5 FTE the next step is determining salary costs.

Salary ranges across the state based on Employment Division data range from an average of a little over $40,000 in the Tri-county metro area to somewhat under $24,000 in the Employment Division Region 9 (Gilliam, Hood River, Sherman, Wasco and Wheeler counties). The average wage in Oregon in 2003 was $34,446. (Most recently defined averaged as listed by the Oregon Employment Department in http://www.qualityinfo.org/olmisj/OlmisZine?zineid=00000001). Jobs listed currently with the Oregon State Employment Division in the category of direct services employee range from $9.00/hr to $16.92/hr.

Putting a configuration of 4.5 FTE in every county with a population greater than 7,000 people (at an average cost of $155,000 annually based on average Oregon wage) would cost well over $5 million and obviously not begin to cover the needs of the most populous counties.

Another way to look at cost is to determine a "unit" cost or cost per service.[20] For instance, cost for shelter services can be determined by taking the total budget for shelter services divided by the number of bednites or the number of people served, bednites being one measure. Direct cost for unit of shelter (not including administrative overhead and using 2004-05 Oregon data from DHS reporting programs) is, on average, $63.00 a night. Most bednite costs fall between $30 and $130/night.

It's a little bit more difficult to get a handle on the cost of non-shelter services. Whereas bednites are a fairly discrete measure (one person staying one night = 1 bednite whether child or adult), a service unit can be linked to the person served or the type of service. One person may receive multiple services and/or multiple hours of service or only one.

Although statistics are currently gathered by DV/SA programs on service provision in any number of areas (crisis intervention, support groups, advocacy, hospital and legal advocacy,

[20] This section was developed using self-reports on statistics and end of year budget as reported to DHS and may contain inconsistencies**. For this reason, it should only be used in an illustrative capacity, not as fact.**

and follow-up), there may be considerable variation in how these numbers are accounted for. However, to get a broad brush look at costs, non-shelter services were estimated at hourly or partial hourly time allotments and these were factored by budget amounts in non-shelter service categories (further broken out into DV and SA services.) Three programs that provide distinct sexual assault services had costs ranging from $155 to $270. [21]

Cost for individual services may be more distinct than this broad brush look. According to program statistics, the greatest percentage of services was follow-up services, at 51%. Cost of this service might be more or less depending on any number of factors. The following table provides an estimate of how much service was provided in each of six categories.

	Sexual Assault Services
2.02%	Hospital Advocacy
6.18%	Legal Advocacy
7.63%	General Advocacy
13.29%	Support Groups
19.59%	Crisis Intervention
51%	Follow-up of all kinds (phone and in-person)

Domestic violence non-shelter services have an average unit cost of about $46.00 a unit. Most service providers have a cost of under $100 per unit. [22]

As discussed previously, cost for each service may vary. The following table provides an estimate of how much service was provided in each of six categories. Perhaps not surprisingly, most of the non-shelter services provided are follow-up services both in person and by phone. What is unclear is how many of these services have been provided to former shelter residents or to other women in need.

	DV and DV/SA Services
0.4%	Hospital Advocacy
9.4%	Legal Advocacy
9.7%	General Advocacy
13.0%	Support group total
25.7%	Crisis total
41.9%	Follow-up all kinds total

More hospital advocacy is provided to SA victims than DV victims, more legal advocacy and general advocacy are provided to DV victims. Roughly equivalent support group services are

[21] For this purpose only service to women was used, 80% of SA services are provided to adult women and 15% to teens, the proportions are roughly the same with the exception of hospital accompaniment where 30% of teens receive this service compared to 64% of adult women. Men account for a little over 2% of SA services. The unit cost would decline to $121/unit if all service recipients were accounted for.

[22] 88% of DV services on average are provided to adult women. The Planning Group based the cost numbers on that. Men account for less than 2% of DV and DV/SA services. Children and teens generally account for less than 10% of services reported except follow-up and support groups where they account for 20% of the service delivery. Unit cost decreases to $34. unit if all service recipients are accounted for.

provided to each group. More general crisis services are provided to DV victims. Eight percent (8%) of all service units are provided to SA victims when aggregating SA and DV data.

The range of costs doesn't seem to be related to program location. High or low program costs are just as likely to occur in rural as in urban programs, although there are slightly higher program costs for special focus programs. Program costs for SA services don't seem to be too related to whether a program is a dual purpose program or a single focus program. A unit cost approach to compensating for services would seem difficult as there is (at least as reported) little consistency in cost. Some programs would find themselves underfunded, others overfunded given a basic reimbursement amount. Yet setting reimbursement amounts program by program would not seem particularly equitable. Furthermore, there is some question as to the consistency of reporting of both financial and service data.

For example, to get a more true sense of cost requires a consistent set of data keeping and reporting. Should reporting be based on hour or ½ hour service increments, on woman/person served, or some other measure? Until these questions are answered and consistency in record keeping and reporting is achieved, figuring out "true" costs will be difficult.

IX. *Meeting DV/SA Needs Through Equitable Funding*

IX.A. Funding Available

The funds included in the scope of the equity study are the Federal STOP Violence Against Women Act (VAWA) funds, the Victims of Crime Act (VOCA), Oregon Domestic and Sexual Violence Services fund (ODSVS), and Oregon Department of Human Services domestic violence fund and Sexual Assault Victims Services Fund (AKA CFAA/SA). Although funds have declined slightly in the past several years, funds for the past two years have hovered around $6.8 million dollars annually. The table below shows funds for fiscal year 2005-6.

Table 12: FUNDS & ALLOCATIONS FOR DV/SA SERVICES FY 2005-06

Fund	Amount Allotted for FY 2005-06	Non-profits Funded	Allocation Method
STOP VAWA Non-competitive	$658,912	38 grantees	MLT formula, with adjustments for Regions 1 & 2
ODSVS Non-competitive	$875,832 (2005-2007) $1,571,328	47 grantees	MLT formula Min. $5,000
ODSVS Competitive	$291,532 (included above)	16 grantees	Competitive grants
VOCA[23] Basic grants (non-comp) FY 10/05-9/06	$1,009,605	40 grantees	Historical precedence Min. $10,000
VOCA Project grants (competitive)	$1,042,321	14 grantees	Competitive grants
Family Violence Prevention Services Act	$1,136,073	42 grantees	MLT formula, with small programs getting additional $1,000
Oregon Marriage License Tax	$ 585,060	41 grantees + OCADSV	MLT formula OCADSV contract for training, TA
Criminal Fines Assess. DV Fund	$1,198,755	41 grantees	MLT formula , adjustments for regions 1&2
Crim Fines Ass. SA Fund	$ 296,391	28 grantees and subgrantees	MLT formula

Each of the funds listed in the table above has requirements delineated by federal legislation or state statute.

[23] VOCA includes substantial funds distributed to DA Offices, Law Enforcement, etc. These are not included.

The administrators of these funds worked with the Planning Group and each other to articulate a set of principles that have guided and could continue to guide funding decisions. These are:

1. Women and children deserve a safe environment.
2. Families and relationships should be violence free.
3. DV and SA victims in all of Oregon's counties should have access to services.
4. DV and SA victims deserve services that are culturally competent to meet their needs.
5. Intervention activities are priority services for DV system funding.
6. Prevention activities are second priority for DV system funding.
7. Prevention activities are priority activities for SA funding.
8. Core DV and SA services must receive stable funding.
9. Program providers must collaborate in order to ensure that distribution of state funds meets needs of communities.
10. Administrators of public money that funds DV/SA services must collaborate to ensure that money is used effectively in all parts of the state.

Any equitable model of allocation of funds must reflect these system principles.

IX.B. Approaches to Funding and Classification

Examining approaches to funding and "equity" requires confronting very thorny issues including:

- What would it take to create an equitable distribution of government funds to domestic violence and sexual assault programs?
- What does "equity" mean when it comes to distributing scarce resources?
- How do the problems and issues of urban areas, especially overwhelming numbers of women and children in need, get balanced with the access issues and resource deficits of rural areas?
- Can governmental dollars pay for everything? Should they?
- What criteria can be used to weigh different distribution options?

This study has grappled with these questions in looking at approaches to funding.

Classification of general approaches to funding.

Competitive and Non-competitive.

In competitive approaches, funds are available to any organization that meets the basic criteria and develops a proposal that ranks higher than other proposals. Competitive approaches are useful when encouraging new ideas and cutting edge approaches to providing service delivery and may be open to state-wide competitions or limited to counties or regions. Competitive approaches often seem fairest, because there appears to be no favoritism in awarding grants. Yet competitive approaches may reward, not the best program, but the best grantwriter or advocate. In addition, in time of scarce resources, funders often give preference to continuation of on-going competitive projects in order to avoid cutting existing programs' staff positions. The result is a reduction in the number of "new" competitive grants funded.

