RESEARCHING NORTH CAROLINA DOMESTIC VIOLENCE AND SEXUAL ASSAULT SERVICE DELIVERY PRACTICES

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REPORT SUMMARY

Goals

A critical element of providing effective community-based domestic violence and sexual assault services is sound knowledge regarding which services work well to improve the lives of those who are surviving and have survived these forms of violence. The overall goal of this research was to develop service guidelines for North Carolina domestic violence and sexual assault agencies. Within this goal, a key aim was to identify—based on the experiences, knowledge, and opinions of the executive directors of North Carolina domestic violence and sexual assault agencies—what services work most effectively for violence survivors. The directors of these agencies represent a rich and underutilized resource regarding both the services and delivery strategies that have worked well for the violence survivors in their communities.

Methods

We used four research methods to accomplish the goals of this investigation:

- an extensive review of the research on domestic violence and sexual assault services published within the past 17 years, including a review of existing recommended practices from other states’ Coalitions;
- in-depth interviews with directors of 12 North Carolina domestic violence and/or sexual assault agencies;
- focus groups and interviews with representatives of state-level funding and advocacy-training organizations; and
- a statewide survey of all executive directors of domestic violence and/or sexual assault agencies in North Carolina.
Findings

Core services

Our findings show there are six core domestic violence and/or sexual assault services that are important for assisting survivors:

- 24-hour crisis telephone lines,
- court and legal advocacy,
- medical and emergency room advocacy,
- counseling,
- support groups, and
- shelter.

The findings regarding specific core service delivery practices, across all research methods, are summarized in Tables 6 through 11 (pp. 99-104), which are included in the full report and are recommended to readers for review. Moreover, regardless of the service being delivered, our findings indicated there are five strategies for service delivery that are important for helping survivors:

- services need to be individually tailored to the needs of each survivor;
- survivors should receive information that enables them to understand the impact of violent trauma, as well as information to help them achieve safety and recovery from trauma;
- service providers should prioritize offering survivors emotional support and empathy;
- providers should emphasize community and interagency collaboration in the delivery of services;
• all survivors should receive services regardless of their personal decisions about pursuing legal charges against the perpetrator.

**Delivery of core services.** In addition to these overall findings regarding core services, the information we gathered on several aspects regarding delivery of core services were also noteworthy:

• Participants agreed on the importance of having shelters continuously staffed (24-hours-a-day, 7-days-a-week, 365-days-a-year) so that staff are available to address the needs of survivors and their families.

• Sizable majorities of participants agreed that crisis services, legal advocacy services, and medical advocacy services should be available 24-hours a day, 7-days a week, and 365-days a year.

• Although not universally endorsed, a significant number of participants agreed that, whenever possible, counseling and support group services should be provided on-site for all clients, and access to these services should not be limited by the clients’ co-occurring problems such as mental illness or substance abuse problems.

• Participants also noted the importance of screening potential support group members for group appropriateness giving consideration to mental illnesses and substance abuse.

• Most participants agreed that open support group formats were most helpful for survivors, and that support groups services are most effective when the groups are comprised of survivors who have experienced similar types of violence.

• The survey findings showed variability among participants’ opinions regarding what should be the goals of support group services.
• A substantial percentage of the participants concurred that counseling services best help clients when provided on-site by agency staff.

• There was strong agreement across participants that shelters best help clients when the shelters have a security system and security protocols in place.

**Ideal Services**

Our investigation showed that although participants considered this group of services to be central to their missions, they were unable to provide these ideal services because of lack of funding or other barriers. Participants most frequently mentioned the following three types of ideal services:

- accessible and welcoming services for all survivors regardless of their situation, background, or characteristics;
- specialized services for children; and
- transitional housing and transportation services.

**Service Confusion and Controversy**

This research also revealed aspects of service delivery where considerable confusion or controversy exists regarding how best to deliver services to survivors. These areas included,

- how to deliver services when survivors have experienced both domestic violence and sexual assault;
- how to deliver services when a survivor is struggling with mental illness and/or substance abuse;
- how to manage community knowledge regarding the location of a domestic violence shelter; and
• how to evaluate the capacity of a combined agency to offer both domestic violence and sexual assault services.

**Challenges to Service Delivery**

In addition to identifying service delivery practices, the research also identified challenges and barriers that impede the delivery of services to survivors. Funding was a common thread among several of these challenges:

- **Limited Funding:** Participants reported that limited funding forces agencies to cut core services to survivors, and makes it difficult to pay staff on a regular basis, which, in turn, creates problems for recruiting and retaining qualified staff.

- **Hoop Jumping:** Participants reported that funding requirements, described by participants as “hoop jumping,” exact a heavy toll by increasing the work demands on agency staff and by reducing the time staff can allot to working directly with survivors.

- **Community Norms:** Participants described challenges in providing services that are posed by community norms. Specifically, participants described both the “good ole boy system” and conservative religious beliefs as community norms which poses challenges to the delivery of services to violence survivors.

- **Sustainability/“Funder Fatigue:”** Agency and service sustainability were generally perceived as critical challenges for domestic violence and sexual assault services by agency directors and state-level participants.

- **Lack of Attention and Resources for Sexual Assault:** Participants not only described an overall low level of public attention directed to the issue of sexual assault, but also detailed the greater difficulties experienced by sexual assault and
combined agencies when trying to bring attention to the issue in ways that could positively influence policy and increase funding for these services.

- **Need for Accessible, Welcoming Services:** Participants expressed concern that not all survivors feel welcome to seek and access services in North Carolina domestic violence and sexual assault agencies. Participants agreed that survivors of all racial/ethnic/cultural backgrounds, sexual orientations, abilities, and immigration statuses should feel welcome by these agencies, and that all North Carolina agencies should be prepared to meet the needs of our state’s diverse population.

- **Need for Comprehensive Services:** Participants described providing services to survivors who are struggling with complex and multiple problems, especially co-occurring mental illness or substance abuse problems. Participants noted a shift has occurred among their client population that was prompted by recent mental health reform efforts. This population shift has presented a new challenge of not only serving more survivors who have comorbid mental health and/or substance abuse issues but also serving survivors whose comorbid conditions are more severe than in the past.

- **Grassroots versus Professionalized Services:** Participants described an ongoing tension between grassroots and professionalization of domestic violence and sexual assault services and staff as a challenge that impacts service delivery efforts.

**Participant Recommendations for Addressing Funding Challenges**

Participants recommended three key ways that funders could modify their funding practices, procedures, and processes to help address the issues identified as hindering service delivery:
• implement greater coordination among funders;
• prioritize funding for core services rather than innovative services; and
• focus efforts to ensure accountability through collection of meaningful data that presents a complete picture of service delivery.

**Study Limitations**

This research had several strong components and processes that helped to ensure to study rigor and the robustness of the overall findings, including the use of multiple methods to investigate domestic violence and sexual assault services delivery practices. However, as with any research study, there are important limitations to this research that should be considered to adequately interpret the findings. Thus, readers should closely review the comprehensive discussion of the research limits included in the full report; however, the most critical study limitations are listed below.

• There is no guarantee that the research team has determined an exhaustive, universal list of all important domestic violence and sexual assault service delivery practices. Other critical service delivery practices likely exist, even though they were not determined by this research.

• Given the findings from the literature review, which suggested that combined domestic violence/sexual assault agencies may have less capacity to provide effective sexual assault services as agencies that focus exclusively on providing sexual assault services, the research findings overall are limited in that the survey findings reflect the overrepresentation of sexual assault service delivery practices conducted by combined agencies.
• The overall aim of this research was the development of guidelines for domestic violence and sexual assault services based on existing research and literature, and supplemented with the opinions, knowledge, and experiences of the directors of North Carolina agencies. Therefore, these findings are based on expert opinion and consensus, and readers should keep in mind that these service delivery practices have not yet been empirically validated or tested.

• The findings from this research can help provide guidance to service providers, as well as suggest recommended guidelines for domestic violence and sexual assault service delivery. However, our findings also show there is no one-size-fits-all approach to helping domestic violence and sexual assault survivors with safety and recovery from trauma.

**Future Research**

The limitations discussed above also point toward the next steps for research in this area. First, and of immediate concern, the research team will examine variations in service delivery practices among North Carolina agencies based on key agency differences. This will be a critical research step because such an examination will help determine the extent to which service delivery practices vary between single-focus agencies (i.e., those that provide only sexual assault services or only domestic violence services) relative to combined agencies, which provide both domestic violence and sexual assault services. Although the grant funding for this research has ended, the research team will continue to work on this aspect of the research, as well as other issues that emerged during the research that we were not able to address within the scope of this project and the funding period. The research team plans to continue
analyzing the data, exploring the meaning and implications of the data, and disseminating our findings. All manuscripts and reports from these future research efforts will be shared with the funder, the North Carolina Governor’s Crime Commission.

In addition, this research raised questions that warrant attention in future research. Specifically, there are four areas for future research where our investigation revealed areas of service delivery where there is controversy, confusion, and little guidance regarding how best to deliver services to survivors.

- **Service Efficacy and Outcomes.** Research must undertake the development of outcome tools to evaluate services and to capture the efficacy of domestic violence and sexual assault services. Furthermore, the service delivery practices developed in this research must be tested by intervention and outcome researchers to determine whether these practices are effective in improving domestic violence and sexual assault survivors’ safety and well-being.

- **Serving Survivors of Domestic Violence and Sexual Assault.** Little guidance exists regarding how best to provide services to survivors who have experienced both domestic violence and sexual assault. The research findings thus suggest the need for domestic violence and sexual assault service delivery practices specific to survivors with both forms of victimization and thus are a recommended next step for future research.

- **Serving Survivors with Mental Illness and/or Substance Abuse.** Again, little guidance exists for how best to provide violence services to survivors who are also struggling with mental illness and/or substance abuse. However, the findings show a critical need for such information among the domestic violence and
sexual assault directors who participated in this study. As a result, the findings call for recommended domestic violence and sexual assault service delivery practices specific to survivors with substance abuse problems and mental illnesses and are recommended for future research.

- **Knowledge about the Location of Domestic Violence Shelters.** This research revealed conflicting findings regarding how best to manage community knowledge about the location of a domestic violence shelter. To our knowledge, no empirical research exists to help address the importance of a hidden location of ensuring survivor and staff safety from violent perpetrators. Thus researchers, in collaboration with shelter service providers, could provide important information about domestic violence shelter services by conducting studies on the value of a hidden shelter location for survivors and staff safety.
INTRODUCTION

Sound knowledge of which services work well to improve the lives of survivors is a critical component of providing effective community-based domestic violence and sexual assault services. Although limited, the existing research has shown that advocacy and shelter services help survivors of domestic violence and sexual assault (Campbell, 2006; Resnick, Acierno, Holmes, Kilpatrick, & Jager, 1999; Wasco et al., 2004). Despite the broad acknowledgement of the value of these efforts, serious gaps persist in the knowledge regarding which services are most effective in helping survivors to achieve safety, violence cessation, and recovery from the trauma of violence (Abel, 2000; Mears, 2003; Wathen & McMillian, 2003). Moreover, community-based domestic violence and sexual assault agencies frequently do not have access to current research about best practices. Recent reports from the UNC at Chapel Hill Injury Prevention Research Center showed that North Carolina domestic violence and sexual assault programs continue to need additional guidance and training on how to best provide services for survivors (Violence Working Group, 2002; 2004). Thus, research-based service guidelines have great potential to be helpful to North Carolina agencies in their service delivery efforts.

This project sought to help address these critical knowledge gaps through four phases of research: (a) an extensive review of the research literature addressing domestic violence and sexual assault services, including a review of current, recommended practices obtained from Coalitions in other states; (b) individual interviews with 12 directors of North Carolina domestic violence and sexual assault agencies; (c) focus groups and personal interviews with state-level funding and
advocacy-training organizations (e.g., the North Carolina Domestic Violence and Sexual Assault Coalitions); and (d) a survey of all executive directors of domestic violence and sexual assault agencies in North Carolina. These four information sources were used to create a foundation for the development of service guidelines for North Carolina domestic violence and sexual assault agencies, which was the primary goal of this research project.

The executive directors of domestic violence and sexual assault agencies represent a rich resource about the services and delivery strategies that have worked well for their communities. However, there is little systematic research identifying the specific services that have proven most effective for the survivors of domestic violence and sexual assault. Thus, the first aim of this research was to identify—based on the directors’ experience, knowledge, and opinions—what services work most effectively for violence survivors and victims. To obtain this information, in-depth, individual interviews were conducted with the directors of North Carolina domestic violence and sexual assault agencies that queried each director about their agency’s service delivery practices. Following the completion of the interview phase of research, a survey of domestic violence and sexual assault services was administered to all North Carolina agency directors.

Although information about service delivery practices from North Carolina directors’ perspectives was a critical component of this research, the research team was confident that findings from a comprehensive review of the literature could augment the interview and survey results. Thus, we conducted a comprehensive review of the
literature addressing domestic violence and sexual assault services, as well as services obtained from other Coalitions throughout the United States.

In addition, in the course of conducting the research, it became clear that North Carolina domestic violence and sexual assault agencies face many challenges in delivering services to violence survivors. Interestingly, many of these challenges appeared to cut across many issues and impact North Carolina agencies in similar ways regardless of their location, size, or service focus (i.e., domestic violence only, sexual assault only, or combined agencies offering both domestic violence and sexual assault services). The research team recognized the importance of understanding these challenges because of their impact on agencies’ service delivery. Thus, we used two strategies to identify and better understand these challenges. First, we included questions regarding these challenges in the director interviews. Second, we conducted focus groups and interviews with representatives from state-level funding and advocacy-training organizations about services and the current challenges facing the domestic violence and sexual assault movements in North Carolina.