Non-competitive approaches, on the other hand, may provide the most stability. Awards may involve the use of a formula or base or both to spread funds around. An example of this is Block Grant and other funding from the Federal government where a base amount is granted to each state and then additional funds are granted on a per capita basis. Non-competitive awards may be made using a request for proposals. From a funder perspective, non-competitive approaches may leave a funder open to questions of partiality if there is limited or no outreach or process for new potential applicants.

Distributing funds

When it comes to making distributions on a non-competitive basis (or when determining how to allocate competitive funds to a smaller geographic unit), a variety of approaches may be taken. These are identified as follows:

SIMPLE OR SINGLE FACTOR APPROACHES

Simple and "identical" distribution based on a single factor.	All funds are divided up by a single factor such as every geographic unit (county). So every county would get the same amount of money. Per capita distribution is another simple approach. Total funds would be divided by the total population and the resulting dollar amount would be allocated to each county or region based on the population of that area. Any other single variable could be used.
Baseline, minimum, or threshold amount	A certain level of funding is determined to be a minimal or threshold level and all geographic units or population units receive at least that baseline amount.

FORMULAE

Simple formula	Two factors, such as population and geography or population and poverty, etc. are used together to create a factored distribution amount.
Complex formula	Similar to above except that the number of factors increases. The more factors, the more complex the formula and the more possibility of flattening the distribution.
Hybrid	Combining simple distribution with a simple or complex formula. A complicating element is how to view add-ons if adopting a hybrid. For instance, if you provide every county or region with a base and then intend to provide a per capita add-on for people in poverty, do you apply the per capita fund to the population over and above those that would be covered by the base, or apply the add-on to everyone? This can be a significant difference in total amount funded.

OTHER

Reimbursement or fee for service basis	A set service is provided and the cost of that service is reimbursed for at a set rate.

IX.C. Achieving Equity with Sufficient Resources (A 'Base + model')

The most equitable approaches involve providing a sufficient base to cover at least the minimal needs of less populated counties while meeting at least the minimal needs of the state's population centers. This would involve applying a base plus an incremental approach to funding more populous areas. A base + model allows for some consistent levels of service, but takes into account the sheer numbers that reside in more populous counties.

In defining the model, the Planning Group looked at a nominal level of direct service staffing needed given established prevalence rates of DV/SA. For instance, a population of 30,000 residents with 9400 women (aged 18-65) would call for three full time staff people (funding up to 2.25 DV staff and .75 SA staff; see page 27). Every additional population increment of 10,000 people/3150 women would mean an additional increment i.e., additional staff person (1 FTE = .75 DV and .25 SA)[24].

Seventeen (17) Oregon counties fall below this threshold of 30,000/9400 and of those, three counties (Gilliam, Sherman and Wheeler) have populations that are probably too small to support a stand-alone program. The remaining 14 counties, those with populations of 7,000 to 30,000 could probably support stand-alone programs but only 11 currently do. These counties may not need three direct service staff however, to have functioning service delivery they need a stable, basic level of support. Base funding should be provided to these 17 counties (full base to fourteen and pro-rata base to three) given ideal funding conditions. This would accommodate direct service needs and potentially cover costs of functioning programs. These counties are primarily rural and frontier counties and this approach acknowledges rural access and resource issues.

A "Base +" Model

Base established to provide some level of stability.

Increments respond to additional resource needs of populous areas.

17 receive full base or pro rata share. 19 counties receive "base + increment" (see FN)

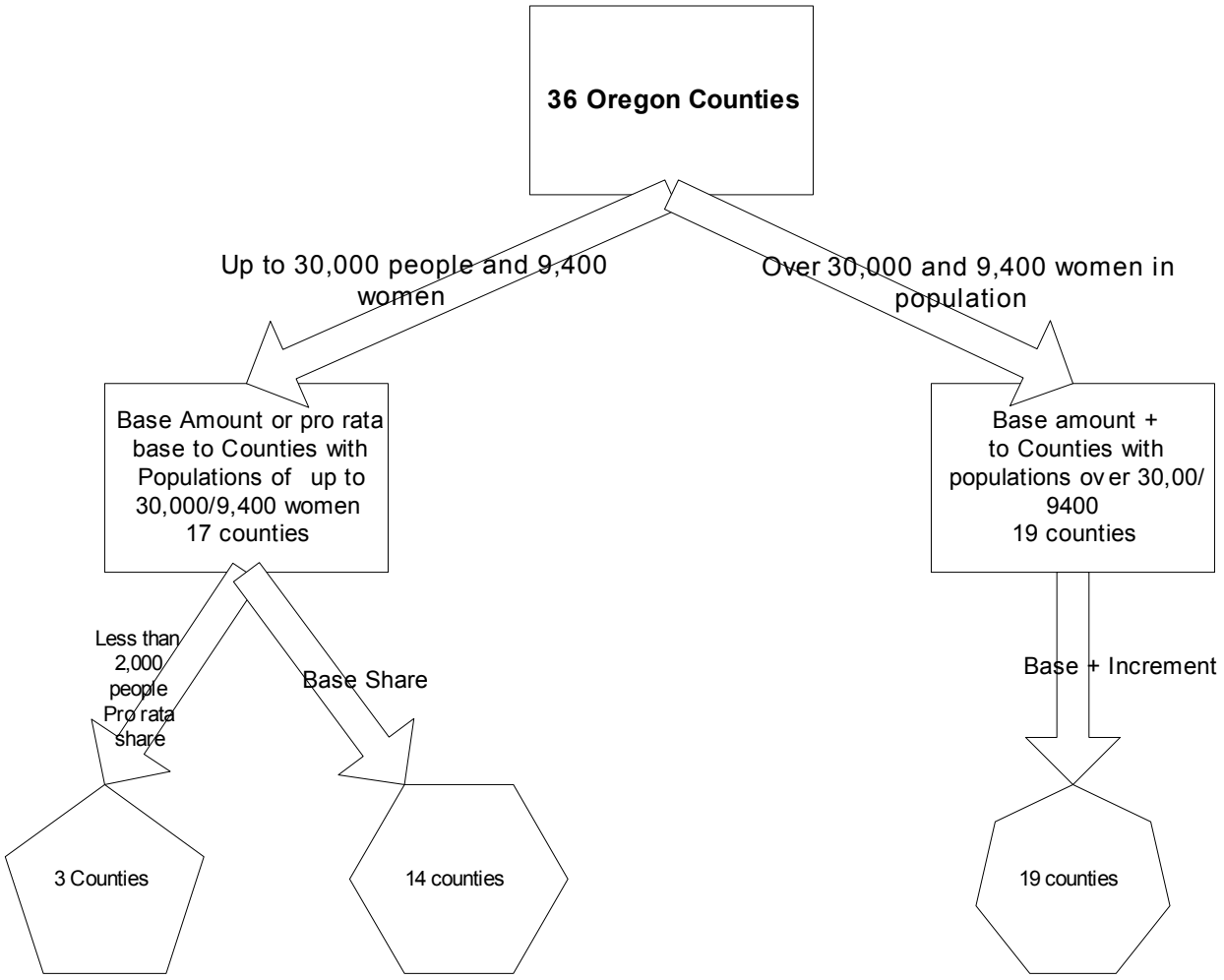
Nineteen (19) other Oregon counties have populations sufficient to require additional staffing. These additional staff increments range from one additional staff to 75 additional (i.e. in addition to the "base" staff). The cost of the base support to 33 Oregon counties and prorata base support to three counties is estimated to be $4,020,000 per year.[25] To fund the additional population increments the estimated amount would be $ 12,260,000/year. A total cost to fund this "base + " model is $16,280,000 per year.

Given that the current funding of the state to DV and SA services is approximately $6,000,000 per year, or less that 40% of what is needed, how can this approach be fit into current funding constraints?

[24] As mentioned earlier this is a very limited, direct service staffing and does not include supervision, support or specialized services.

[25] A base annual starting point of $120,000 with $40,000 increments. An increment could be a dollar amount or a staff equivalent.

Example of Base + Model Application



County
GILLIAM
SHERMAN
WHEELER

County
BAKER
CROOK
CURRY
GRANT
HARNEY
HOOD RIVER
JEFFERSON
LAKE
MALHEUR
MORROW
TILLAMOOK
UNION
WALLOWA
WASCO

County	Increment
BENTON	7.00
CLACKAMAS	36.25
CLATSOP	1.00
COLUMBIA	2.00
COOS	3.50
DESCHUTES	12.50
DOUGLAS	7.50
JACKSON	17.50
JOSEPHINE	5.25
KLAMATH	3.50
LANE	34.00
LINCOLN	1.75
LINN	8.00
MARION	27.50
MULTNOMAH	75.00
POLK	4.00
UMATILLA	4.00
WASHINGTON	49.75
YAMHILL	6.50

IX.D. Achieving Equity with In-Sufficient Resources

Ideally, the state should increase public safety for women and children by guaranteeing a minimum level of service to address DV/SA victims' needs. However, insufficient resources render this a challenging goal.