This report first describes the research methods used to conduct each phase of research: the literature review, the interviews, the focus groups, and the survey. We then present the key findings from these four research phases in conjunction with recommended service delivery practices. The report concludes by describing the research team’s conclusions, the limitations of this research, and next steps for research in this field.
RESEARCH METHODS

Literature Review: Research Methods

We used two strategies to garner domestic violence and sexual assault services literature. The first strategy was to conduct a systematic search of computerized article databases, including PubMed, PsychInfo, and Social Work Abstracts. Keywords used in the database searches included domestic violence, partner violence, family violence, rape, sexual violence, sexual assault, interventions, services, programs, and evaluation. In addition, once we identified an appropriate article, we then conducted a backward search of the reference sections to locate additional publications for review. These search efforts yielded 17,306 articles and books addressing aspects of domestic violence and sexual assault services. For our review, we included any published article, book, or book chapter that described domestic violence and/or sexual assault service delivery practice, or made recommendations about how these services should be delivered. Because the aim of this research was to better understand domestic violence and sexual assault services in community-based agencies, we focused our review on literature that described services that could be conducted in community-based domestic violence and sexual assault agencies. In addition, our aim was to inform service delivery practices in the current service environment and context rather than examining past service delivery practices. Thus, we chose to focus on articles published between 1990 and 2007. Once these criteria were applied, we narrowed the literature to 28 articles, books, and book chapters describing domestic violence (n=14) and sexual assault services (n=14) for review.
As a second strategy to gather domestic violence and sexual assault services literature, we contacted all the Domestic Violence and Sexual Assault Coalitions that could be identified through web searches throughout the United States via e-mail or telephone. We inquired if these organizations had a best practice manual, services training manual, or any documents pertaining to service recommendations or service guidelines. We regarded the inclusion of the Coalitions as critically important because these organizations are typically the primary agent for training community-based domestic violence and sexual assault agency staff in service provision. In addition, these organizations often provide leadership to the agencies in their state by recommending service standards and service delivery practices. Therefore, we felt that it was critical to include in our review any recommendations on service delivery practices developed by the Coalitions. When we identified a Coalition with a relevant manual, we invited the Coalition to send us the document for inclusion in our review. These efforts resulted in 15 additional documents (7 addressing domestic violence, 6 addressing sexual assault, and one addressing both) for review, for a total of 43 articles, books, manuals, or other documents.

*Interview and Focus Groups: Research Methods*

*Executive director recruitment.* We developed our sampling frame for recruiting agency executive directors into this study by identifying all North Carolina domestic violence and sexual assault agencies through the Web sites of the following organizations: the North Carolina Council for Women, the North Carolina Coalition Against Sexual Assault (NCCASA), and the North Carolina Coalition Against Domestic Violence (NCCADV). Using the information garnered from these sites, we created a
comprehensive database of all North Carolina domestic violence and sexual assault agencies. This final list of executive directors (n=105) was then used as our sampling frame. To recruit participants, information letters about the research study were sent to all the executive directors. The letters informed potential participants about the study described here as well as the larger investigation. In addition, Dr. Macy gave brief presentations at the NCCADV and NCCASA annual meetings about the overall investigation, as well as this specific research study.

The directors were invited to participate in the interviews based on random, purposeful sampling procedures. These procedures were used both in order to give all directors in North Carolina an opportunity to be sampled, and to ensure that directors from agencies with diverse characteristics were sampled. Specifically, we wanted to ensure that the study included directors who represented agencies that varied on the following dimensions: (a) service delivery focus: single focus (i.e., domestic violence only, or sexual assault only), or dual focus (i.e., both domestic violence and sexual assault services); (b) service geography: rural, suburban, and urban; and (c) region of the state. Thus, the sampling procedures helped to ensure that we garnered information-rich data about the directors and their agencies, as well as ensuring that directors from diverse agencies participated in the interviews.

Once identified using the sampling procedures, invitations to participate were sent to participants via a letter in a personally addressed envelope marked as confidential and mailed through the U.S. Postal Service to each sampled director. Approximately 1 week after the invitation letter was mailed, the Dr. Macy telephoned directors to confirm they had received the invitation to participate, and to answer any
questions that the director had regarding the research or study participation. Overall, Dr. Macy established contact with 16 directors. Four of the potential participants did not respond to the invitation to participate, which yielded a response rate of 75%. Of the four who declined to participate (non-responders), all were directors of domestic violence-only agencies, but otherwise varied on agency location and service geography.

Of the 12 participants who responded, two of the executive directors felt that an associate director or staff member at their agency could better offer information regarding the agency’s services and service delivery practices, and one executive director was on leave. Thus, among the 12 participating agencies, three were represented by an associate director or other staff member. Of the 10 executive directors who participated in the interviews, two requested that the agency’s associate director also participate in the interview. In these two cases, the executive directors expressed that the agency’s associate director had expertise that would add to the research. Thus, among all participating agencies, two were represented by both the executive director and an associate director in the interviews.

**State-level organization recruitment.** Before formally beginning this research study, and to better understand the major issues facing North Carolina domestic violence and sexual assault service providers, Dr. Macy held informal meetings with key personnel in domestic violence and sexual assault services who are active at the local or state level. At every meeting, Dr. Macy asked for a list of state organizations—both governmental and private—that should be invited to participate in the research. These meetings generated a list of eight key organizations. Subsequently, Dr. Macy identified a contact person at each organization and e-mailed an invitation to that person and the
organization’s staff to participate in a focus group concerned with domestic violence and 
sexual assault. Only one of the organizations did not respond to the invitation to 
participate, which yielded a response rate of 87.5%.

Participant information. The approximate total of 130 agencies (including satellite 
agencies of larger agencies), is a relatively small number of domestic violence and 
sexual assault for a state the size of North Carolina. Moreover, these programs rely 
heavily on outside funding sources for their existence, including the Governor’s Crime 
Commission that funded this research. In addition, the staff at the various North 
Carolina organizations that fund domestic violence/sexual assault services and provide 
advocacy or assistance to service providers is also a relatively small group of people 
who work closely with one another on a regular basis. Thus, the main risk of study 
participation posed to participants was that an expression of an unpopular opinion or a 
marginal viewpoint may have a negative impact on their reputation, agency, 
organization, or the funding that sustains their organization. Therefore, the research 
team was concerned with protecting the privacy and confidentiality of the participants. 
One strategy we used to protect participants was to limit the demographic information 
we collected from participants to prevent the identity of a participant being deduced 
through such information. We used this strategy to help assure the participants that 
there was very low likelihood that their comments could be attributed to them, and that 
they could be honest and frank in their comments with little concern of repercussions. 
Although limited in scope, some information was collected for this research.

Among the domestic violence and sexual assault agency participants, five 
represented agencies that provided both domestic violence and sexual assault services
(hereafter combined agencies), three represented agencies that provided domestic violence services, and four represented agencies that provided sexual assault services. Six participants represented agencies that provided services to rural communities, and six of the participants represented agencies that provided services to urban or suburban communities. The participants also represented agencies from various parts of the state, with two participants representing each of the following regions: central, southeast, northeast, northwest, southwest, and the far west. The participants represented diverse agencies in terms of number of staff, ranging from 2-27 full/part-time employees; the average number of employees was 12 (standard deviation= 8.51).

The participants reported a range of years of experience at their respective agencies, from 1-30 years with an average of nearly 10 years (average= 9.82; standard deviation= 8.49). Likewise, the participants reported a range of years of experience at their respective fields of domestic violence, sexual assault, or domestic violence/sexual assault, from 1-30 years with an average of over 16 years (average= 16.29; standard deviation= 8.53). In terms of education background, 6 of the interview participants had graduate degrees, 6 had completed college or had taken college coursework, and two had completed community college/associate degrees.

Among the organizational focus groups, four were held with staff of state governmental agencies, and three were held with staff of private, non-profit organizations. Three of the organizations were primarily concerned with domestic violence; two were primarily concerned with sexual assault, and two were concerned with both domestic violence and sexual assault. Five of the agencies primarily provided funding to domestic violence and sexual assault agencies, two of the organizations
primarily provided advocacy and assistance to agencies and service providers. The number of focus group participants at each organization ranged from two to seven, with an average number of participants across all focus groups of almost four (the mathematical average was 3.7). The number of focus group participants varied based on the number of staff at each agency who worked directly with domestic violence and/or sexual assault issues. In one instance, a state-level participant was not able to attend the focus group held at this participant’s organization. In order to accommodate this participant, to increase participation, and to maximize the viewpoints reflected in the research findings, Dr. Macy held an individual interview with this state-level participant.

**Interview and focus group procedures.** All interviews and focus groups were conducted by Dr. Macy using two standardized interview guides; one developed for use with the agency directors, and one developed for use with the state organizations. The research team developed the interview guides based on their extensive review of the literature addressing domestic violence and sexual assault services. Both interview guides used open-ended questions in a semi-structured format to allow for the widest range of responses. In addition to questions concerned with domestic violence and sexual assault services, the interview questions addressed the challenges that currently faced North Carolina domestic violence and sexual assault agencies, the challenges that faced the domestic violence and sexual assault movements in the state, and the funding issues for domestic violence and sexual assault services.

The interviews and focus groups were conducted at a location chosen by the participants. Most of the agency director participants chose to have the interviews conducted at their office, though two interviews were conducted at off-site locations.
The average length of the director interviews was nearly 2 hours (1 hour, 54 minutes). All focus groups were held at the offices of the participating state organizations. The average focus group session was slightly more than 90 minutes (1 hour, 35 minutes). All interviews and focus groups were recorded; the recordings were transcribed later by a research assistant.

**Analysis.** Two members of the research team analyzed all the interview and focus group data, which had been transcribed into Microsoft Word documents. When we conducted the content analysis of the transcripts, we used an open-coding approach. That is, to identify themes, we focused on the participants’ opinions, viewpoints, and perspectives, although we also used the questions from the interviews/focus groups to guide the analysis. Even though we focused on finding central themes or concepts across interviews, focus groups, and participants, we also searched for divergent cases and alternative explanations.

The two team members coded four transcripts independently, and then conferred to develop an initial coding scheme; the research assistant then coded all the transcripts to develop an overall coding scheme. Afterwards, Dr. Macy systematically reviewed all the codes as well as the transcripts, and developed new codes as needed. Subsequently, we conferred on the new codes, and organized codes into umbrella codes and subcodes. This process of coding-review-conferring continued iteratively until all the data were coded, the analysis efforts showed convergence and saturation, and the key themes were identified.

After the themes and preliminary findings were identified, we sent a summary of these findings to as many participants as possible (i.e., during the analysis period, some
participants had left the agencies) with a request for their feedback. We sent these preliminary results to director participants at nine agencies, of which six responded to our request for feedback. In addition, the summary of the preliminary results was also sent to the person with whom we made initial contact at the participating state organizations. We encouraged the contact person to present the findings to all participating staff. From these contacts, we received feedback from seven participants representing six organizations. All feedback was used to finalize the results.

Survey: Research Methods

Participants and procedures. We used the same sampling frame that we developed to recruit executive directors for the in-depth interviews for conducting our study survey. This final list of executive directors (n=105) comprised our study sample. However, because several months had passed since we developed the database of North Carolina agencies and directors, we contacted the agencies to update their contact information and name of their executive director. By the time the survey was sent out, two agencies had ceased operation, thus our final sample was 103 agencies.

We conducted the survey administration over a 10-week period. To encourage maximum participation and to reduce the response burden for the participants, participants could complete either a paper version or an electronic version of the survey. The participants received information about the Web-based survey in a personalized e-mail, as well as a paper version of the survey delivered to via U.S. mail with a personalized cover letter. To encourage maximum participation, the executive directors were contacted several times during the survey period by e-mail, U.S. mail, and telephone. However, the first e-mail and cover letter provided potential participants
several ways of opting out of the study and preventing further contact. In addition, both NCCADV and the NCCASA printed a notification about the survey in one of their monthly newsletters during the survey administration period.

Typically, the executive director of the agency was the best person to respond to the survey. However, we also knew that some agencies had an associate director or other staff member who directs the services the agency provides. In the cover letter that accompanied both the e-mail and paper version of the survey, we invited the directors to either complete the survey themselves or to designate the staff member who they felt was most knowledgeable about services to complete the survey.

Surveys were mailed and e-mailed to 103 agency executive directors. At the end of the survey administration, we had a 94% response rate (n= 97).

**Instrument.** The research team developed the survey questions based on the extensive review of the literature, and the qualitative results from in-depth interviews with North Carolina domestic violence and sexual assault agency directors about their services delivery practices. (The entire survey instrument can be found in Appendix D). After developing an initial survey instrument, the survey was pilot-tested by two staff members at three agencies (the NCCDV, the NCCASA, and the North Carolina Domestic Violence Commission) and with other researchers and key personnel who work with domestic violence and sexual assault agencies and services in North Carolina. The pilot feedback was used to revise, refine, and finalize the survey.

**Measures.** The survey was comprised of items that recorded responses using a Likert-scale, items that asked participants to rank order their responses, and open-ended questions that provided space for participants to clarify their responses if they so
desired. The survey instructions asked participants to answer the service questions only if their agencies provided that specific core service. In addition, the survey also included questions about agency and participant characteristics.