The problems to address in allocating DV/SA program funds are several:

- Sparse population in frontier counties.
- Depressed economy in frontier and rural areas of state.
- Difficulty of community based non profits to be self-supporting in communities that have high poverty rates and low education rates.
- Dependence of nonprofit programs in rural and frontier areas on government funds, but local governments cannot provide substantial support because they are faced with severely distressed economies, and with large areas of publicly owned land that are not part of the tax base.
- Complex, multiple challenges of the Tri-County metropolitan area where the population is significantly larger that any other area of the state, where large numbers of residents have as their primary language a language other than English, where programs serve a mix of urban, suburban and rural areas.
- Arrangements where 2 or more counties are served by one provider (i.e. COBRA, Linn-Benton, Grant-Harney).
- Counties, i.e. Sherman, Gilliam, Wheeler, that are too sparsely populated to support their own DV/SA resource.

Public Policy and Funding

"The state should use dollars to increase public safety for women and children. This is a matter of public policy." *Service provider*

"It is important to keep the policy debate simple. An over-arching, immense need for resources puts pressure on people, causes stress." *Stakeholder*

"DV/SA services are inadequately funded. It doesn't matter where in the state you are, services are few and far between." *Stakeholder*

Each of the problems listed above poses a challenge in defining an evenhanded allocation of resources. However, in conducting the equity study the Planning Group also wanted to consider the possibility that government funds had a limited role in the support of community based services. Accordingly, one of the questions included in interviews and surveys and in meetings of DV/SA service providers was, "What is the role of the state money?" Responses varied:

- State resources should fund the core of service budgets.
- State should guarantee a minimum ("floor") service level.
- State should provide a safety net.
- The state should facilitate stability of service provision.
- The state's priority should be victims' services; education is secondary.
- The state should build infrastructure to meet the needs of the most vulnerable populations.
- The state should provide money for identifying and implementing best practices.
- State money should be a stand-alone resource, and should not be linked to or fluctuate when programs are able to secure funds from local government or philanthropy.

Respondents agreed on two principles, however. First, they believed that state funds should facilitate **stability** of DV/SA services, and second, they believed that state funds should ensure **that victims in all parts of the state could access DV/SA services**. Ensuring service might mean providing flexibility for fund use. If, for instance, a program could fund its direct service with local dollars, state funds could be used for the director or other staff.

More than ten general approaches to formula funding were examined and almost every one of these had variations that were tested as well. The formulas that had the most promise for providing equity were those that combined a base with some kind of per capita adjustment, either based on total population or on population with access-barrier characteristics. **The difficulty is that there is not quite enough money to begin to make adjustments without affecting current allocations. So while the ultimate solution may be equitable, getting to that solution has inherent inequities.**

The following three models were examined.

Three models examined in detail for the equity study included the following:

1) Population/geography formula (currently in use with some funds) applied to all funds

2) Reimbursement model with or without a base

3) Safety net ("Base service") plus population adjustment

The Population/Geography Model

A population/geography formula attempts to balance the needs of population centers with the needs of rural/frontier communities. The formula currently in place weights population twice to square miles once and the resulting percentage makes up the percent of funds received. One of the results of this approach is that rural areas with similar populations, and perhaps similar access issues, are funded differently with rural communities east of the Cascades receiving proportionately more money than those west of the mountains. In fact, early in the application of this formula, a major adjustment had to be made for Region 1 (Clatsop, Columbia and Tillamook) which would have received a substandard funding amount because of its small size (Tina Frost, former Executive Director of Oregon Coalition Against Sexual and Domestic Violence, personal correspondence).

Applying this approach to all of the funds (without providing an adequate base), would skew funding even further, with some of the least populous areas receiving the greatest gains. Furthermore, as funds to the system increase, allocations would become increasingly skewed.

The Reimbursement Model

A reimbursement model, with or without a base, on the surface looks like an equitable solution: fund services provided. A reimbursement model without a base would not provide stability for smaller programs in rural areas. Service statistics currently available show greatest volume of service in urban areas and population centers. While a base would provide some stability, it would minimize the amount available for reimbursement. And, as mentioned earlier, much of the money could be spent reimbursing just one service element – shelter. Capping funds available for any one service element would be necessary. Even so, funds available would not be sufficient to fund services in any meaningful way. There is also the problem of retooling systems for this kind of approach. Definitions of service units would have to be clear and

adequate accounting systems implemented both on the program level and on the funder administrative level. Finally, without some cap, Oregon might run into similar problems as sister state Minnesota, which abandoned a reimbursement model because costs skyrocketed even as individual client numbers decreased.

A Base + Model

Finally the Planning Group examined a safety net (or base) + model. The safety net guarantees a base amount of money for each county with adjustments either based on a simple per capita or on a formula for access factors (the study examined using poverty and Non/Limited-English speaking). As in the "Achieving Equity with More Sufficient Resources" section, this approach attempts to provide equity to the paradox that is Oregon: provide enough resources to fund access in rural and frontier communities where resources may be limited, and provide enough resources to urban communities and population centers where there are sheer numbers of women needing service.

The application of a base + per model would look like this:

Base goes to	Population Over 2,000 and up to 30,000 people/9400 women	$XX.00 (Base amount)
Base + goes to	Counties w/ populations greater than 30,000 people and 9400 women. Increment for the remainder of the population (over 30,000)	Base ($XX.00) + Balance of population times per capita dollar amount = total allocation

Per capita amount is determined by taking total funds available, subtracting amount allocated for base amounts, and then dividing that remainder dollar amount by the number of people not covered by base. This is unlike the model discussed earlier where the add-on was based on a "unit" -- this formula is based both on total population and a "unit" measure that relates to the number of women aged 18-64 in a county.

Recap of Options and Pros and Cons

Model + Main Elements	Pros	Cons
Population/Geography Extension of currently used formula weighting population twice and square miles once.	❖ Attempts to compensate for rural and frontier access issues. Most successful for large counties with small or moderate populations. ❖ Some of the funding sources use it currently and it has a history in the service system. It is simple and was arrived at by consensus.	❖ Including geography in a formula feels inequitable to providers because space not people or services is being funded. It's a surrogate for access, but not consistently as it is not a surrogate that extends equally to small geographic areas. ❖ Doesn't compensate for access issues rural counties that are moderately sized both geographically and population-wise. ❖ Fifty percent (50%) of the population receives 35% of the resources. A ratio which creates the prospect of under serving the population centers.
Reimbursement Model Programs are reimbursed on a per service basis	❖ Programs are paid for services rendered making fiscal accountability clearer. ❖ Unit cost is fixed and administratively clear what you're "purchasing" ❖ Program statistic management would become more uniform.	❖ No guaranteed floor for programs or counties unless one is developed. ❖ May have budget control issues for funders. Minnesota experienced this problem. ❖ Programs with low shelter use may not be able to obtain sufficient reimbursements to maintain services. ❖ Management and accounting infrastructure at the program and the funder levels are insufficient currently and would need to be substantially developed. The cost of this is unknown at this point.
Base + Model Base of set amount + per capita increments. After funding the base, the remaining funds would be distributed to counties with populations of over 30,000 people (and 9400 women)	❖ Counties with populations between 7,000-30,000 would have a base sufficient to fund some basic direct service operations. ❖ All counties, regardless of population, would receive some resource in order to provide or contract for services. ❖ The base amount could meet the basic needs of counties with populations under 30,000 ❖ Counties with greater populations would receive additional resources to address greater numbers.	❖ The base funding is not a sufficient safety net to meet the needs of populous counties. ❖ Population based increments to the safety net, at current funding levels, would not be sufficient to fund some of the populous counties at their current level. ❖ Programs which serve more than one county could benefit disproportionately.

The Planning Group recommends option 3 (base +) using a per capita add-on because it is flexible, can be expanded as monies are added to system, fits current funding/operating norms, and doesn't require funders or programs to overhaul their billing and fund accounting systems. It is also compatible with the staffing approach discussed on page 27. However, just funding the base at $120,000 in the "base +" model would cost over $4 million/year. And further application of the "base plus per capita" model, would cost over $16 million/year. With the available money projected at nearly $6 million per year, the problem is one of defining equitable when total resources available are insufficient.

IX. E. Adjusting Approaches to Achieve Equity

If the base is increased immediately (totaling $4,020,000), most of the money currently provided would go to funding the base leaving a relatively small amount available for any per capita adjustments. In other words, funding half of the counties to a base of $120,000 would be born by the other half, the half with the greater concentration of population. This approach also could prove to be a disincentive for counties to work for an overall increased amount of funding. Some kind of incremental base or partial base could be implemented but that doesn't substantially affect the amount available to compensate for population centers.

Since $6 million as a working figure represents 36% of the potential total amount needed, reducing both the base and the remaining available amount might be the most reasonable approach. This would reduce the base to $45,000 for those counties with a program "headquarters" and related proportional decreases for counties with satellite programs.

Stepping down both base amounts and per capita fund to fit within the parameters of current funds available has the advantage potentially of continuing to encourage all counties to work together to create a bigger funding pool. Increases in the funding pool could then be applied proportionately, until full base funding kicked in perhaps at fifty percent of funds needed or perhaps at a greater level.

Finally, we have the issue of Oregon's anomalous counties, areas that make the implementation of this approach to equity even more complicated. Oregon has three counties where the combined population of all three (5,320) is less than 1% (.2%) of the state's total, while the three most populous counties (the contiguous Tri-county area of Clackamas, Multnomah and Washington counties) contain 43% of the state's population. It might be useful to treat these anomalies separately especially since the Tri-county area's current allocation includes the pre-determined appropriation for culturally specific services.

Recommendation as to (short-term) implementation:

- Decrease the percentage identified for base to 37% of amount estimated to be needed for base.
- Incrementally fund bases for the remaining counties as follows (annually):
  - "Headquarters" county (a primary provider is based here) = $45,000
  - Satellite county (services are provided by a primary provider whose headquarters is in another county).
    - = $30,000 if county has population greater than 20,000
    - = $26,800 if county has population greater than 10,000 but less than 20,000.
    - = $11,250 if county has population less than 10,000 but greater than 2,000.
    - = $45,000 if county has population over 40,000

- Remove anomalous counties and fund at a current rate or approximately $3.95 per capita for smallest and $1.13 for largest. Treat the 3 smallest and 3 largest each as a unit as they are contiguous and either do or could share service resources.
- Distribute remaining funds on a per capita basis using total population for each county inclusive of the population covered by the base.

This approach is not without problems as it shifts approximately $500,000 with some counties gaining and others losing when compared to current estimated allocation.

Recommendation as to continued implementation:

There are at least four approaches to dealing with allocations as more funds are available.

- Step up the base first.
- Incrementally step up both base and per capita allocations except for anomalous counties.
- Increase allocation for anomalous counties by "x" percent and then distribute the rest.
- Incrementally step up base, per capita and anomalous counties together.

The last approach seems the most reasonable in spreading the victory of increased funding to all concerned. However, one last adjustment will need to be addressed at some point.

- At the point at which the majority (90% maybe) of counties have a base + per capita allocation that meets or exceeds $120,000, shift the use of the per capita calculation from using total population to determine per capita to "total population minus 30,000." This "balance of population" number would then be used to calculate per capita.

If a total appropriation of $8.5 million per year were committed to the SA/DV services network, it would be possible for current program funding to mostly remain the same and to fund up to the base level those counties that currently receive less than $120,000. This amount is the lowest point at which implementation of a "base +" model can occur without significantly destabilizing current funding. In addition, it is likely that the concept of anomalous counties would cease being relevant at this funding level (8.5 million).

X. Recommendations Specific to Equitable Distribution of Funds

1. State government has a responsibility for public health and safety, and services to victims of DV/SA are a significant part of upholding that responsibility.

2. Counties rather than (OCASDV) regions should be the geographical unit for DV/SA services planning and allocation. Justice and social services are organized by counties, and these are networks that coordinate with DV/SA providers. Providers, however, should be encouraged to work together for mutual benefit in developing and maintaining effective and efficient DV/SA services across as well as within county lines.

3. The state's role should be to establish/maintain a safety net of DV/SA services to assist victims in every part of the state. An appropriate level of service needs to be available in every county of the state. There needs to be a credible base of services to meet the needs of rural communities and sufficient extent of resources to meet the needs of urban communities.

4. Funding stability via a reasonable base while compensating for population density is almost mutually exclusive when funds are limited. Ensuring service accessibility in every part of the state affects the ability to fund population centers. Conversely, funding population centers or density first, affects the ability to fund a base in the balance of counties where population does not reach critical mass. An equitable funding allocation formula must meet the test of funding a credible base of services in each of Oregon's counties. A formula that combines a minimum base to ensure service access in frontier and rural counties with additional funding apportioned by population to ensure access in urban areas of counties meets this test.

5. Oregon should provide at least a basic level of services in every county. This base should be roughly equivalent to support 3 direct service staff (2.25 for DV and .75 for SA) or roughly $120,000/year based on staffing needs related to potential incidence. This base should be sufficient to provide direct SA and DV services to the "typical" county of 30,000 people and 9,000 women ages18-65.

6. In addition to providing a basic level of services, Oregon should distribute funding on a per capita basis. Even a simple per capita reflects the reality of the state's various population centers that experience numbers proportionately greater than the least populous areas.

7. Oregon needs culturally appropriate services available to culturally specific populations throughout the state, including Native Americans living on or off reservations, Latino/Hispanics, African Americans, and non-English speaking immigrants. (See recommendation # 11, below)

8. Oregon communities need to have DV/SA services appropriate for all types of victims, including seniors and those who have developmental and/or physical disabilities. The DV/SA system should look for ways to collaborate with service providers who have expertise in senior services and services to people with disabilities.

9. The DV/SA services network is a public-private partnership, with nonprofit organizations throughout the state providing emergency intervention, shelter and advocacy for DV/SA victims. Historically, these non-profits have been grass-roots organizations responding to community needs and therefore, are sensitive to maintaining autonomy in decision making about services in their geographical areas. State funds should ensure stability of services, but programs need the flexibility to identify the best use of monies available to them.

10. Government funds have been integral to the stability of DV/SA victim services throughout Oregon. A competitive funding process can encourage research and development of best services practices, which is necessary for an effective, thriving services network. But competitive funds are not an efficient approach to providing service stability. Accordingly, Oregon should make available in noncompetitive grants a level of resources that funds a credible base of DV/SA services in all areas of the state.

11. Access issues of different sorts affect urban and rural populations, but some access issues are parallel. Access issues related to poverty, ethnicity or language occur in both urban and rural areas. Work to fund additional dollars specific to access issues which may be language, culture, or poverty depending on the county. These could then be distributed as an additional allocation specifically to access issues.

12. Sexual assault (not as part of IPV) in some studies represents 22% of violence against women (SA+DV). As a result, the prevailing attempt to provide 20% – 25% of funds to sexual assault seems reasonable and should be continued.

13. To maintain current program funding/stability and take steps toward implementing a “base + model”, roughly $8.5 million/year would be needed.

XI. Recommendations for DV/SA Victims' Services Network

In addition to the recommendations specific to equitable allocation of state funds, the Planning Group has several observations about Oregon's DV/SA services network and some recommendations. These are:

1. Providers and their communities need to encourage the state to at least double its support of DV/SA services, either by increasing support from the general fund, or by developing new sources of money. In the past decade, growth of the services network has come as a result of increases in federal funds to Oregon. These funds are currently threatened with cutbacks, and it is unrealistic to think that increased federal funds will be available in the next few years.

2. Build a "trade association" similar to the youth system model which is effective in stating and pursuing statewide goals for services.

3. Create a state level office (officer) whose responsibility it is to ensure a coordinated, statewide response to DV/SA public safety issues, (similar to the role the Domestic Violence Coordinator plays in Multnomah County). The Governor's office, the Attorney General's office, or the Health Dept. would each be a possible location for this office.

4. In some cases, DV programs provide services that may be eligible for funds from other agencies. For instance, can shelters get education and mental health money to serve children? Could community action money serve victims of DV or SA who are homeless? These possibilities need to be examined and pursued if they have merit.

5. State administrators of funds to DV/SA programs should consider establishing/clarifying a process whereby providers qualify to submit proposals for state funds.

6. DV/SA providers want to be sure that the limited resources available to serve DV/SA victims are used efficiently and effectively. State administrators should consider developing standards for services provision that can be a tool for quality control statewide, perhaps even develop an accreditation process. Washington State has one for sexual assault providers.

7. In conducting the equity study the Planning Group found DV/SA providers in both rural and urban areas concerned that services take advantage of economies of scale. However, there was no consensus about where these exist. Both rural and urban areas were suggested for assessment. For example, how large an area can a provider serve and still remain effective? Or, how large can an agency be and still remain effective?

8. Are there some services, like a crisis line, that could effectively serve a region or the state as a whole? Programs should be encouraged to use the competitive grant process to explore some of these "best practice" issues.

9. The DV/SA network needs clearer and more consistent data about services, cost of services, and service use patterns. State administrators and their advisory committees should continue to work on this issue.

10. Frontier, rural, and urban service providers seem to face a serious divide in understanding each other and quite possibly in working together. Programs and organizations, **at all levels**, should be encouraged to enter into a serious and ongoing dialogue to bridge these differences. The future of effective DV/SA services in Oregon may depend on it.

> ***"The urban -- rural split is more pronounced than it was a few years ago. The challenge is to rebuild relationship."***
> ***Stakeholder***

APPENDIX A: BIBLIOGRAPHY

Alford, K, and O'Meara, A., **Stretching District Nursing Services to Meet Rural Needs.** *Australian Journal of Rural Health,* Vol. 9, 2001.

Bachman, Ronet, **A Comparison of Annual Incidence Rates and Contextual Characteristics of Intimate Partner Violence Against Women from the National Crime Victimization Survey and the National Violence Against Women Survey.** *Violence Against Women,* August 2000.