The rank-order items were used to assess the participants’ opinions about service delivery goals for six types of domestic violence and sexual assault services. The specific directions to participants included,

"Based on your opinions, please rank the services in order of importance of what services should do for clients. For example, give the ranking of 1 to the item you feel is the most important thing for a client to receive from that service, 2 for the second important, 3 for the third important, and so on.

Several responses items were listed across questions for all six services because they were potentially relevant to all the services. Examples of these items included, “Client received emotional support, such as kindness, caring, and empathy from agency staff/volunteer,” and “Client received help with planning for safety such as vary routine, plan for what to do if perpetrator becomes violent again, memorize emergency numbers.” However, each set of questions also listed items specific to that service. Example of these items include the following: “Client was accompanied to court, trials, and legal meetings,” for legal advocacy; “Client received information about medical options, as appropriate to advocacy role and not in conflict with advice of medical professionals” for medical advocacy; and “Client received a safe place to live free from violence” for shelter services.

The Likert-scale items were used to assess the participants’ opinions about service delivery practices for six types of domestic violence and sexual assault
services: crisis services, legal advocacy, medical advocacy, support groups, individual counseling, and shelter services. Specifically, participants were asked to choose among the following responses to questions about the way services should be delivered to best help survivors: strongly agree, agree, disagree, and strongly disagree. Examples of survey items included the following:

1. Crisis services best help clients when agency staff/volunteers respond to clients’ requests for help, rather than an answering service who then relays the call to staff/volunteers.

2. Legal advocacy services best help clients when available 24-hours a day, 7-days a week, 365-days a year. For example staff/volunteers are available to meet survivor at police station or with attorneys at night and on weekends.

3. Medical advocacy services best help clients when provided by staff rather than volunteers.

4. Support group services best help clients when those with specific violence experiences are helped to form their own group with members with similar experiences. For example, sexual assault survivors, domestic violence survivors, adult survivors of child sexual abuse would form separate support groups.

5. Shelter services best help clients when the shelter location is hidden from most in the community.

Questions that were relevant to all or most of the services, such as “available 24-hours a day, 7-days a week, 365-days a year” or “provided by staff rather than volunteers” were asked across all services. However, specific questions were asked about unique aspects of services as well. For example, “Shelter services best help clients when
clients with adolescent male children are referred elsewhere” and “Support group services best help clients when open and ongoing (clients are welcome to join the group any time that they like and attend as many or as few sessions as they would like).”

Survey analysis. To identify directors’ opinions regarding how domestic violence and sexual assault services should be delivered—including their opinions about critical service goals and service delivery practices—descriptive analyses were conducted. Specifically, we analyzed participants’ responses to the various items with means, standard deviations, and ranges. These descriptive statistics can be found in Appendix A, Tables 12 through 18 for crisis services, legal advocacy, medical advocacy, support group, counseling and shelter respectively.

For the service delivery goals, a ranking of 1 indicated the highest importance, and less importance was indicated by rankings further up the number ladder. As illustrated in Tables 12 through 18 included in Appendix A, the mean indicates the average rank of importance for that item. The mode indicates the most frequent ranking that an item received from participants. The standard deviation and the range indicate the variability in rankings among participants. When interpreting these results, readers should keep in mind that the numbers of items varied for each service question (e.g., for crisis there were seven items, for legal advocacy there were nine items). The number of items ranked in each service area is listed at the top of the table. For rankings of the service delivery practices, the mean indicates the average agreement, with 4 indicating strong agreement and 1 indicating strong disagreement. The mode indicates the response that the item received most frequently from participants. The standard deviation and the range indicate the variability in responses among participants.
LITERATURE REVIEW: KEY FINDINGS

Overall, the literature review showed that core services recommended for domestic violence survivors included 24-hour crisis services with emphasis on telephone hotline services, legal advocacy, support groups, individual counseling, and shelter. Similarly, the literature review showed that core services recommended for sexual assault survivors included 24-hour crisis services with emphasis on telephone hotline services, legal and medical advocacy, support groups, and individual counseling. The key findings from the review are summarized in Table 1 (domestic violence services) and Table 2 (sexual assault services). Within the tables, the core services are listed along with recommended service goals, provider interventions (i.e., what strategies should be used when delivering the service), and service delivery practices.

In addition, the literature review showed that despite the general agreement found in the literature concerning how these services should be delivered, our review also showed that controversy exists in several areas. Specifically, there was little agreement in the areas of (a) staffing of domestic violence shelters, (b) sheltering domestic violence survivors who have substance abuse problems, (c) how, or if, combined agencies can effectively offer both domestic violence and sexual assault services, and (d) how combined agencies can best offer services to survivors who have experienced both forms of violence. These areas of controversy are described in detail below.

Staffing Shelters

There were conflicting results as to whether survivors should have access to staff at all times (Arizona Coalition Against Domestic Violence, 2000) and whether shelters
should be staffed at all times (Wisconsin Coalition Against Domestic Violence, 2003). Although much of the literature acknowledged that survivors could have needs that require staff support at any time, other literature included in the review emphasized the philosophical reasons for not staffing the shelter at all times. For example, the Maine Coalition (2005) described shelter services as “a cooperative living arrangement where shelter residents share duties and responsibilities with minimal supervision.” Similarly, some service literature recommended that while living in the shelter, survivors should be able to gain or regain control over their lives, and that close supervision by staff—and strict shelter rules—may prohibit survivors from regaining this sense of control (Ohio Domestic Violence Network, 2003).

Domestic Violence Shelters and Substance Abuse

Another area with little clarity in the literature concerned sheltering survivors who have problems with substance abuse. Some sources recommended these survivors should not be excluded from shelter services based on substance abuse problems (Ohio Domestic Violence Network, 2003). However, other literature noted that allowing women with an active substance abuse problem to stay in shelter is a specialized service that many shelters do not offer; as a result, shelters often require women to be substance free (Johnson, Crowley, & Sigler, 1992; Zerman, 2004; Zweig, Schlichter, & Burt, 2002). Although much of the literature emphasizes that it is critical that shelters should serve all survivors, little guidance is given to domestic violence service providers about how best to accommodate survivors who have substance abuse problems in shelter.
**Combined Services**

Despite the fact that a majority of agencies in the United States as well as in North Carolina are combined agencies, that is, they provide both domestic violence and sexual assault services, questions regarding the effectiveness of this dual focus permeated the literature. Specifically, researchers and practitioners have asked whether combined agencies work as well as single-focused agencies (i.e., provide only one type of service: domestic violence services only or sexual assault services only.) Some research suggests that combined agencies do not perform as well as single-focused agencies (Byington, Martin, DiNitto & Maxwell, 1991). For example, O’Sullivan and Carlton’s (2001) research showed that single-focused sexual assault agencies tend to serve greater numbers of sexual assault survivors than agencies with combined services. These authors posited that when services are combined, the problem of domestic violence may overwhelm the “identity and culture” of the agency, including how staff time and other agency resources are prioritized and deployed. As a result, combined agency staff is less able to provide outreach to those who have experienced sexual violence.

However, other investigators have pointed out the risks of separate, stand-alone sexual assault and domestic violence agencies. Specifically, Bergen (1996) maintained that single-focus agencies do not necessarily help women who have experienced both sexual violence and partner violence either from one or multiple perpetrators. That is, domestic violence agency staff members are not necessarily trained in the medical and legal advocacy needed by sexual assault survivors. Likewise, staff at sexual assault
agencies may define rape by an intimate partner as domestic violence, and refer women to a domestic violence agency. Women who have experienced both sexual violence and domestic violence may feel that one of these important problems was ignored, or may be referred to other agencies for services (Bergen, 1996).

Other researchers point out that not all domestic violence agencies have policies and procedures to address sexual violence, even within the context of an intimate relationship (Johnson et al., 1992). For example, a woman who experiences sexual violence and receives help from a domestic violence agency may find later that the sexual violence was insufficiently documented to support legal proceedings. In fact, Bergen (1996) argued that for some domestic violence agencies, sexual violence, even within the context of an intimate relationship, is determined to be outside the scope of expertise of the agency staff. Thus, these agencies tend to refer these survivors to sexual assault agencies for services. The risk of such referrals is that survivors may not follow-up on referral and as a result not receive violence services of any kind.

Unfortunately to our knowledge, there is no systematic, empirical research about how often sexual assault survivors tend to be referred away from domestic violence services.

However, the literature does offer some recommendations for addressing this area of controversy. For example, there are a few clear recommendations that service providers should be crossed-trained in both domestic violence and sexual assault service provision (Bergen, 1996; North Carolina Coalition Against Domestic Violence 2006). In addition, O'Sullivan and Carlton (2001) recommended that each program within combined agencies should have control over its own budget, staff, and program activities. However, given the overlap in victimizations among the clientele who seek
services from both domestic violence and sexual assault agencies, as well as the ongoing concern reflected in this literature that when services are combined the sexual assault programming suffers, the controversy and lack of clarity on this issue of combined services is a critical and ongoing concern.
<table>
<thead>
<tr>
<th>Core Service and Citations</th>
<th>Service Goal</th>
<th>Provider Interventions</th>
<th>Service Delivery Practices</th>
</tr>
</thead>
</table>
| **Crisis Services/Hotline**  | • Survivors’ immediate safety is improved  
• Survivors’ capacity to cope effectively with their crisis situation is enhanced  
• Survivors’ have more information about partner violence, safety resources, and better understands legal and other options | • Offer survivors emotional support  
• Give information about domestic violence, stress management, and referral to other services  
• Help survivor make decisions about crisis situation | • Telephone line staffed with trained service providers  
• Service available 24-hours a day  
• Survivors should receive an immediate response  
• Telephone line should be able to handle multiple callers  
• Telephone service should be toll-free for survivors, even those who call collect  
• Able to respond to survivors who do not speak English, as well as hearing-impaired survivors |
| Arizona Coalition Against Domestic Violence, 2000;  
Indiana Coalition Against Domestic Violence, 2005;  
Kansas Coalition Against Sexual and Domestic Violence, 2004;  
Maine Coalition to End Domestic Violence, 2005;  
North Carolina Coalition Against Domestic Violence, 2006;  
Ohio Domestic Violence Network, 2003; Roberts & Roberts, 2002;  
Virginians Against Domestic Violence, 2003;  
Wisconsin Coalition Against Domestic Violence, 2003;  
Zerman, 2004 | | |
| **Legal/Court Advocacy**  | • Survivors’ safety is improved  
• Survivor is informed about legal policies and procedures | • Provide survivors with support, information, referrals  
• Accompany survivors to civil or criminal proceedings  
• Help ensure that perpetrators are held responsible  
• Ensure that legal system treats | |
| Bybee & Sullivan, 2002;  
Harris & Weber, 2002;  
Kansas Coalition Against Sexual and Domestic Violence, 2004;  
Maine Coalition to End Domestic Violence, 2005;  
McDermott & Garofalo, 2004;  
North Carolina Coalition Against Domestic Violence, | | |
<table>
<thead>
<tr>
<th>Support Group</th>
<th>Individual Counseling</th>
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</table>

- Survivors’ safety is improved
- Survivor’s are less socially isolated
- Survivors’ have a better understanding of and more knowledge about domestic violence
- Survivors have less self-blame
- Survivors have increased self-efficacy
- Survivors have increased self-esteem
- Survivors’ learn from others’ experiences with the violence
- Normalize the survivors’ reactions to the violence
- Give information about law, health and human services
- Give information on domestic violence dynamics
- Focus on safety planning

- Focus on safety planning
- Focus on problem-solving
- Normalize the survivors’ reactions to

- Support groups should have two leaders
- Leaders/facilitators should have knowledge of domestic violence
- Leaders/facilitators should ensure group members’ safety and confidentiality while survivors’ attend group meetings
- Hold group meetings in accessible location (e.g., parking and public transport available)
- Offer childcare during group meetings
- Hold meetings weekly on consistent time and day to encourage participation

- Ensure safety and confidentiality of survivors while she attends counseling
- Counseling should be and structured and focused
### Dynamics
- Survivors have less self-blame
- Survivors have increased self-efficacy
- Survivors have increased self-esteem

### The Violence
- Help survivor make decisions about her relationship and her safety
- Provide information
- Offer support

### Shelter
**Arizona Coalition Against Domestic Violence, 2000;**
**Indiana Coalition Against Domestic Violence, 2005;**
**Johnson et al., 1992;**
**Kansas Coalition Against Sexual and Domestic Violence, 2004;**
**North Carolina Coalition Against Domestic Violence, 2004;**
**Maine Coalition to End Domestic Violence, 2005;**
**Ohio Domestic Violence Network, 2003;**
**Wisconsin Coalition Against Domestic Violence, 2003;**
**Indiana Coalition Against Domestic Violence, 2005;**
**Zerman, 2004;**
**Zweig, et al., 2002**

- Survivors’ safety is improved
- Survivors are less socially isolated
- Survivors have less self-blame
- Survivors have increased self-efficacy
- Survivors have increased self-esteem
- Survivors learn from others’ experiences
- Survivors receive help accessing other community resources and services, including health, financial, housing

### Connect Survivors to Other Domestic Violence Services
- Connect survivors to other domestic violence services (i.e., support groups, counseling)
- Connect survivors to other community services to address their health, housing, and economic needs

### Provide Crisis Admissions
- Provide crisis admissions 24 hours a day, 7 days a week, 365 days a year
- New admissions to the shelter should receive intake and assessment within 24 hours
- Survivors should have their basic needs met (i.e., food, clothing, hygiene, adequate sleeping, living and dining space)
- Shelter should not screen out survivors based on any personal characteristics or because the survivor is unwilling to take out a protection order against the perpetrator
- During their shelter stay, staff should work with survivors to develop an individualized plan for attaining their goals
Table 2. Literature Review Results: Recommended Sexual Assault Services Goals, Interventions and Components

<table>
<thead>
<tr>
<th>Core Service and Citations</th>
<th>Service Goal</th>
<th>Provider Interventions</th>
<th>Service Delivery Practices</th>
</tr>
</thead>
</table>
| **Crisis Services/Hotline**| • Survivors’ capacity to cope effectively with their crisis situation is enhanced  
Arkansas Coalition Against Sexual Assault, 2004;  
California Coalition Against Sexual Assault, n.d.;  
Florida Coalition Against Sexual Assault, n.d.;  
Illinois Coalition Against Sexual Assault, 2004;  
Kansas Coalition Against Sexual and Domestic Violence, 2004;  
North Carolina Coalition Against Sexual Assault, 2000;  
Texas Association Against Sexual Assault, 2004 | • Provide non-judgmental emotional support  
• Provide empathetic responses  
• Clarify and identify survivors feelings  
• Give guidance, information, and referral to other services  
• Use active listening skills  
• Help survivors with problem solving  
• Emphasize survivors’ strengths and resources  
• Help survivors explore options  
• Assess and address safety and suicide risk | • Telephone line staffed with trained service providers  
• Service available 24-hours a day  
• Survivors should receive an immediate response |
| **Medical/ER Advocacy**     | • Survivor returns to the pre-rape levels of functioning  
Acosta, 2002;  
Berger, 1997;  
California Coalition Against Sexual Assault, n.d.;  
Campbell, 1998;  
Campbell, 2006;  
Daane, 1996;  
Dunlap et al., 2004;  
Green & Panacek, 2005;  
Florida Coalition Against Sexual Assault, n.d.;  
Illinois Coalition Against Sexual Assault, 2004;  
| • Ensure that survivor does not experience “secondary victimization” by health care system  
• Normalize survivors reactions to the rape  
• Give information about medical care and help survivor make informed decisions about medical care  
• Give information about victim’s rights, options, and follow-up services | • Services should be available 24 hours a day, 7 days a week, 365 days a year  
• Services may be needed for years depending on survivors’ recovery  
• Service providers should be knowledgeable about medical/forensic policies and procedures |
<table>
<thead>
<tr>
<th>Crime Victims' Compensation</th>
<th>Legal/Court Advocacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Give information about Crime Victims’ Compensation</td>
<td>Give help preparing for court appearances</td>
</tr>
<tr>
<td>Encourage survivors to be as involved in making own medical decisions</td>
<td>Give help monitoring the prosecution case throughout the legal systems</td>
</tr>
<tr>
<td>Discuss with survivors with helpful coping strategies, including social support</td>
<td>Services should be available 24 hours a day, 7 days a week, 365 days a year</td>
</tr>
<tr>
<td>Follow-up with survivors 24–48 hours after the assault, and then contact survivors on weekly basis until services are no longer needed</td>
<td>Services may be needed for years depending on the legal process</td>
</tr>
<tr>
<td>Follow-up with survivors 24–48 hours after the assault, and then contact survivors on weekly basis until services are no longer needed</td>
<td>Service providers should be knowledgeable about legal policies and procedures</td>
</tr>
</tbody>
</table>

**Ledray, 1996; Osterman et al., 2001; O'Sullivan & Carlton, 2001; Resnick et al., 2005; Texas Association Against Sexual Assault, 2004**

<table>
<thead>
<tr>
<th>Legal/Court Advocacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Berger, 1997; California Coalition Against Sexual Assault, n.d.; Campbell, 1998; Campbell, 2006; Daane, 1996; Dunlap et al., 2004; Florida Coalition Against Sexual Assault, n.d.; Illinois Coalition Against Sexual Assault, 2004; O’Sullivan &amp; Carlton, 2001; Resnick et al., 2005; Texas Association Against Sexual Assault, 2004</td>
</tr>
</tbody>
</table>

- Survivors returns to the pre-rape levels of functioning
- Survivor is informed about legal policies and procedures
- Ensure that survivor does not experience “secondary victimization” in legal system
- Normalize survivors reactions to the rape
- Follow-up with phone calls and visits to survivor
- Accompany survivors to legal appointments, interviews, trials, and sentencing
- Give help to make informed decisions about police reporting
- Give help preparing for police reporting
-Give help preparing for court appearances
- Give help monitoring the prosecution case throughout the legal systems

- Services should be available 24 hours a day, 7 days a week, 365 days a year
- Services may be needed for years depending on the legal process
- Service providers should be knowledgeable about legal policies and procedures
| **Support Group**
Arkansas Coalition Against Sexual Assault, 2004; California Coalition Against Sexual Assault, n.d.; Carey, 1998; Florida Coalition Against Sexual Assault, in press; Koss & Harvey, 1991 | **Survivor better able to manage the trauma of the sexual assault**
- Survivors feel supported and understood | **Normalize sexual assault by providing information about its prevalence and other educational information on sexual assault**
- Reduce isolation and promote relationships
- Emphasize mutual support and aid
- Encourage adaptive coping
- Provide role models for recovery
- Offer acceptance, empathy and encouragement
- Teach survivors skills to manage feelings
- Teach survivors skills to reduce self-blame
- Foster connections with other groups members, so that survivor able to trust others | • Give help with protective/no-contact/anti-harassment orders
• Give information/help with Crime Victims’ Compensation applications
• Provide information about the criminal justice system and civil remedies
• Liaise with police, prosecutors, and other legal professionals on the survivors’ behalf
• The group should have two groups leaders/facilitators
• Facilitators should have knowledge of sexual assault and trauma
• Hold group meetings in accessible location (e.g., parking and public transportation available)
• Offer childcare during group meetings
• Hold meetings weekly on consistent time and day |
<table>
<thead>
<tr>
<th>Individual Counseling</th>
<th>Achievements</th>
<th>Providers’ Responsibilities</th>
</tr>
</thead>
</table>
| Arkansas Coalition Against Sexual Assault, 2004; Gilbert, 1994; Illinois Coalition Against Sexual Assault, 2004; Koss & Harvey, 1991; North Carolina Coalition Against Sexual Assault, 2000 | • Survivor returns to the pre-rape levels of functioning  
• Survivor better understands his/her reactions to sexual assault and trauma  
• Reduce emotional distress  
• Develop and/or enhance positive coping skills | • Counseling should be and structured and focused  
• Providers should be prepared to educate survivors about medical and legal procedures, including rape kits, medical examination, and court procedures  
• Providers should be well versed in community and state polices  
• Providers should have contacts within the medical and legal systems |
|                                             | • Normalize sexual assault by providing information about its prevalence and other educational information on sexual assault  
• Normalize survivors’ reactions to the assault  
• Provide resources  
• Offer acceptance, support and empathy  
• Address high priority needs and problems  
• Identify and involve social support  
• Help make necessary arrangements concerning work, parenting, or school  
• Educate the survivor about what the future may hold in terms of his/her reactions |
INTERVIEW AND FOCUS GROUPS: KEY FINDINGS

Critical and Core Services

Information obtained through interviews with 12 North Carolina domestic violence (n=3), sexual assault (n=4), and combined domestic violence and sexual assault (n=5) agency executive and associate directors identified six critical and core services for violence survivors: 24-hour crisis lines, counseling, support groups, court/legal advocacy, medical/emergency room advocacy, and shelter. However, among this small sample, shelter services were exclusively offered by agencies providing domestic violence services, and medical advocacy was primarily offered by agencies providing sexual assault services. In addition to these core services, participants described ideal services, that is, the services they consider central to their missions and would like to provide, but are not able to provide because of lack of funding or other barriers. Three types of ideal services were mentioned by participants: (a) accessible and welcoming services for all survivors regardless of their situation, background, or characteristics, (b) specialized services for children, and (c) transitional housing and transportation services.

In addition, a majority of participants described four service delivery practices that are important for helping survivors regardless of the core service being delivered: individualized service, making information available and accessible, agency and community collaboration, and full services available to all survivors. First, participants acknowledged that services need to be individualized for each survivor:

*Because each case is an individual situation that we have to look at and see what we can do for that person. You can’t just make this big blanket statement that DV victims need this, this, and this. Because each one is an individual.*

– domestic violence agency participant
Second, survivors should receive information that enables them to understand the impact of violent trauma, as well as information about the available options and resources because this information may help with their safety and recovery from violent trauma.

[The] biggest service that I feel I provide clients is the information... they think they only have one option, this or this. No matter what the situation is, there’s always more than one option available to you.... “You have these choices, all this stuff is available to you.” Once she gets that information just allowing her to make her own decisions, empowerment, that’s a big deal and education.... Get her thinking more critically about her situation. Even things like getting her thinking about her safety, even if she’s not going to leave now, even if she just wants this information from me and this is going to be the end of the conversation. I have that brief period of time of okay... “You need time to think about this and decide what you want to do, but I’m really worried about your safety. Can you take a few minutes and talk about if something happens between now and when you’ve made your decision, what you’re going to do?” Get her thinking about that, get her planning it out, preparing for it.

– combined agency participant

Third, all participants described the importance of community and interagency collaboration, either via formal mechanisms such as a Sexual Assault Response Team or Community Coordinated Response Teams. In addition, participants recommended other collaborative efforts such as having the agency director sit on various boards of other service agencies in the community. Participants described how an emphasis on community collaboration, including having positive, working relationships with health care, social services, and legal service professionals, ensures better services for survivors. However, participants also described the need to maintain a balance between advocating for survivors and preserving positive relationships with other community providers and professionals. One participant from a combined agency stated,

I used to say if I didn’t make somebody mad at least once a day I wasn’t doing my job. But you can do your job and still not tick anybody off, and as small as this
town is, you can’t afford it. You really can’t afford it, because you’re going to have to turn around and need them later.

Fourth, a majority of the participants raised the point that all survivors should receive all and any services offered by the agency no matter what decision they make about pursuing legal charges against the perpetrator. One participant from a sexual assault agency stated,

Whatever course of action they take it is not contingent on what services they get from us, so whether they report or don’t report, or prosecute or not prosecute, doesn’t matter to us. We will continue to follow-up with them weekly until they say, “You know, I think I’m doing okay. You don’t need to call anymore.”

Crisis services. All participants indicated that crisis telephone hotline services are a critical part of their current service delivery practices. The most frequently mentioned reasons for the importance of providing crisis services included the following: (a) violence can happen at any time, and survivors need to be able to access services at any time; (b) telephone hotlines are an important gateway for survivors to access information and referral; (c) even a brief crisis intervention may make a critical difference in a survivor’s life and safety.

You know what happens in the middle of the night, or what happens on a holiday or on a weekend, and New Year’s, and the Super Bowl Game, or whatever’s on and it’s on a Sunday, who do people access? You need a 24-hour hotline so that even if we can’t provide the services for them, maybe we can refer them out. You know, a lot of times you’ll get someone who doesn’t want to stay within our area because everyone knows everyone else and she’s afraid that he’s going to find out that she’s there. So that person on the hotline can give the referrals and make the arrangements for the police to take her to the other county and something like that.

– domestic violence agency participant

Counseling. All participants reported that their agencies offered counseling services to survivors, and described counseling as a critical service for survivors. It was noteworthy that some participants described offering distinct sets of counseling
services. For example, most all participants distinguished between mental health counseling, which was often delivered by mental health professionals, and supportive counseling that does not necessarily have a mental health focus, and may be delivered by staff or volunteers without mental health expertise. Although many agencies described being unable to offer mental health services because they lacked funding for mental health professionals, one participant described how offering mental health services on-site can be beneficial for survivors:

*We also have one of our advocates [who] has her master’s degree and has completed her counseling steps. So recently we’ve added in the opportunity for clients to come here and receive individual counseling sessions with her. That has actually been a blessing for certain clients who [previously] utilized [name of the local community mental health provider] agency, [they were] excellent to work with... But once in awhile, we get clients who just do not feel comfortable going there because [they say] “So and so goes there,” or “I’m going to run into someone I know.” And this [on-site counseling] has been a really good alternative for those clients that need that counseling but are afraid of running into somebody they know in a public place like that.*

– combined agency participant

Similarly, participants discussed the importance of their agencies offering counseling services because of the limited availability of community mental health services.

*For us, our community counseling is a huge piece because of mental health reform, and our community mental health agency is now booking folks 4 to 6 weeks out. And so if we had someone in crisis that had to wait 4 to 6 weeks, I’m not sure where they would be in 4 to 6 weeks, they may be committed in that amount of time depending on what their mental health state was or what’s going on in their life.*

– sexual assault agency participant

Support groups. Support groups were offered by all participating agencies, and were reported to be critical services by all participants. In addition, most participants described offering open, ongoing support groups. However, a few participants described the logistical challenges of maintaining an ongoing, open support group. One participant
explained how her agency uses a weekly “support group” as a way to initially engage clients in services.