Bates, L, Lynne Hancock, Danna Peterkin, **"A little encouragement": health services and domestic violence.** *International Journal of Health Care Quality Assurance*, 2001.Vol.14.

Benson, Michael L.' Wooldredge, John' Thistlethwaite, Amy B., Fox, Greer Litton, **The Correlation between Race and Domestic Violence is Confounded with Community Context**. *Social Problems*, Aug 2004.

Bergen, Raquel Kennedy, **Studying Wife Rape: Reflections on the Past, Present, and Future** *Violence Against Women,* Vol. 10, no. 12, December 2004.

Berliner, L., Fine, D., Moore, D., **Sexual Assault Experiences and Perceptions of Community Reponses to Sexual Assault: A Survey of Washington State Women**. Washington State University/Social and Economic Sciences Research, October, 2001.

Braitstein P, **Sexual violence among a cohort of injection drug users.** *Social Science Medicine*, 2003 Aug; Vol. 57.

California State Auditor/Bureau of State Audits, **Experiences and Problems in Program Administration, and Alternative Administrative Structures for the Domestic Violence -- Program Might Improve Program Delivery.**
Summary of Report 2002-107 - October 2002 Office of Criminal Justice Planning:
From: http://www.bsa.ca.gov/reports/summary.php?id=375

Center for Disease Control**, Prevalence of Intimate Partner Violence and Injuries --- Washington**, 1998, *Morbidity and Mortality Weekly,* July 7, 2000

Center for Disease Control, **Building Data Systems for Monitoring and Responding to Violence Against Women: Recommendations from a Workshop on Building Data Systems for Monitoring and Responding to Violence Against Women (VAW)**
http://www.cdc.gov/mmwr/preview/mmwrhtml/rr491

Chenoweth Lesley, **Violence and Women with Disabilities**. Vio*lence Against Women,* December 1996.

Coleman, Stephen Ph.D**, An evaluation of Minnesota's shelter program for battered women - A report to the Minnesota legislature**. Center for Applied Research & Policy Analysis, School of Law Enforcement, Criminal Justice, and Public Safety, Metropolitan State University, 2001

Corbin, William R., Bernat, Jeffrey A.,Calhoun, Karen S., McNair, Lily D., Seals, Kari L.**, The Role of Alcohol Expectancies and Alcohol Consumption Among Sexually Victimized and Nonvictimized College Women.** *Journal of Interpersonal Violence*, Apr. 2001, Vol. 16 Issue 4.

Council On Accreditation, **Beta Version Standards for Private Organizations and Public Agencies,** 2005**.** http://www.coanet.org/front3/page.cfm?sect=1&cont=3603

Derene, Steve**, Crime Victims Fund Report: Past, Present, and Future,** National Association of VOCA Assistance Administrators, 2005.

Eby, Kimberly K., **Exploring the Stressors of Low-Income Women with Abusive Partners: Understanding Their Needs and Developing Effective Community Responses**. *Journal of Family Violence*; Aug 2004.

El-Bassel, Nabila *,* Louisa Gilbert*,* Elwin Wu, et.al.*,* **Relationship Between Drug Abuse and Intimate Partner Violence: A Longitudinal Study Among Women Receiving Methadone.** *American Journal of Public Health*, Mar 2005.Vol.95.

Evans, Susan, **Beyond gender: Class, poverty *and* domestic violence.** :*Australian Social Work,* Mar 2005.

Farmer Amy and Jill Tiefenthaler, **Domestic Violence: The Value of Services as Signals.** *Economic Behavior and the Family,* 2001, Vol. 86, No 2.

Farmer, Amy and Tiefenthaler, Jill, **Explaining the Recent Decline in Domestic Violence,** *Contemporary Economic Policy,* Vol. 21, No. 2, April 2003.

Field, Craig A., Caetano, Raul1 Nelson, Scott, **Alcohol and Violence Related Cognitive Risk Factors Associated with the Perpetration of Intimate Partner Violence.** *Journal of Family Violence*, Aug 2004.

Foss, Louisa L.; Warnke, Melanie A, **Fundamentalist Protestant Christian Women: Recognizing Cultural and Gender Influences on Domestic Violence.** *Counseling & Values*, Oct. 2003, Vol. 48 Issue 1.

Frias, S and Angel, R.,**The Risk of Partner Violence Among Low-Income Hispanic Subgroups.** *Journal of Marriage and Family,* Vol. 67 August 2005.

Gandy, Rebecca , **Transforming a Feminist Cause into a Corporation**, unpublished paper for Governance of Nonprofit Organizations class at Portland State University, June, 2006.

Gelles Richard, **Estimating Incident and Prevalence of Violence Against Women.** *Violence Against Women,* July 2000.

Hughes TL, **Sexual assault and alcohol abuse: a comparison of lesbians and heterosexual women.** *Journal of Substance Abuse*, 2001; Vol. 13.

Humphrey JA, **Women's vulnerability to sexual assault from adolescence to young adulthood.** *Journal of Adolescent Health*, 2000 Dec; Vol. 27 (6).

Kaplan, E. and Merson, M**., Allocating HIV Resources: Balance Efficiency and Equity.** *American Journal of Public Health,* Vol. 92, No. 12, Dec. 2002.

Krishnan, Satya P., Judith C. Hilbert, Marilyn Pase. **An examination of intimate partner violence in rural communities: results from a hospital emergency department study from Southwest United States.** *Family and Community Health,* April 2001.

Krishnan Satya P., Judith C. Hilbert, Dawn VanLeeuwen, **Domestic violence and help-seeking behaviors among rural women: results from a shelter-based study**. *Family and Community Health,* April. 2001.

Lee, Roberta *,* Vetta L Sanders Thompson*,* Mindy B Mechanic*,* **Intimate partner violence and women of color: A call for innovations.** *American Journal of Public Health*, Apr. 2002.Vol.92.

Lian Davis, Jan Hagen, and Teresa Early, **Social Services for Battered Women: Are they Adequate, Appropriate, Accessible.** *Social Work,* November 1994.

Logan, T K; Walker, Robert; Leukefeld, Carl G**, Rural, Urban Influences, and Urban Differences Among Domestic Violence Arrestees.** *Journal of Interpersonal Violence,* Mar 2001, Vol. 16 Issue 3.

Logan, Tk; Evans, Lucy; Stevenson, Erin; Jordan, Carol E., **Barriers to Service for Rural and Urban Survivors of Rape**. *Journal of Interpersonal Violence* , 20, no. 5 (2005).

Magdol, Lynn, Terrie E. Moffitt, Avshalom Caspi, Phil A. Silva, **Developmental antecedents of partner abuse: a prospective-longitudinal study.** *Journal of Abnormal Psychology,* August 1998.

Mannix, E., Neale, M, and Northcroft, G **, Equity, Equality, Need: The Effects of Organizational Culture on the Distribution of Benefits and Burdens**. . *Organization Behavior and Human Decision Processes*, Vol. 63, No. 3. 1995.

Marks, James, M.D., MPH, Cassidy, Elaine, Ph.D. **Does a Failure to Count Mean That It Fails to Count? Addressing Intimate Partner Violence.** *Am J Prev Med* June, 2006.

McClennen JC, **Domestic violence between same-gender partners: recent findings and future research.** *Journal of Interpersonal Violence*, 2005 Feb.

McHugo, Gregory J o, Yael Caspi, Nina Kammerer, Ruta Mazelis, et al., **The Assessment of Trauma History in Women With Co-occurring Substance Abuse and Mental Disorders and a History of Interpersonal Violence.** *The Journal of Behavioral Health Services & Research,* Apr-Jun 2005.

Melbin Anna ,Cris M.Sullivan,and Debra Cain, **Transitional Supportive Housing Programs: Battered Women 's Perspectives and Recommendations.** *AFFILIA*, Vol.18 No.4,Winter 2003.

Mezey, Nancy , Lori A Post, Christopher D Maxwell, **Redefining intimate partner violence: Women's experiences with physical violence and non-physical abuse by age**. *The International Journal of Sociology and Social Policy,* 2002.Vol.22.

Mohler-Kuo M, **Correlates of rape while intoxicated in a national sample of college women.** *Journal of the Study of Alcohol,* 2004 Jan.

Murty, Susan , Corinne Peek-Asa, Craig Zwerling, Ann M Stromquist, et al., **Physical and emotional partner abuse reported by men and women in a rural community.** *American Journal of Public Health*. Washington: Jul 2003.Vol.93.

Nam, Yunju' Tolman, Richard" **Partner abuse and welfare receipt among African American and Latino women living in a low-income neighborhood**. *Social Work Research*, Dec. 2002, Vol. 26 Issue 4.

National Institute of Justice**,Violence Against Women: Identifying Risk Factors.** *www.ojp.usdoj.gov/nij* Editor 's Note: This Research in Brief is based on two studies — 1)Jacquelyn W.White and Paige Hall Smith of the University of North Carolina – Greensboro 2)Jane A.Siegel of Rutgers University –Camden and Linda M.Williams of the Stone Center at Wellesley College 2004.

O'Kane, A, and Tsey, K., **Towards mental health resource allocation and service development in rural and remote Australia.** *Australasian Psychiatry***,** Vol 12, No. 4, Dec. 2004

Orchowsky, Stan and Weiss, Angela, **Domestic Violence and Sexual Assault Data Collection Systems in the United States.** *Violence Against Women*, August, 2000.

Parmey, Angela., **Violence Against Women Research Post VAWA: Where Have We Been, Where Are We Going?** *Violence Against Women 2004 10.*

Peterson, Ruth , Kathryn E. Moracco, Karen M. Goldstein, Kathryn Andersen Clark, **Moving beyond disclosure: women's perspectives on barriers and motivators to seeking assistance for intimate partner violence**. *Women & Health*. July 2004.

Pyles, Loretta and Judy L. Postmus**, Addressing the Problem of Domestic Violence: How Far Have We Come?** *AFFILIA,* Vol. 19 No. 4, Winter 2004

Sarla Sharma*,* **Domestic violence against minority women: Interventions, preventions and health implications.** *Equal Opportunities International*, 1997.Vol.16.

.Schafer, John; Caetano, Raul; Clark, Catherine L**., Rates of Intimate Partner Violence in the United States.** *American Journal of Public Health*, Nov98, Vol. 88 Issue 11.

Schecter Susan and Eldeson, Jeffrey**, Effective Intervention in Domestic Violence and Child Maltreatment Cases: Guidelines for Policy and Practice**. 1998 National Council of Juvenile and Family Court Judges, 1999. It is available at http://www.thegreenbook.info.

Schollenberger, J. Campbell, P. Sharps, et.al., **African American HMO Enrollees Their Experiences With Partner Abuse and Its Effect on Their Health and Use of Medical Services.** *Violence Against Women,* May 2003**.**

Socting, Ingrid, Nichole Fairbrother, William Koch, **Sexual Assault of Women Prevention Efforts and Risk Factors,** *Violence Against Women*, January 2004**.**

Sokoloff, Natalie and Dupont, Ida, **Domestic Violence at the Intersections of Race, Class, and Gender Challenges and Contributions to Understanding Violence Against Marginalized Women in Diverse Communities.** . *Violence Against Women***,** January 2005.

Stacey, Williams, L.; Mickelson, Kristin D*.,* **The Nexus of Domestic Violence and Poverty.** Violence *Against Women*, Mar 2004, Vol. 10.

Stevens, Tomika, N. Ruggiero, Kenneth J. Kilpatrick, et.al., **Variables Differentiating Singly and Multiply Victimized Youth: Results From the National Survey of Adolescents and Implication.** *Child Maltreatment*; Aug 2005, Vol. 10 Issue 3.

Thompson**,** Robert S. , Amy E. Bonomi, Melissa Anderson, et.al., **Intimate Partner Violence: Prevalence, Types, and Chronicity in Adult Women.** *Journal of Preventive Medicine,* June 2006.

Tiefenthaler, Farmer, A, and Saambira, A., **Services and Intimate Partner Violence in the United States: A County-Level Analysis.** *Journal of Marriage and Family* 67 August 2005.

Tjaden , Patricia and Nancy Thoennes, **Extent, Nature, and Consequences of Rape Victimization :Findings From the National Violence Against Women Survey.** National Institute of Justice *www.ojp.usdoj.gov/nij, Jan. 2006*

Tjaden Patricia, Nancy Thoennes, **Extent, Nature, and Consequences of Intimate Partner Violence Findings From the National Violence Against Women Survey.** NIJ/CDC July 2000 NCJ 181867 .

Ulbrich, Particia Jami Stockdale, **Making family planning clinics an empowerment zone for rural battered women**. *Women & Health*, Feb-March 2002 .

VAdata: The Virginia Sexual & Domestic Violence Data Collection System. http://www.vadv.org/facts.html

Van Hightower, Nicki and Joe Gorton, **A Case Study of Community-Based Responses to Rural Woman Battering.** *Violence Against Women,* July 2002**.**

Verhoek-Oftedahl, W., Ph.D., Pearlman, D., PhD, Coutu-Babcock, Joyce, MAT, **Improving Surveillance of Intimate Partner Violence by Use of Multiple Data Sources.** *Am J Prev Med* 2000;19.

Vest, Joshua t, MPH, Tegan K. Catlin, MPH, John J. Chen, PhD, Ross C. Brownson, PhD., **Multistate Analysis of Factors Associated with Intimate Partner Violence.** *J Prev Med* 2002;22(3)

Wharton Carol, **Establishing Shelters for Battered Women**. *Qualitative Sociology***,** Summer 1987.

Wilke, Dina J.Vinton, Linda, **The Nature and Impact of *Domestic Violence* Across Age Cohorts**. *Affilia: Journal of Women & Social Work*, Fall 2005, Vol. 20 Issue 3.

Witte, Ann Dryden, **The dynamics of domestic violence.** *The American Economic Review,* May 1995.Vol.85.

Wycoff, M**, Organizational Change in Grassroots Organizations**. Unpublished paper for Governance of Nonprofit Organizations class at Portland State University, June, 2006.

Oregon Specific Studies

1998 Oregon Domestic Violence Need Assessment, Glick, B., Johnson, S. and Pham, C. Oregon Health Division and Multnomah County Health Departments. 2000.

2002 Oregon Crime Victims' Needs Assessment, Regional Research Institute, Portland State University. 2003.

A Study of VAWA Funded Domestic Violence Shelters Programs in Oregon,

Allocation Plan for the Oregon Domestic and Sexual Violence Services Fund
Oregon Department of Justice, Crime Victims Assistance Section, 2002.

Costs of IPV against Oregon Women, Drach, L. (2005) Portland, OR: Oregon Department of Human Services, Office of Disease Prevention and Epidemiology.

Oregon Department of Human Services, **Oregon Women's Health and Safety Survey:** ***Intimate Partner Violence in Oregon Findings from the Oregon Women 's Health and Safety Survey, 2004.*** www.dhs.state.or.us/publichealth/ipv/
Technical contact :Linda Drach, IPV Data Collection Project

Oregon Department of Human Services, Health Services, Center for Health Statistics and Vital Records, Oregon Behavioral Risk Factor Surveillance System (BRFSS) results
http://www.dhs.state.or.us/dhs/ph/chs/brfs/brfsdata.shtml

Cultural Competency Plan for Programs Serving Victims of Domestic Violence and Sexual Assault in Oregon. Glick, B. Criminal Justice Services Division

Listening to Survivors: Assessment of the Needs of Domestic Violence Victims in Oregon, Governor's Council on Domestic Violence. 2001.

Oregon Violence Against Women Prevention Plan, Oregon Department of Human Services, Office of Disease Prevention and Epidemiology, 2005.

Rape in Oregon, Kilpatrick, D.G. and Ruggiero, K.J. 2003

Recommendations to Prevent Sexual Violence in Oregon, Sexual Violence Prevention Plan Steering Committee, Attorney General's Sexual Assault Task Force (SATF), 2006.

STOP Violence against Women Formula Grant Program Implementation Plan for Oregon, Glick, B. Criminal Justice Services Division, Oregon Department of State Police, 2003.

State of Oregon Consolidated Plan 2001-2005
Section 3: Housing Market Analysis, Housing and Community Development

United Way Resources
http://www.unitedway-pdx.org/resourceCenter/research.htm

APPENDIX B

EQUITY STUDY INTERVIEWS

Steve Derene, Director of NAVAA
Dale Penn, Director of the Lottery Commission
Helena Hite, RN
Janine Simms, Director of Lakeview Crisis Center
Wanda Powless, Director of Klamath County Crisis Center
Renee Mize, Advocate at Harney HOPE
Leroy Cavrell, Director of the United Way in Klamath Falls
Laura Van Cleve, Director of Harney HOPE
Laura Moulton, Harney County Victims Assistance Program
Karen Johnson, Grant County Victims Assistance Program
Karen Darling, Counselor, Asanti Health Care
Joanne Bowman, Director, Oregon Action
Sarah McDowell, Director of Programa Hispano
Jamie Dick, Lake County CAMI
Kelly Hileman, Lake County Victims Assistance Program
Chiquita Rollins, Multnomah County DV Program Advocate
Arnold Green, Executive Director of Community Works
Jamie Y. Crighton, Indian Country Coalition Against Domestic and Sexual Violence
Kris Billhardt, Director of Volunteers of America's shelter program in Mult. County
Lea Ann Easton, Attorney (served on Attorney General's Task Force)
Sybil Hebb, Director of Legislative Advocacy, Oregon Law Center
Robin Selig, State Support Unit, Oregon Law Center
Deborah Holton, Sexual Assault Victim's Advocate, Columbia Co. Women's Resource Center
Eva Kutas, Office of Investigation and Training, Health Services, Dept. of Human Services
Desiree Allen-Cruz, DV Coordinator for Confederated Tribes of Umatilla Indian Reservation
Ann Kneeland, Director of the DV Clinic, Lane County Legal Aid Services
Patrick Moore, Roseburg Police Department
Vanessa Becker, Director of Battered Persons Advocacy in Roseburg
John Richmond, Manager for Children's Protective Services, Oregon Dept. of Human Services
Mandy Davis, former member of the Governor's SA Task Force
Cathy Oliverio-Relang, IRCO
Tina Frost, former director of the Oregon Coalition Against Domestic and Sexual Violence.