*But the victims of sexual assault really don’t all come in as a group . . . They come in once, and then they’ll come in individually, but they don’t want to come in as a group. I’ve never seen it work. We’ve tried it several times and it has never worked . . . [The group] gets advertised in the newspaper every week that if they want to come, there’s a SA support group Tuesday nights from 6 to 8, there is an advocate that’s here at that time if people come in. So, we get new people coming in, but it’s never a group.*

– sexual assault agency participant

In addition, several participants, regardless of their agencies’ service deliver focus, distinguished between support and counseling groups. That is, the support groups offered by most agencies have a mutual-aid orientation. One participant described this type of group:

*The group leader] doesn’t do any counseling, she’s just here and she knows all about domestic violence and she’ll say different feelings and things about what’s happening with domestic violence. Then she’ll let them talk, and it’s a support group where they can all get together . . . it’s a support group so that they feel better about themselves and they continue to come and we let them come as long as they want. And then if they stop coming and they feel, “Oh, I need to get back to that group,” — it’s open. They can come back in.*

– combined agency participant

In a similar way, a participant representing a sexual assault agency described the aim of their support group by saying, “...to deal with certain emotional responses to their assault. We don’t have discussions about what happened because that can affect the case outcomes. This is strictly just a group to deal with emotional response to the assault.” Furthermore, one domestic violence participant described the purpose of her agency’s counseling group as “pattern changing,” meaning its purpose was to help survivors gain insight about the impact of violence in their lives, and to help survivors make significant, positive changes in their lives.
Some agencies offered multiple types of support groups. One agency offered a support group for survivors who had gotten through the immediate aftermath of the trauma, and this group was led by a trained human service professional. The participant representing a domestic violence agency described the group:

On occasion, when there’s interest among our clientele, and when there’s sufficient interest to warrant it, we’ll have a 10-week what we call process group, which is more of a life-skills [group], delving deeper into the issue for people who are beyond the immediate crisis and want to move on.

A common issue that was addressed in several of the interviews was the importance of screening potential support group members for group appropriateness. Participants described how the absence of a screening process had created problems in the past when survivors with mental illness or substance abuse problems wanted to attend support group meetings. One participant described her agency’s current screening practices:

[The counselor] requires them to come for some individual counseling beforehand just to assess if they’re appropriate for group . . . She’ll meet with them one or two times to really kind of assess, and sometimes they’ll end up in individual counseling longer than they perceive they needed to be, but that’s sort of the treatment plan that they’ve agreed on with the long-term goal being the support group.

– sexual assault agency participant

Court/Legal Advocacy. Court or legal advocacy was also described by participants as a crucial service for violence survivors. A domestic violence agency participant described a legal advocate as, “Somebody that they can turn to who will stand up with them.” A sexual assault participant described the importance of court advocacy by saying, “If you’re not going to court with folks, you’re leaving them hanging. It’s like you heal them up this far, and then ‘Bye, you’re on your own!’.” Another participant elaborated on the importance of court advocacy by explaining,
If you’ve never been to court before, it can be very intimidating, it can be intimidating for someone who’s been in court . . . [survivors] don’t know the process, they don’t know the procedure, they’re scared, they’re afraid they’re going to see [the perpetrator] and . . . as a client coming in who has absolutely no idea what’s going on, they get lost in the shuffle and maybe some things they could ask for in the protective order that are very, very important like, for instance, the car, they don’t even know to ask for that! Or “Can I go back in the house and get my kid’s clothes?” or “Why do I have to fill out this paperwork? Why do I have to be in court? What’s going to happen to him? Am I going to be able to see the kids? How am I going to pay the bills?” That’s why I think court advocacy is so important, because they really are scared to death and they don’t know what to expect.

– domestic violence agency participant

Participants also described additional service delivery practices and strategies for court and legal advocacy. First, advocates should have “a good rapport” with police and legal professionals in the community.

[Our court advocate] knows these attorneys, she knows the judges, she knows these people, she has a good rapport and that is very important in this community. They don’t always get along but they respect each other and they know they can depend on each other. So that is vital . . .

– domestic violence agency participant

Second, advocates should collaboratively work with legal professionals, being mindful of the limits of their legal expertise, and work as a “silent partner” with legal professionals.

. . . . So we have a mutual agreement amongst the disciplines, that when we go to the DA’s office that’s the DA’s job or the assistant DA’s job to inform the victims of their rights and what they can do legally and that sort of thing. Now if there are things we can help to explain we will, but we typically like to stay as a silent partner and be there as a support to that victim. If they [the DA] have to leave that room, the victim is not sitting there by themselves. We’re there to answer questions after it if they have questions about anything the DA said or before we leave that office if there are questions let’s ask them now. If they’re afraid to ask, we’ll ask for them, so it’s that sort of relationship. But when they’re up there it’s the DA and the victim talking back and forth, and we just really stay silent.

– sexual assault agency participant

In addition, this point was addressed by two participants in the feedback they provided after reviewing the preliminary findings of this study. These participants pointed out that
although the advocate may often know more about domestic violence or sexual assault issues than the judges or attorneys, advocates must always be careful not to give survivors legal advice or to cross into the role of an attorney. In other words, advocates must remain mindful of providing services within their expertise and role.

**Medical/Emergency Room (ER) Advocacy.** In this sample, medical and ER advocacy tended to be delivered by the agencies that provided sexual assault services. Those providing medical advocacy reported a strong conviction that not only was such advocacy a critical service for sexual assault survivors but also that their agency was uniquely positioned in terms of knowledge, skills, and supports to offer this service. One participant representing a sexual assault agency described the aim of this type of advocacy:

*To ensure that an adult knows about emergency contraception, to communicate and educate folks about victim’s compensation. There’s no one else in our county that talks about victim’s compensation. No one, the hospitals don’t do it, law enforcement don’t do it. So it’s really all the core pieces that we’re doing.*

Another sexual assault agency participant stated,

*They’ve got to have someone that can walk them through that traumatic crisis moment because we don’t have anyone else in our county that can do that. No one else with the training, no one else with the qualifications that knows how to do that.*

**Shelter.** Participants whose agencies provided shelter services to domestic violence survivors described these services as a critical service for their clients. In addition, participants discussed specific service delivery practices to ensure shelter services are safe and helpful to survivors: (a) having staff on site 24 hours a day, 7 days a week, 365 days a year, (b) having rules and structure while also treating survivors like
adults, and (c) accommodating survivors with adolescent male children. Across interviews, participants described these service delivery practices in a similar manner.

Although interview participants acknowledged that uninterrupted staffing for shelters is costly, most participants concurred such staffing costs were a “good investment” for the several reasons. First, the many needs of survivors and their families, including substance abuse problems and mental illnesses, may require round-the-clock responses. Second, survivors who first arrive at the shelter during the night may need the help of a staff member with the transition into the shelter. Third, the presence of staff members provides a “safety net” for survivors. If staff members are always on-site, survivors are assured someone will be available if a need or problem arises. Fourth, survivors, who have recently survived a terrible experience and who have been “traumatized and battered,” may need services, such as counseling, at any time, day or night. Typical participant comments included the following:

There is no shelter that should operate without being manned 24/7. And we’ve done it both ways, because early on we couldn’t afford to have somebody 24/7. But I can tell you that when you don’t [staff 24/7] you’re set up for failure . . . There’s just too much that can go wrong for the families, the people coming there, there’s just too much that can happen. And I know it means extra money, but I think it’s really a good investment . . . So there’s always somebody available for them, somebody to help them through difficult times, somebody to oversee what’s going on. So I think that’s an important one. It’s just money well spent. It just is. I know sometimes that’s hard for programs, especially small programs to do, and we started out as a little tiny grassroots program, and so that’s what we had to do, too. But we saw a big difference when we made the change.

– combined agency participant

Aside from people coming [to the shelter], people can get sick, people can have needs, people just might need to talk to somebody other than just another person that’s in the shelter. There’s all different needs that can go on during that time—and I did this, so I know it’s true—if you don’t have somebody that’s in the shelter, then if you have somebody that needs to come into the shelter...you have to go in the middle of the night and go to the shelter to put that person in, so you put the person in, get them settled, then you’re leaving a brand new person
who is just coming into the shelter, for the rest of the night by themselves in a strange house with strange people.
– combined agency participant

However, while acknowledging that having staff at the shelter at all times can be helpful, one participant emphasized that having flexibility in staffing the shelter helps the agency deploy their limited resources more effectively:

What we were doing before we were mandated to do 24/7, was we were electing to have double coverage during those times when the women and children were in the house and when case management was really needed. And when everybody is asleep and you’ve got a stable house and women aren’t in a fight with one another and they’re not using or whatever, then we’ve got a lead client who’s in touch with staff if there’s a problem.
– domestic violence agency participant

Participants described the need for clear shelter rules and policies for resident-survivors to ensure the safety of both shelter residents and staff (e.g., policies regarding medications, substance, or weapons) as well as to accommodate the realities of communal living (e.g., keep common areas clean, be considerate of others’ space and privacy). One participant’s comments summarized the comments of many:

Of course we keep the drugs locked up and they have to come in....Every shelter program has their own policies and procedures and grievances and what constitutes asking someone to leave. Which of course we don’t want to do, but if things get out of hand, you have to because you have to look at the overall picture, the safety of everyone else and staff. Same thing if someone brings weapons in the house. We don’t search them, but if we find something…
– combined agency participant

However, participants also acknowledged the important of treating survivors like adults and having flexibility in shelter rules and policies to accommodate unique situations. One domestic violence agency participant stated, “You say, ‘These are the rules, but they’re not in stone. Come back and talk if you have a situation.” And we can
work it out.” Another participant described the importance of sensitivity in formulating shelter policies:

> I know some people go into shelters and they’re told what to do in ways they’re told at home by that batterer—and they don’t need that again. They need to be treated like adults that can think for themselves and all of that. I mean, not that there shouldn’t be rules and regulations, but sometimes the things that they make them do or have them do are over and above what they need to be dictated to given the fact that they’re an adult person.

– combined agency participant

Although participants described this service delivery practice as controversial, participants emphasized the importance of accommodating older male children of survivors in shelter.

> If you tell a family—[for example,] you have boys and girls, and your son is 15—"Well, I’m sorry, your daughter, who is 16, can come in the shelter, but your son, who is 15 cannot...he’s got to go someplace else." First of all, if I was a mom, I wouldn’t go to that shelter. I’d say, “Forget it, I don’t need your shelter!” Secondly, we’re trying to make changes in males, and how do we make changes...if we tell them that they’re not okay,... we can’t trust them enough,...they’re not good enough to come into our shelter. What kind of message does that give them? So, we’re perpetuating the very thing that we say we’re trying to stop... and we’ve been sheltering for these many years and we have not had problems with teenage boys. That has not been an issue for us.

– combined agency participant

**Ideal Services**

*Accessible services.* Throughout the interviews, participants described a strong desire to ensure that the core services offered by their agencies—crisis hotline, counseling, support group, court/legal advocacy, medical advocacy, and shelter—are available and accessible to the diverse members of their respective communities.

However, participants also frequently described not having sufficient funding to deliver
services in the most accessible way. As a result, accessible services were described in ideal terms rather than as the current methods of delivering services. For example, when asked how she would change services if she had more funding, one sexual assault agency participant stated, “We would be paying people to offer bilingual services for everything we do. So we would have adequate resources, not just to be scraping by on bilingual needs we have.” Another domestic violence agency participant spoke of the need for bilingual staff as an unfunded and unmet need:

*I think if we had the capacity to really provide the same level of services to all the diverse populations in this community.... We’re not serving Hispanics in the way that we need to. We had a person that at least was bilingual until she went to graduate school, and now we have a core of volunteers that really does the best that they can....*

*Children’s services.* Regardless of their agency type, participants described services for children as a critical service. One combined agency participant described this ideal service by saying, “I mean you can give all these support groups to the adults, but little Tommy down here seeing all this stuff going on, who’s going to help him? Is he going to grow up to be an abuser?” Similarly, half of the participants representing sexual assault agencies described the utility of integrating child services into their agencies. Although most of the participants described these as critical services, they also reported that their agencies did not currently offer specialized children services. Participants described funding limitations and the demands of serving adult survivors among the key barriers to providing specialized children’s services.

*Children, we have expanded our shelter and stuff, tried to make everything more child-friendly, tried to make it to where, when a child ...walks in they feel welcome, they feel safe. ...I would like to continue to expand on what we do with the kids that come to shelter. ...We’re currently doing a lot of what we do with the school system with the kids that come to shelter, we’ll do the little programs with*
them after hours and play games, things like that. But I’d like to see more of that happening. And part of that, too, is limited funding.
– domestic violence agency participant

Transportation and transitional housing. The importance of transportation and transitional housing for survivors were issues that were raised repeatedly, and especially among participants whose agencies provided services to domestic violence survivors. Unfortunately, participants reported that their agencies were unable to offer long-term transitional housing for survivors, or to help survivors with transportation needs. In addition, few affordable housing resources and low-cost transportation systems existed in their communities.

In a rural community, there aren’t a lot of open housing opportunities. You want to have something that is safe, that is affordable, and for example, in [our] county there’s not a lot. A lot of people live on family land. Well, if you’re having a dispute with your husband you’re already on family land, where are you going to go? And you can’t tell him to move out—he’s living with his parents which is across the driveway. A lot of people live in mobile homes, and you know it’s just very difficult to find affordable housing that is accessible . . . if there isn’t a second vehicle, there’s certainly no bus transportation in any of our communities. There is [name of local transportation system] which is the rural transportation, but it’s primarily for Medicaid. There is a route here [our] city, there’s several routes actually and they make regular stops all day long, which is kind of like a bus but it costs $1.00 each time you get on or off for each person.
– domestic violence agency participant

Service Delivery: Areas of Uncertainty

In addition to the core and ideal services, participants described areas of service delivery where they are facing considerable uncertainty and challenges. That is, these were areas of service delivery where directors expressed concern and confusion about how best to deliver services when the following issues are present: (a) when a survivor has experienced both domestic violence and sexual assault, (b) when a survivor is
struggling with mental illness or substance abuse, and (c) when managing community knowledge about the location of a domestic violence shelter.

*Surviving Domestic Violence and Sexual Assault.* A majority of the participants discussed the frequent challenge of providing services to survivors who have experienced the combination of domestic violence and sexual assault. Participants reported that there is a frequent overlap in the types of victimization among their clientele. Participants expressed concern about their agencies’ capacity to adequately assess both problems and to provide comprehensive services that addressed the multiple victimizations survivors may have experienced. One combined agency participant stated, “With domestic violence and sexual assault, ...many times victims present as domestic violence victims [although] in reality they’re both, but the other part doesn’t come out for a very long time.”

*Substance abuse and mental illness.* The challenge of working with survivors with substance abuse problems or mental illnesses was raised in all interviews, and was frequently emphasized by participants from agencies that offered shelter services. Most participants reported that their agencies had a policy or protocol for substance abuse issues among survivors. One participant described the typical policy of her agency:

> We do not let a woman in if she’s been using drugs. She has to be clean 24 hours before she can come, and she cannot be drinking either. If she is drinking she cannot come into the shelter. Usually, we refer them to the Salvation Army.

–combined agency participant

Although there were agency policies, participants described the tension between wanting to offer all survivors services and managing the issue of substance abuse. This tension was often framed in terms of a conflict between wanting to serve the survivors
with substance abuse problems, while also ensuring the safety of both other survivors and staff. The following exchange between a participant and the interviewer typified participants’ comments regarding survivors with substance abuse issues.

**Participant:** It really is a judgment call. If we believe that they’re going to be a danger to the rest of the people in the shelter, then we really can’t [allow shelter access]. We try to find resources for them, services for them. We try to provide other services for them. I mean, if we can, we want to do that because, as you know, many people who are in abusive situations—the way they survive is by going unconscious, so to speak.

**Interviewer:** ...It’s a coping mechanism.

**Participant:** Absolutely. So if we can help them we want to do that. But if they’re really a danger, then it would be unconscionable to take them in and make their needs more important than the whole rest of the shelter needs. So it really becomes a judgment call, but it’s a very hard one because we really want to help those women, too. And believe it’s important to do that.

–combined agency participant

The pervasive nature of co-occurring violence and substance abuse was echoed by a participant from a domestic violence agency who commented on shelter policies.

*[Substance abuse] just compounds the problem, and then, of course, we’re talking about clients being in the shelter, that ...changes the dynamics of the women in the shelter that are staying there. You know, you have someone that comes in, that’s addicted, and maybe she does have prescriptions for drugs but they’re for 3 different doctors and she wants to take her drugs and she’s asking the other clients for money so she can go buy them somewhere or she’s out trying to prostitute so she can get money for it.

Similar tensions and challenges were described by participants when speaking about their desire to offer all survivors services, and needing to manage the survivors’ mental illnesses and psychiatric medications. Participants described both wanting to provide services to all women, regardless of their mental illnesses, as well as being uncertain about how best to manage psychiatric symptoms and medications. Typical comments included the following.

*In the past, when women would come into the shelter, we would take any prescription drugs that they have. We would put it in a bag and lock it in a file*
cabinet, and we’d make out a med sheet and everything. We’d make out their
meds, staff would sign a sheet, they would sign out a sheet. And now the
coalition says, “No, that takes away their control.” Well, when you’ve got people
in there taking psychotic medications and you’ve got babies crawling around on
the floor....
   – combined agency participant

Mental health reform has had a huge impact on, not necessarily the numbers of
clients we see, but how much energy they suck. If I can, I mean just making it as
blatant as I can, we aren’t a clinical environment. We have clinicians on staff but
they don’t perform their work in a clinical, medical way. Nor do we necessarily
want them to, but because they [clients] are falling through the cracks
everywhere else, our clients are coming sicker and more addicted and needing
our services and taking more of our time—and they need it somewhere—but it’s
not coming from anywhere else, so all those types of system failures we feel.
   – domestic violence agency participant

Shelter location. Many of the participants whose agencies operated shelters
described the philosophical and practical reasons of maintaining a balance between
keeping the shelter location public and keeping a “low profile” to help ensure survivors’
safety:

   ...We’ve never been a hidden shelter, I mean I know now some people are
questioning hidden shelters. Well, we’ve always chosen not to be. We don’t have
a sign out front and we kind of have tried to keep a lower profile over time, but
we’ve never been hidden because, first, I don’t believe there is such a thing
personally—because how would I hide this building, that would be ridiculous. At
least in rural communities, I don’t believe you can hide . . . And secondly, from a
philosophical standpoint I personally always felt the women shouldn’t have to
hide out—they are the victims, they’re not the bad guy here. They have to live in
the community, their children have to go to school in the community, some
women work in the community, so what we have to do as programs is really
make sure that they can be safe. Now obviously, there are times when
somebody can’t even stay in the community and be safe, so it becomes a
judgment call—an assessment of the situation—but I really do believe it’s okay
not to be hidden and that the community can support that safety.
   – combined agency participant

However, the fact that a shelter is not hidden can pose challenges for service providers,
depending on the lethality and persistence of a perpetrator. One participant whose
agency was located in a small, rural community stated:
I do have a few clients that I just would not feel safe with them in shelter, and it’s not necessarily them, it’s the abusers. They [the clients] would not be safe in this shelter. I know enough about the abuser and about their personal history, and the abuser knows where we’re at and whatever that I just do not feel they would be safe in this shelter.

– combined agency participant

It is noteworthy that this issue received the most feedback comments. In addition, the feedback revealed considerable disagreement regarding the issue of shelter identity, that is whether the shelter location should be hidden, undisclosed (i.e., the location is not widely known or publicized but it is not entirely hidden), or fully known in the community. Some participants strongly disagreed with the notion of the shelter location partially or fully disclosed, and argued that shelters should always be as hidden as possible. Alternatively, some participants argued that shelters can never be fully hidden and that perpetrators who are determined can often find shelter locations. The feedback provided by these participants also emphasized the importance of security systems and protocols for shelters.

Challenges Impacting Service Delivery

One finding that emerged early in the course of this research was that North Carolina domestic violence and sexual assault agencies face many challenges in delivering services to violence survivors. As agency directors discussed these challenges, it became clear that these challenges impacted the agencies’ capacity to provide services to violence survivors. Given this finding, the research team decided it was important to highlight these challenges in this report. The findings presented here are derived from the qualitative analyses of both the director interviews and the focus group discussions with state-level organizations.
Funding. The dearth of funding for domestic violence and sexual assault services was described in every interview and every focus group as the key challenge facing domestic violence and sexual assault agencies. Across all interviews and focus groups participants reported that limited funding—both in terms of amount and time—affects agencies, staff, and service delivery practices. The impact of these limits force domestic violence and sexual assault agencies to cut the number of core services they provide to survivors, and makes it difficult to pay staff on a regular basis, which, in turn, creates problems for recruiting and retaining staff. A participant from a combined agency stated that one of the “biggest challenge[s is] finding funding in order to keep the shelter and the office open. We’ve had to cut the budget back again this year, there has actually been times where we couldn’t make payroll.” Further, participants spoke of the difficulties that agencies have in recruiting and retaining qualified staff. In addition, participants described how limited funds exacerbate the serious problem of staff burnout for domestic violence and sexual assault agencies. Because of limited funds, staff members often fill multiple roles within their agencies, work long hours at a demanding job, and thus tend to burnout in a short time. Typical comments included the following.

*How many quality people are you going to get when they know they’re only on a two-year grant, or a one-year grant as they keep switching over. If you want, especially with sexual assault, you’re dealing so much with PTSD [Post Traumatic Stress Disorder], the counseling is at a different level and you need quality people, you need quality advocates to perform this, and it is very difficult to keep quality people and train because every 2 years or every 1 year they’re likely rotating out until we get a grant again to serve these victims. And because a case can take a year to a year and a half to go to court.*

– sexual assault agency participant

*Burnout is another big reason why we have turnover. I’ve lost 3 office managers in three years. And my current office manager has been here for 2 years but she is literally working herself to death.*

– domestic violence agency participant
The issues of filling multiple roles and burnout were particularly acute for agency executive directors. Several directors described these issues as “wearing many hats” and having “many balls in the air.”

I mean you’ve always got so many different balls in the air; ...you’ve got your staff issues and turnover and transition and training... When you’re a volunteer agency, you’ve got how many volunteers you’re recruiting, are they diverse, are they culturally competent, those kinds of issues. Who are your clients? And the whole issue of are we reaching out to the right groups?...Who do we have on the board?...Do we have the right people on the board to help us access both financial resources and community resources? ...Then programmatically, Are we doing the right things? Are we reaching the right populations with our education and outreach programs? Why aren’t people signing up for our support groups? ...And then the money part, pulling together enough resources—and it’s really budget magic at times—because you’re living in one budget year, trying to get through that budget year, having to think ahead to plan for the future with resources you don’t know that you’re going to have for sure. And then getting a whole board of directors of about 20 people to buy into your wing and a prayer method of budgeting, and helping them pull those funds together.
—sexual assault agency participant

“Hoop Jumping” to obtain funding. A consistent theme voiced throughout the interviews with the community agency participants was the significant challenges posed to their agencies by funders' requirements that were described as “hoop jumping.” The comments of one domestic violence agency participant summarized the opinions of many:

You have to fill out an application in triplicate, each of these applications have one or two forms that have to be signed by your board chair, five forms that need to be signed by your board chair and your Exec, three of those maybe need to be notarized but only if it’s been signed in blue. I mean come on! ... Am I going to get in trouble? I’m not going to get my funding if I sign that fourth one in blue. It has to be exactly three blue signatures and then one copy of the blue signature.

In addition, participants described this hoop jumping as exacting a heavy toll on agency staff and the services that they are able to deliver to survivors.
You just think if you didn’t have to struggle and jump through hoops and
everything to get money, you could provide better services. You would have the
time to provide better services and you’d have, you wouldn’t be as stressed and
worrying about, “Well, are we going to make payroll?” You’re worried about
making payroll, and you’re short on staff and then you’ve got somebody walking
in in a major crisis, and you have to move from, “Oh, gosh we’re going to do
this,” to you know, really try to be sympathetic with what’s going on with her.
– combined agency participant

Participants recognized the hoop jumping requirements as funders’ efforts to
maintain a level of accountability for the money that the agency received, and
participants concurred that there is a need for accountability. One agency participant
stated, “There needs to be accountability and I want there to be, and I don’t want people
not being good shepherds of money that’s donated. That’s not the way it should be.”
However, the agency participants also felt burdened by the diverse and ever-changing
requirements of their various funders. One domestic violence agency participant stated,

We’re not just hearing from one funder, “Here are your regulations,” we’re
hearing it from all our funders. And they’re not the same damn regulations,
they’re not the same damn statistics that we have to give to each funder, so it
ends up being this situation where [participant’s agency name] is reporting to one
funder one thing, and to the other funder the other thing, and together they talk
and come up with a brand new number that’s not correct at all.

One state-level participant concurred with this perspective:

The financial resources for [domestic violence and sexual assault services] is
just a very complex system that is difficult for state agencies and incredibly
difficult for local agencies to work with and work through….You know a lot of
requirements, funding guidelines, and that sort of thing that just don’t fit together
well and aren’t really conducive to putting together a coherent program at the
local level.

In a more positive vein, agency participants reported that having effective grants
managers at funding agencies was invaluable in helping them to navigate these funding
complexities. A typical participant comment was provided by a participant representing
a domestic violence agency:
Having been here 4 years plus, I can tell you that having a good person, a good supportive person in that [grants manager] position goes a long way, not only for new programs or programs that aren’t new but have new people who are now managing those chores. …Having those people who are supportive means the world to us. Someone that we’re not afraid to call and say, “Help! What do I do? What did I do wrong? How do I fix it?” Having someone who will pick up the phone and call us is actually better.

Participants recommended ways that funding processes, practices, and processes could be improved. The three most frequently mentioned recommendations included (a) greater coordination among funders, (b) funders should prioritize funding core services (i.e., crisis hotlines, advocacy, counseling, support groups, and shelter) rather than prioritizing innovative services, and (c) funders should collect meaningful data as part of funding requirements aimed toward ensuring accountability.

**Greater coordination among funders.** Across interviews and focus groups the idea of better coordination among funding organizations was frequently mentioned as a way to avoid funding requirements described as “reinventing the wheel.” One state-level participant commented:

Coordination, talking to each other. … I think we’ve all touched upon it, but that’s the one way to make sure that money is spent in the wisest way possible instead of each of us coming at it from different angles and suddenly we realize we’ve been doing some of the same things for 2 years and reinventing the wheel, so to speak. So, at both the state level and the federal level, doing more coordination.

This participant comment highlights the need for greater funding coordination not only among state agencies but also among federal agencies because federal agencies and policies often mandate state policies, procedures and priorities for funding.