Appendix C

SYNOPSIS OF RESEARCH ON OTHER STATES

The study examined how other states allocate their resources for addressing sexual assault and domestic violence service needs. Six states were considered: Colorado, Washington, Kansas, Minnesota, Maine and Wyoming. Kansas, Colorado, and Maine were chosen because of their similarity in overall density. Washington and Minnesota were suggested because they had grappled with the issue of equity for urban and rural areas, although neither state is similar to Oregon in the number of frontier counties. Wyoming was briefly examined because of its preponderance of rural and frontier areas.

Three of the states (Kansas, Colorado and Maine) basically rely on a competitive process to distribute funds with funding decisions essentially made by advisory bodies. Wyoming uses a geography/population formula with a base on which it took 4 years (!) for committee members to reach consensus. The formula, which weights geography at 20% and population at 80%, has been in place for only one year. These four states all rely primarily if not solely on federal funds.

Washington State, on the other hand, includes state generated funds in its distribution mechanism. Washington uses a combination of competitive processes and formula processes to distribute its funds. Non-competitive funds are distributed on a population/geography formula with base. The base appears to be $40,000. In addition, sexual assault service providers have a "rigorous" accreditation process that must be successfully completed before funds are allocated.

Minnesota has in the past used a reimbursement fee-for-service method that resulted in escalating costs even when the number of women served decreased. In 2002-2003, Minnesota developed a complex formula that relied on five factors applied to judicial districts: population, land area, reported crime, minority population and foundation giving. These factors were weighted as follows: population – 3, land area – 3, reported crime – 2, minority population – 1, foundation giving – 1.[26] In addition to this formula, Minnesota reserved some VAWA funds for competitive projects.

The subsequent pages outline in more detail some of the findings from investigating other state methodologies.

[26] Minnesota is considered a "foundation rich" state with a great proportion of foundation funds going to the metro areas. As a result, the formula was further modified to compensate for this discrepancy. This is not the case in Oregon which is considered relatively poor philanthropically.

A Six State Analysis of Domestic Violence, Sexual Assault and General Crime Victim Resource Allocation

Methodology
Four states were selected for an initial comparative analysis of funding sources and distribution mechanisms for domestic violence, sexual assault and general crime victim resources, including VAWA, VOCA, general and state dedicated funds. The states, Washington, Colorado, Kansas and Maine were selected for comparable population and demographics by The Planning Group, in consultation with the Advisory Committee for the DVSA study. After the initial analysis was completed, Wyoming and Minnesota were added for a review of their funding formulas.

The analysis was conducted through web site and document reviews followed by telephone interviews and email conversations with key personnel in the aforementioned states.

Summary of Findings

State by State Review
Washington
Sources of Funds:
Federal
- VOCA – Divided into thirds, with a third each going to Domestic Violence (DV), Core Sexual Assault services (SA) and General Crime Victims (GC).
- S.T.O.P VAWA
- Family Violence Prevention and Services Act (FVPSA)

State
- General Fund
- A $30 surcharge on filing fees for divorce and separation - $24 goes to the state and $6 remains in the county of origin (new in 2005)

Funding Distribution
DV, SA and GC services are all administered separately and will be addressed sequentially.

Domestic Violence
DV services are broken out by shelter and non shelter-based services.

Emergency Shelter Funds
Shelters are funded through 1/3 of VOCA, 70% of FVPSA, state general funds and the new surcharge. These funds are pooled and are distributed non-competitively on an annual basis. Although the program is non-competitive, grantees submit an annual renewal request. Currently there are 43 funded shelters.

All of the funding sources are pooled and funds are distributed according to a funding formula that was developed by Kay Sohl of TACS in collaboration with the Washington State Coalition Against Domestic Violence and the State.

The formula begins with a base level of funding with increases for population and geographic area (as determined by square miles). Awards range from $40,000 to over $200,000.

New applicants
New providers seeking funding may submit an application form, and if they are approved, the subsequent reduction in resources is evenly distributed amongst the other providers. It is rare that new providers are brought into the system because the requirements for funding are fairly stringent.

Non-Shelter-Based Services
FVPSA and the new surcharge fund 12 agencies.

Historically these funds have been distributed competitively on a 3 year cycle, with specific emphasis on underserved victims of family violence. However, since the bulk of the new surcharge will be used to fund these services, they are still in the process of determining rules and definitions for the distribution of those funds. It is likely that the process will remain competitive.

Sexual Assault
Sexual Assault funding includes 1/3 of the State's VOCA allocation, Federal rape prevention and education funds, state general funds and two sources of dedicated state funds: a portion of the Public Safety and Education Fund (funded through traffic infractions) and Violence Reduction and Drug Enforcement Funds.

The available funds are pooled together and allocated by formula. It is incumbent on the State to verify that the funds are being used for eligible activities based on the providers' reports.

There are three categories of activities:

1. Sexual Assault Core Services – These include prevention services and the resources are allocated on a non-competitive basis to 38 providers coving every region in the state.

   The Core Services program makes a serious commitment to their providers including stable funding and ongoing technical assistance and support in order to assure the ongoing provision of high quality services.

   Each provider has been through a rigorous accreditation process (first implemented in 1997), with a renewal process every four years (although until recently, it was every biennium). Accreditation requires a 90-95% pass rate on a series of core standards. A drop below the pass rate places an organization in a provisional status, requiring annual accreditation reviews until a passing score is achieved. If a site's score drops below a certain threshold, the organization will fail and not achieve any accreditation status. This has happened twice since the program was instituted.

Because of the significant investment Washington places in these programs, they provide ongoing substantive technical assistance and support so there are no surprises at the time of accreditation. The reason accreditation was moved to a four year cycle is because it is a time consuming process for the providers. However, if they fall behind on their record keeping, it becomes an impossibly daunting task to pull together 4 years of records, so there is support to ensure that this doesn't happen.

2. Sexual Assault Specialized Services – By statute, these funds are to be distributed competitively, but they used a modified process. Each county receives a base of funding (determined by formula) with an add-on for population. Each county must have a community planning process to determine who is best qualified to deliver eligible services and how the available resources should be split amongst the qualified providers. Eligible activities include: therapy, support groups and medical social work. Each service includes standards for the training and qualification of providers and there are service standards with purposes and goals.

   The rationale behind this approach is that those on the local level have a much better sense of the qualifications and reputations of the local providers and that this community-based process will increase the local sense of ownership and fosters communication and collaboration.

   All providers and agencies that interact with victims and survivors, including schools, school districts and hospitals, are encouraged to participate in the community-based decision-making process.

3. Services to Tribes and Marginalized Communities – Funding is provided on a competitive basis to those providers that have *both* a history of providing advocacy and prevention services *and* experience working in the community that they are serve. Awards are given on a biennial basis, with annual contracts.
   a. Tribal services – Only tribes and tribal organizations are eligible for this funding pool. There are a very few instances in which a tribe has a long standing relationship with a non-tribally affiliated service provider. Those collaboratives are eligible for funding as long as the tribe is the applicant. All partners must be handled in a subcontracting arrangement.
   b. Services in marginalized communities – They are only in their third year of the availability of this funding pool, but the parameters are the same as for tribal services.

General Crime Victims

This program recently completed a strategic planning process for Victim Services, which is currently only funded through VOCA. The intention is to find other funding to help implement the plan.

The state has been divided into 13 regions (based loosely on county-lines with some lower-population counties grouped together) and each region will determine their own funding process as laid out by an application process. If the plans submitted by a region meet eligibility requirements to provide core services, they will receive funding. A team of facilitators has been hired to help each region develop plans that are uniquely designed to meet that region's needs.

Funding Equity Issues

- Although the funding formula is good and provides a stable base of funding or service providers, there remain issues of equity. The base funding covers the inelastic costs of operating a facility, but urban providers feel that their base should be higher than that of a rural or frontier provider because of the differential numbers of clients served.
- Funding for shelter-based services are increasing, and minimum client requirements are not. There remain unanswered questions about how to equitably distribute funding for shelter-based services as well as whether shelters should be providing, non-shelter based services.
- All shelters receive a comparable base of funding even though not all shelter providers maintain their own buildings. Some use safe houses, other contract for shelter space from other providers. This creates equity issues that need to be addressed.

Cultural Competency

For the SA programs, cultural competency is built in to the core standards and technical assistance is provided to both develop cultural competency plans and demonstrate progress towards cultural competency goals between certifications. This is also the reason they created the culturally specific funding pools. They continue to struggle with diversifying staff and boards although there is willingness and interest, translating ideas into real change continues to be a challenge.