However, participants provided differing perspectives regarding how this coordination among funders could best occur. Some participants thought having multiple state-level funding agencies created duplication and needless complications.
The following comments of a sexual assault agency participant represented a common recommendation for the state:

Throw all that money in one big pot, have one streamlined state agency administer it and divvy it out, and figure out a way to measure, like … the rape prevention funds need to be used for this, and those funds need to be used for that. But goodness, you could cut a lot of state money if you didn't have 3 separate entities scurrying to administer all this money—and they work very hard to do it.

However, the perspective of a state-level participant held that the lack of coordination demonstrated a need for greater leadership among funders, but not necessarily a need for consolidation of funding agencies:

You know I struggle with the idea that it [funding] should be in one place or it should be in a lot of places, because it really is…just about leadership, and it shouldn’t really matter that it’s in such and such an agency. I mean, there is something about leadership within those agencies and how well it gets spent, but [the issue] shouldn’t be that we should consolidate it somewhere. I don’t think that that’s necessarily the answer, but I do worry that we don’t have the same levels of leadership by each of the funders to really get together and figure this out and do it in a really coordinated way.

Fund core services. A majority of participants—both state-level and agency-level—in interviews and focus groups described funders’ emphasis on innovative services and original programs as a considerable challenge for obtaining funding to provide core services. One domestic violence agency participant described this challenge by saying, “Innovative, innovative, innovative, everybody wants innovative. And the thing is, we twist ourselves into pretzels trying to show that what we’re doing is innovative, but the fact of the matter is, it’s still shelter, counseling, court advocacy and outreach.” A majority of the state-level participants concurred with this perspective, and the comments of one state-level participant summarized the viewpoint of many:

Programs end up being grant driven, and they’re continually having to come up with these new initiatives. So they get a program up and running and it goes well.
If they’re lucky to get 2- or 3-year funding, they’ve got a 2- or 3-year great program. It’s not a new initiative anymore, now they need operational funding to continue it along and to keep it going, and who does operational funding? It’s not out there.

Collect meaningful data. Although participants concurred on the need to ensure accountability, agency director participants wanted funders to collect meaningful data as part of their funding requirements, rather than requiring unique data sets for each funder. Specifically, participants reported that funders should collect meaningful and useful information regarding agencies’ service delivery practices. For example, a participant representing a sexual assault agency said this type of meaningful information would show the multiple services that a survivor receives from the agency and over what course of time the agency works with that survivor:

You only get to count that person once, even if you’re working with them 3 years, because that’s how long it takes for the court case to happen, and follow up, and things like that. I mean…you don’t get to count that individual each time you’re seeing them for each different crisis that comes up as a result of the crime being committed. You get to count…that first time that you see them, and then it’s not counted anymore as a continuation. So you’re still seeing this person, so you’ve got 25 people that you’re seeing that you don’t get credit for, you only get credit for the 15 that have been new victims in that year.

Similarly, a state-level participant described the important of collecting data to document how funds are being spent and whether funds are being used in the most effective ways:

So if you’re spending 5 million dollars it’s really hard to say we need another 5 million without knowing how the first 5 million is really being spent. So I think some of the challenges, I think the North Carolina General Assembly certainly has been supportive of domestic violence efforts, but I think it sort of gets to a point when you keep saying, “We need additional increases,” you really have to start to be specific about what those increases are for, rather than these agencies [that] simply don’t have enough money to run on. Because as that pot gets bigger and bigger, people start to say, “Well actually, there is a fair amount of money going there [already, but] where is it going?”
Community norms. All agency participants reported that their community norms posed significant challenges in providing services in their communities, and described these challenges in two ways: (a) the “good ole boy” system; and (b) conservative religious norms that posed challenges to service delivery to violence survivors in their communities. The following participant comments described how these community norms worked against their advocacy efforts in their local communities, courts, and law enforcement.

You’ve got a lot of Southerners that it’s a way of lifestyle for them — it’s been that way all their life, a good ole boy society. And you’ve got some in the churches that pray you’ve got to work it out, or you’ve made your bed you’ve got to lie in it.

– combined agency participant

It’s your wife, it’s your business. If she didn’t fuss at you, if she didn’t run her mouth at you so much…They can always find alibis and reasons not to take it [domestic violence] seriously and see the severity of it until something major happens—and then, all the sudden, they’re all about it until things settle down and it’s back to business as usual.

– domestic violence agency participant

When it come time to go to court, [the perpetrator] was in court and half the courtroom was full of church people—and it was her [the victim] and me on the other side. That’s very intimidating, these are the people that she went to church with every week, saw socially outside of church even, did things together as families and stuff.

– combined agency participant

In addition, agency participants described how the community norms required them to be mindful of how they framed their services in their respective communities, as well as with what issues their agency aligned. One sexual assault agency participant stated,

The whole pro-choice thing that really would not bode well in Western North Carolina, it may bode well in Charlotte, it may bode well in Raleigh . . . And it seems that sometimes the Coalition aligns themselves with folks that it would not be beneficial for us to align ourselves with in the Western part of the state—it would make it very difficult for us to raise money if we were aligned with some of those folks. We’re in the Bible belt and folks just don’t … see things and we have
to overcome a lot of stigmas in the Western part of the state. We had 142 cases of incest last year. I mean those are huge, people keep that in their family for generations. They’re going to take care of it their own way, they don’t want anybody even coming to seek our services, and how dare we align ourselves with a pro-choice group.

Sustainability. Agency and service sustainability were seen as critical challenge for domestic violence and sexual assault agencies by both agency and state-level participants. However, participants provided a range of perspectives regarding sustainability. Some participants representing state-level organizations described how agencies should strive to tap into multiple and diverse funding streams because funding from their agencies is not always guaranteed and because of “funder-fatigue.” A typical comment from a state-level participant summed up this viewpoint:

Their [agencies] biggest challenge...is ongoing funding. Funding from multiple sources...so that they can sustain themselves and not have to rely just on our funding because, inevitably what we hear and what we believe to be for the most part true, is that they couldn’t keep going were it not for our funding. We also believe though, that at some point you are disabling them—as opposed to enabling them—because they feel that comfort and security of knowing that they’re going to get this funding. And while you don’t tell them you’re going to get it next year, and next year, and next year, you fund them for 10 or 12 straight years, so they have every reason to think they’ll get it —but then all the sudden, we can’t give it.

However, agency participants described two reasons why finding alternative, ongoing funding presented considerable challenges. First, participants representing agencies located in rural areas described the dearth of resources in their local communities—including county, city, and the local business community—as a tremendous challenge in finding local funding for their services. One participant representing a rural community combined agency stated, “I mean, in an environment like this, what am I going to do? Go ask the local McDonald’s for $20,000? It’s not going
to happen.” Second, given the other demands of their work, agency participants described not having the time or resources to find and apply for various grants.

   Just like I said, it’s hard for programs to continue to maintain. There’s a lot of emphasis on finding alternatives. The thing is finding those alternatives—takes a lot of time, …staff here’s already stretched thin as it is. You know, just sitting down and just finding grants—period—takes so much time. Because you comb through all this stuff and you think, “Oh well, this one looks good!” and then after you’ve spent two hours on this thing [grant application] you find one little blurb that knocks you out of it. And you’ve just spent two hours messing with something that you can’t even qualify for.
   
   – combined agency participant

   Lack of attention and resources for sexual assault. Agency participants as well as state-level participants described the lack of attention given the problem of sexual assault at all levels—federal, state, community, and local agency—as a key challenge facing both sexual assault and combined agencies. Participants not only described the low level of attention paid to sexual assault by funders, but also the greater difficulty that sexual assault agencies encounter when trying to bring attention to the issue in ways that could impact policy and increase funding for services. In turn, the lack of policy and funding directed toward sexual assault services has impacted agency service delivery practices. One sexual assault agency participant described this challenge in the following way:

   There doesn’t seem to be anybody that’s looking at the big picture of our sexual assaults: Are they increasing? Are they decreasing?…What’s going on statewide? There doesn’t seem to be that kind of thing going on either, and if we could get a handle on that, we could lobby. We could say, “This is what’s happening in our state, doesn’t this matter to you?” But, as we are right now, these little, stand-alone satellite agencies, we don’t have a big voice, we don’t have a huge voice, and that’s hard.
Other participants described how the lack of attention to the problem of sexual assault impacts both their service delivery practices and their clients who are survivors of sexual assault:

*This is an intimate crime against these victims. It is so humiliating for them to talk about—and then you’re letting inexperienced, untrained people, at $15,000 a year [serve these clients]. It is the second highest felony in North Carolina under murder. Murder is the only crime in North Carolina that carries any higher sentencing than rape, and you give that $15,000 a year to serve its victims.*

– sexual assault agency participant

In addition, all sexual assault agency participants and the majority of state-level participants questioned the capacity of combined agencies (i.e., those that provide both domestic violence and sexual assault services) to effectively provide sexual assault services. The comments of these participants described opinions that held sexual assault services offered by combined agencies suffer because of the intensive, ongoing nature of domestic violence work, and the limited resources in combined agencies dedicated exclusively to sexual assault services. Typical participant comments highlighted the concerns regarding combined agencies capacity to effectively offer sexual assault services:

*I think when I started in this role I definitely wondered if efficiencies wouldn’t eventually and inevitably lead to a DV program and SA program merging… Now after having been really directly in this field for 6 or 7 years, I feel that any merger of DV and SA programs will inevitably dilute the effectiveness of the SA program. I know that if we were combined with the DV program we would see a lot fewer victims than what we do see. And I think I see that in other agencies that it’s harder for them to even go out and do the community work that they need to do to promote the rape crisis services because they’re constantly being sucked into the emergency level services for DV. …I think keeping it separate really avoids some of that.*

– sexual assault agency participant

*There was one [domestic violence] program and I was working with a volunteer who had been there for 2 years…We were in the crisis room together and she put the caller on hold and she turned to me and she said, “Where do I refer a*
rape victim, where can she get services?” I said, “Here. Us. You’re supposed to be trained and know how to handle this call.”

—state-level participant

If you have a SA point person and they’re one person in a program with 12 DV [staff], they’re going to end up being marginalized, being the keeper of the knowledge and there isn’t going to be that spread across the program where you’ve got the philosophy, you’ve got the commitment, you’ve got the understanding of how these two issues do and don’t line up with each other.

—state-level participant

Despite the concern about the capacity of combined agencies to provide sexual assault services effectively, one participant representing a sexual assault agency described the ongoing pressure to combine with the domestic violence agencies in their communities. Her description of the pressure to combine highlighted the impact of limited funding and resources for sexual assault services:

When I was telling [a colleague] about the push for merging domestic violence and sexual assault, she said that has sort of the feel of “Can’t you girls get your act together?” [and] that if it’s perceived as women’s issues then it’s really not worth paying your director very much, and it’s really not worth professionalizing the services, and it’s really not worth having one issue get a full focus. Whereas our community has two or three affordable housing related land trust type of agencies led by men.

Need for accessible, welcoming services. Although a minority, many of the participants raised the issue of accessible and welcoming services as a key challenge for domestic violence and sexual assault agencies. As previously mentioned, several agency participants described the challenge of providing accessible, welcoming services given their limited funding. Likewise, state-level participants expressed concern that survivors of all racial/ethnic/cultural backgrounds, sexual orientations, abilities, and immigration statuses feel welcome to seek and access services in North Carolina domestic violence and sexual assault agencies. One state-level participant stated, “I
think that racism is a pretty big issue in a lot of programs . . . I feel like I talk to people [everyday] who feel oppressed in programs mostly because of racism.” Other state-level participants made similar statements:

. . . We had this understanding of empowerment and where we came from, which was White, middle-class women, which, you know, I don’t think there’s anything bad with that, it’s just that we have to be informed about what we want for our future. And we know that we are not reaching communities because we are excluding people from influential positions and decision-making positions.

– state-level participant

I mean, access is one issue in general, but even in places where people do have some access, I don’t think everyone is comfortable accessing the services or is made to feel welcome, or the services aren’t necessarily targeting “them.” And I’m speaking of language issues, I’m speaking of immigration issues, I’m speaking of sexual orientation.