The DV programs continue to struggle with definitions of marginalized populations and whether that means cultural or service needs (see general comments for more detail).

General Comments

- Because the funds are pooled, it is incumbent on the State to verify that the service and funding source are matched. This takes a huge burden off the providers because they are able to deliver their services without having to worry about which pot of money is being used to pay staff. This greatly reduces the number of people who need to stay current on the regulations regarding what funds may be used for what service and therefore increases compliance.
- The separation of SA and DV services really facilitate the delivery of both types of services. Often when the services are combined in a single contract or funding pool, DV services tend to overtake SA resources. This is done out of sheer need, not ill will, but the distinction reinforces to providers that each of these services have a population who needs these services and although the populations may overlap, they are distinct.
- Definitions need to be revisited and clarified in several areas:

- Service descriptions – Shelters have more resources than in the past and have started branching out into non-shelter-based services (such as advocacy). Service definitions need to be created so that there is a common set of definitions that can be specified in contracts.
- Target populations – there has been "definitional creep" as shelters that were originally meant to serve victims of intimate partner violence are now addressing intergenerational or inter-familial violence. The question of whether the definitions for targeted populations should be expanded, or whether other funding sources should be used to serve these populations remain unanswered for the moment.
- There is lack of clarity in the non-shelter DV programs as to what is meant by "underserved". There is some confusion with the legislature as to whether that definition is limited to populations (e.g. ethnicity, sexual orientation or geographic placement) or may include under-provided services (e.g. therapy).

Kansas

Sources of Funds

Federal – Administered through the Governors Office

- VOCA
- VAWA
- FVPSA

State – Administered through the Attorney General's Office

Funding Distribution

All federal funding is distributed annually on a competitive basis. FVPSA funds are distributed by formula, which was developed in consultation with the domestic violence providers who are grant recipients. There is a base amount of funding with add-ons for shelters, population, square miles and population. This is a new process (previously all DV and SA funds were distributed through the Governor's Office) so there is a percentage added for previous grant award so that providers don't suffer from a drastic funding reduction. This will be phased out over time. There are currently 22 DV programs receiving federal funds.

Funding Equity Issues

There is no structure, beyond the formula, to address equity. It is up to the grantees to make their cases in their applications. This model is new enough that there are no lessons learned at this point in time.

Cultural Competency

There is no formal process for integrating cultural competency into their grants, but they are mindful of it when reviewing grant applications.

General Comments

None at this time.

Colorado

Sources of Funds

Federal

- VAWA (25% SA, 74% DV, 1% stalking, dating violence and other crims against women)
- VOCA (10% child abuse, 10% SA, 10% DV, 10% underserved and the remainder is dispersed to general crime victim services).

State

Colorado has no dedicated general funds for this purpose. Instead they distribute State Victim Assistance and Local Enforcement (VALE) funds, whose role it is to fill the gaps in victim services by funding programs which provide services on a statewide basis. The sources of these funds are fins on misdemeanors and traffic violations. 11% of what is collected in each district is sent to the state. There are 9 grants available from a pool of $800,000 that may only be used for statewide or model projects that can be duplicated. In addition to the grant funds, the VALE funds are used to fund 3 coalitions: the Sexual Colorado Coalition, the Domestic Violence Colorado Coalition and the Colorado Organization for Victim Assistance. These funds are also used to fund state victim programs in the following agencies: the Attorney General's Victim Services Program, the Department of victim services program for the AG office, the Department of Corrections, State Patrol and the Division of Youth Corrections.

Funding Distribution

There is a common competitive application for VOCA, VAWA and VALE funds. VOCA applications are biennial and beginning in 2006, State VALE will become biennial as well. Currently VAWA and State VALE are annual processes. The reason for this distinction is the stability of funding. VAWA funds are too uncertain to allocate biennially.

Funding decisions are made by advisory boards. The VOCA and VALE boards have 18 and 7 people, respectively and are appointed by the Governor. The VAWA board has 12 members and is appointed by the Department of Public Safety.

There was a great deal of discussion amongst the boards in the recent past to create a funding formula similar to Minnesota and Wyoming (which sounds like it is very similar to the formula used by Washington) in which funding would be pooled, applicants would submit a service proposal and it would be incumbent of the state to verify that the funding was matched to the services. However, they couldn't get adequate support for the proposal and it was dropped.

Funding Equity Issues

There are no minimum core services. VOCA priorities are set in consultation with Local VALE boards. There are no minimums for VAWA funding, but the VAWA bard prefers not to recommend funding below $7,500 so that providers can count on a stable base and they also have a preferred maximum, but none of this is codified.

The VOCA board has an expressed philosophy regarding the equitable distribution of funds to rural and frontier areas so that there are services in all communities. However, they are faced with two types of frontier areas, each with their own set of challenges. The eastern plains include a large geographic region, but are relatively accessible year-round. The western slopes can be inaccessible during the winter months and that makes service provision very difficult. They do give a disproportionately large allocation to the western slopes to address this challenge.

Cultural Competency
Colorado acknowledges that this is a real challenge area for them. Their grant applications include questions about addressing cultural competency and they allocate VOCA training dollars on cultural competency training, but they are not satisfied with what they have achieved. Part of their issue is the lack of resources to enforce the requirement that all providers either be culturally competent or have a plan to achieve cultural competency.

General Comments
The following are some lessons that they have learned over time:

- When there are fewer funds to distribute, they try to allocate funds in such a way that the reductions to any one facility or program are gradual and produce a minimal impact on providers.
- Their priority is funding infrastructure, so their applicant pool is fairly stable. They do receive applications from new applicants every year and they do fund a portion of those new applicants, so it is not a closed pool. But, the turnover is small which works well for everyone involved because it maintains a fairly stable funding pool.
- The boards have developed and matured over the years and the competitive process is now at a place where it is working well.

Maine

Sources of Funds

Federal

- VAWA – Administered by the Department of Public Safety
- Byrne Funds – Historical funding source, although that program has ended. Administered by the Department of Public Safety
- VOCA – Administered by the Department of Human Services

State
No funding apparent.

Funding Distribution
VAWA funds are distributed competitively and there is no base or minimum funding available. Byrne funds, when they were available, included DV and SA providers in their applicant pool.

Funding decisions are made by the Justice Assistance Council, a board of 16 stakeholders including representatives from the courts, corrections, victim services representatives, representatives from the DV and SA coalitions, the Attorney Generals office and other

key stakeholders. This body makes decisions on a range of justice-related funding pools, so the council members have a broad perspective on the issues in the state and are therefore capable of making funding allocations with a holistic perspective.

There is no weight or formulaic advantage given for cultural competency in the aggregate. Each proposal is reviewed individually and funding is distributed based on the provider's capability to provide services. It is the Council's philosophy that equity is achieved through the consistency of the process, not by granting special recognition for other factors.

The Council does have the authority to pull proposals out of sequence in a situation of an emergency need, and that is done on occasion. However, even if a proposal is pulled out of sequence, it is given the same scrutiny as it would have had it remained in the queue.

General Comments

- Maine seemed to have a very different philosophy than any other state that was reviewed. They were the only state that placed process above all other considerations.
- The disconnect between the distribution of VOCA and VAWA funding was greater than in Kansas, which was the other state that had different agencies administering DV and SA funding. The lack of awareness of the DHS program seemed particularly odd in such a small state.

Minnesota

Funding Formula

The funding formula was developed, with stakeholder feedback, to address a 46% funding reduction with an eye to maintaining some form of equity. The formula uses the following weighted factors:

- Population
- Land area
- Reported Crime
- Minority Population
- Foundation Giving

Foundation giving was assessed over a 10 year period to allow for funding trends and was adjusted to address the relative ease of access to foundation funding of urban over rural providers.

Wyoming

Funding Formula

The funding formula provides a base of $30,000, plus increases for geographic distribution (weighted at 20%) and population (weighted at 80%) to every county and reservation in the state. Wyoming is a state with a large percentage of sparsely populated areas and the high percentage allocated to geographic distribution is a reflection of the special needs of those areas.

Currently there is only one provider in every county, but if there were to be more than one provider, the county allocation would be divided amongst the providers and no additional funding would be allocated to the county.

Process

The formula was developed by a committee of program directors, representatives from the DVSA coalition, staff from the offices of the Division of Victim Services and other stakeholders. It took four years for the committee members to reach consensus on the formula process and this is the first year of implementation.

The formula was a response to changing funding patterns in which exacerbated an existing inequity of funding between large and small providers. Although the new formula addresses many of the equity issues there remained an issue with four programs that would have received significant funding cuts with the new formula. So a compromise was reached in which those four programs had their funding rolled back to 2004 levels to bring them within range without an unreasonable cut.

General Comments

- When selecting a decision-making committee, be sure to be very inclusive. They excluded including a representative from the legislature which hampered their ability to effectively communicate the intent of the formula.
- The final decision was made by a vote and the results were announced to the group as a whole. It would have been more effective to speak with each committee member individually to share the results before announcing the results to the public at large because it would have improved buy-in.