– state-level participant

Need for comprehensive services. Another critical challenge for agencies described by a majority of participants was providing services to survivors who are struggling with complex and multiple problems, especially mental illness and substance abuse. Several participants reported that as a result of recent mental health reform efforts in North Carolina, community agencies are seeing greater numbers of people with more severe mental illnesses and substance abuse problems. One state-level participant described the challenge:

A lot of times when somebody’s in crisis, it’s hard to know if they’re a substance abuser or if they have mental health issues. You know, what came first and what you’re dealing with. At shelter setting in particular, and community setting, I have women coming into shelters…that were addicted to methamphetamine or whatever, and others who were maybe schizophrenic or, another really common, have really bad PTSD. That kind of stuff, and so that really affects the ability to live in community . . . when you have people in shelter who have multiple vulnerabilities. It’s not just domestic violence or not just sexual assault, there’s this multitude of issues that are layered like an onion. There’s nobody there to kind of parse this out and kind of see, what’s the most life-threatening thing that we have right here, is it the batterer? or is this person suicidal? or has this person … just taken a bottle of pills? You know,…that sort of thing.
Moreover, several participants stated that the increased numbers of clients with multiple problems necessitates a change in service delivery practice. Some state-level participants proposed that a radical change in service delivery practices is needed; a viewpoint reflected in the following participant comments:

_The substance abuse and people who are really struggling with mental health and are battered, and probably were sexually abused as children. I mean, they probably have this lifetime victimization, is a group that absolutely needs services. I’m not convinced that the domestic violence programs that we have today are in the position to provide them with what they need—and that’s not saying the domestic violence program has fallen down on the job—I don’t think they were constructed in a way that they could have [met these needs]. I mean that’s a tough group to work with anyway, even if you have really strong programs and trained staff and all that sort of thing._

– state-level participant

_There’s this long history of the way you do things, and the inability to break through that sort of tradition and way of doing business to look at the field differently, I think, I mean the fact we have separate sexual assault and domestic violence programs, the fact that we deal with violence against children differently than we do adults, the fact that we stove pipe the treatment of those and that we don’t interact between mental health and treatment programs that are designed for domestic violence or child abuse very well. I think the biggest challenge is figuring out how to look at this, the violence that occurs, more holistically and figure out a delivery system and a response to it that changes that tradition and the focus that we’ve had in the past. And I think that’s a huge challenge._

– state-level participant

**Grassroots versus Professionalization.** Participants described the ongoing challenge created by tensions between grassroots and professionalized approaches to domestic violence and sexual assault services and staffing. Some participants expressed the opinion that the skills, training, and expertise of staff with professional human services education are invaluable to providing services to survivors, and equally valuable to running and managing agencies. However, other participants described the training deficits of professional staff for working with violence survivors, and the ways in
which these deficits impact services for survivors. In addition, some participants expressed the opinion that the move toward professionalized domestic violence and sexual assault services would mean the loss of the energy, enthusiasm, and motivation found when survivors and volunteers provide these services. One state-level participant described the grassroots movement and its loss in this way:

With all the funding that’s coming from the federal and state level, we’re having a lot of…identifying our survivors as “clients” and kind of moving them into the category of …“the people who need help.” Whereas, this used to be a grassroots movement where you were helping out your sisters and your brothers, and I think that [moving to professionalized service] kind of deflated a lot of the energy and the motivation to get into the movement.

Another state-level participant worried that the move toward professionalized domestic violence and sexual assault services was leading to professionals entering the field without having specialized knowledge about domestic violence or sexual assault:

We’re at a point where . . . violence against women, has sort of been co-opted in a way by the larger social work community. And people get hired to run programs by boards who aren’t very well-educated sometimes….So we’ve moved away from the grassroots, is I guess what I’m saying… sometimes I talk to people who have worked at programs or victims who have been in programs where they feel like the people who are running them really don’t understand [violence against women].

However, other participants acknowledged a need for experienced professionals to provide services to traumatized survivors. One sexual assault agency participant said,"If your daughter was raped, would you want a volunteer or a trained counselor there at 3 a.m. in the morning?" Other participants described a need for both grassroots passion and professional expertise in domestic violence and sexual assault services. One participant specifically stated that there is a need for greater “integration” between grassroots passion and professional expertise. Other participants stated that striking the
right balance between these two approaches to service delivery may continue to be a challenge in the near-future. Typical participant comments included the following:

[When I began working in this field] I was a new social worker and a grassroots feminist at the same time, and I listened to this huge conflict and, for me, it’s so necessary to have both, and it’s such a gift to have the grassroots perspective and people who are professionally trained and bring those specializations whatever they are . . . I think it’s important that you keep both supported and alive. I read this long, involved thing from the national coalition where they were taking these positions that were just extreme, and it’s like, “What about some integration?”

– domestic violence agency participant

This has been such a grassroots movement for so long. I mean it’s been passion and care that’s moved the field forward over the last 20 or 30 years. ...Then shifting that to a more scientific approach and a practice-based approach—and not leaving, I think, a bad taste in people’s mouths or not leaving people feeling like what they’ve done is worthless and meaningless—because it’s [the grassroots] really been a foundation to build upon and try to make stronger, but how to do that in such a way that people don’t feel negated for all the work they have done is, I think, a huge challenge and one that we continue to face and will continue to face for a while.

– state-level participant
SURVEY: KEY FINDINGS

Participant and Agency Characteristics

Tables 3 and 4 summarize the characteristics of the survey participants and agencies, respectively. The majority of participants described themselves as “executive director,” “co-executive director,” or “interim executive director” (72.16%). Ten participants described their role at their agencies as “program director” or “program manager,” or “program coordinator” (10.31%). Six participants reported they were “advocates” (6.18%), and eight participants described their role in other ways (e.g., “associate directors,” “shelter director,” “supervisor,” “educator,” 8.25%). Three participants did not provide information about their role (3%). Participants tended to have high education levels with most having completed either graduate degrees (41.2%) or college degrees (32.9%). In addition, the survey participants reported having multiple years of experience providing domestic violence and/or sexual assault services. Most often, participants reported having 1 to 5 years of experience in providing domestic violence services (23%). Moreover, 68% of the sample reported 6 years or more of experience providing domestic violence services, and over 30% of the sample reported 16 years or more of experience providing domestic violence services. Similarly, nearly 60% of the sample reported 6 years or more of experience providing sexual assault services, with the greatest percentage of these participants (nearly 26%) reporting between 6 and 10 years of experience, and an additional 20% reporting 16 years or more of experience. It is noteworthy that 18.3% of sexual assault services participants reported none or less than 1 year experience providing services as
compared to 8.5% of domestic violence services participants who reported none or less than 1 year of experience with providing services.

Overall, the participants came from agencies that were diverse in some important ways. The participants’ agencies were located in various regions of the state, with 20% of agencies located in the southwest, over 20% located in the west, and nearly 20% located in the central part of North Carolina. The eastern and northwestern parts of the state were also represented among the survey participants. In addition, the agencies showed considerable variation in their number of staff and volunteers. On average, agencies had 8 full-time employees, 5 part-time employees, and 38 volunteers. However, staff numbers ranged from 1 to 100 full-time employees and from 0 to 20 part-time employees. The number of volunteers involved in the agencies showed even greater variability and ranged from 0 to over 300 volunteers.

Despite the considerable differences in staffing, the agencies represented by participants were similar in important ways. Nearly 70% of the participants came from agencies that provided both domestic violence and sexual assault services (i.e. combined agencies), almost 20% that provided domestic violence services only, and 11.5% providing sexual assault service only. Most of the agencies provided their services to survivors in rural communities (86.3%), whereas 17.5% of agencies provided services in suburban areas and 19.5% of agencies provided services in urban areas. It is worth noting that agencies could indicate multiple service areas, therefore these response items exceed 100%.
Table 3. Survey Findings: Participant Characteristics (n = 97– 93a)

<table>
<thead>
<tr>
<th>Years Experience Providing Domestic Violence Services</th>
<th>None</th>
<th>&lt; 1</th>
<th>1-5</th>
<th>6-10</th>
<th>11-15</th>
<th>16-20</th>
<th>&gt; 20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Years Experience Providing Sexual Assault Services</td>
<td>None</td>
<td>&lt; 1</td>
<td>1-5</td>
<td>6-10</td>
<td>11-15</td>
<td>16-20</td>
<td>&gt; 20</td>
</tr>
<tr>
<td>Years in Current Position</td>
<td>&lt; 1</td>
<td>1-5</td>
<td>6-10</td>
<td>11-15</td>
<td>16-20</td>
<td>&gt; 20</td>
<td></td>
</tr>
<tr>
<td>Education Attainment</td>
<td>Completed HS/GED or Some College</td>
<td>Completed Community College/ Associate Degree</td>
<td>Completed 4-year College Degree</td>
<td>Completed Graduate Degree</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agency Position</td>
<td>Executive Director</td>
<td>Program Director</td>
<td>Victim Advocate</td>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>70 (72.16%)</td>
<td>10 (10.31%)</td>
<td>6 (6.18%)</td>
<td>8 (8.25%)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a Sample range reflects missing values
<table>
<thead>
<tr>
<th>Service Focus</th>
<th>Domestic Violence Only</th>
<th>Sexual Assault Only</th>
<th>Combined Domestic Violence and Sexual Assault</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>18 (18.8%)</td>
<td>11 (11.5%)</td>
<td>67 (69.8%)</td>
</tr>
<tr>
<td>State Region</td>
<td>Central 18 (18.6%)</td>
<td>Northeast 14 (14.4%)</td>
<td>Northwest 12 (12.4%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Southeast 20 (20.6%)</td>
<td>Southwest 23 (23.7%)</td>
</tr>
<tr>
<td>Rural Service Delivery Area</td>
<td>Yes 82 (86.3%)</td>
<td>No 13 (13.7%)</td>
<td></td>
</tr>
<tr>
<td>Suburban Service Delivery Area</td>
<td>Yes 17 (17.5%)</td>
<td>No 80 (82.5%)</td>
<td></td>
</tr>
<tr>
<td>Urban Service Delivery Area</td>
<td>Yes 19 (19.6%)</td>
<td>No 78 (80.4%)</td>
<td></td>
</tr>
<tr>
<td>Number of Full-Time Staff</td>
<td>Mean 8.35</td>
<td>Standard Deviation 11.03</td>
<td>Range 1-100</td>
</tr>
<tr>
<td>Number of Part-Time Staff</td>
<td>Mean 5.21</td>
<td>Standard Deviation 4.28</td>
<td>Range 0-20</td>
</tr>
<tr>
<td>Number of Volunteers</td>
<td>Mean 38.32</td>
<td>Standard Deviation 51.02</td>
<td>Range 0-305</td>
</tr>
</tbody>
</table>

*aSample range reflects missing values*
Service Goals

Series of rank-order items were used to assess participants’ opinions regarding what benefits clients should typically receive from the core services: crisis services, legal advocacy, medical advocacy, support groups, counseling, and shelter. Participants were asked to rank-order the service-delivery goals by assigning the ranking of 1 to the item they perceived as the most important benefit for a client to receive from that service, 2 for the benefit of second importance, with ranking of important diminishing as scores increased. The survey instructions asked participants to rank order service items only if their agencies provided that specific service. Descriptive analyses were conducted on participants’ responses, including the mean, standard deviation, mode, and range for all the items. These results can be found in appendix A in tables 12-18. In addition, figures 1-6 present graphics illustrating the participants’ responses to these items. For each core service, the graphics show the percentage of participants who ranked the benefit 1, 2, 3, 4, or 5. In other words, these graphs show the percentage of participants who ranked the benefit as a high priority for that core service.
Figure 1 illustrates survey participants’ opinions regarding the benefits clients should receive from crisis services. Overall, the items given highest priority were emotional support (ranked in top five by 94.3% of participants), help with planning for safety (93%), receiving information on violence and trauma (83.9%), and referral to other community services as needed (81.6%).

Figure 1. Percentage of participants who ranked item as a high priority (1-5) for crisis services
Figure 2 shows survey participants’ opinions about what benefits clients should receive from legal advocacy services. Overall, the items of high priority included receiving information about legal options as appropriate to the advocacy role (92.7% of participants), help with completing legal paperwork (i.e., victims’ compensation, 90.2%), accompaniment to court, trial, and legal meetings (87.8%), emotional support (85.2% of participants), and help with planning for safety (81.5%).

Figure 2. Percentage of participants who ranked item as a high priority (1-5) for legal advocacy

<table>
<thead>
<tr>
<th>What Should Clients Receive from Legal Advocacy?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional Support</td>
</tr>
<tr>
<td>Plan for Safety</td>
</tr>
<tr>
<td>Building Social Support</td>
</tr>
<tr>
<td>Violence/Trauma Information</td>
</tr>
<tr>
<td>Community Referrals</td>
</tr>
<tr>
<td>Self-Care Strategies</td>
</tr>
<tr>
<td>Victim Comp Help</td>
</tr>
<tr>
<td>Legal Options/Information</td>
</tr>
<tr>
<td>Legal Accompaniment</td>
</tr>
</tbody>
</table>
Figure 3 presents survey participants’ opinions about what benefits clients should receive from medical advocacy services. Overall, participants showed significant agreement on the top three high priority items, which included *emotional support* (ranked in top five by 94.2%), *receiving information about medical options as appropriate to the advocacy role* (94.2%), and *accompaniment to medical appointments*, such as a first-response medical appointment (89.7%).

**Figure 3. Percentage of participants who ranked item as a high priority (1-5) for medical advocacy**

![Bar chart showing percentages of participants ranking different benefits as high priority for medical advocacy.](chart.png)
Figure 4 depicts survey participants’ opinions about the benefits clients should receive from participating in support group services. In general, high priority items included *emotional support* (ranked in top five by 86.3% of participants) and *receiving information about violence and trauma* (68.4%). Participants showed limited consensus on the other benefits: only 56.3% of participants ranked *help with life problems* (e.g., education, employment, finances housing or parenting), only 55.8% ranked *help with safety*, and only 53.2% ranked *self-care strategies* among the top five benefits. The other benefits (e.g., forming positive relationships with other survivors, community referrals) were ranked among the top five priorities by less than 50% of participants. These findings suggest variability among participants’ opinions for these support group benefits.

**Figure 4. Percentage of participants who ranked item as a high priority (1-5) for support group**
Figure 5 displays survey participants’ opinions about the benefits clients should typically receive from counseling services. Overall, participants provided high rankings for emotional support (ranked in top five by 88%), planning for safety (75.6%), and receiving information about violence and trauma (79.5%), and help with self-esteem (73.5%).

**Figure 5. Percentage of participants who ranked item as a high priority (1-5) for counseling services**
Figure 6 illustrates survey participants’ opinions about the benefits clients should receive from shelter services. Overall, participants provided high priority rankings for receiving a safe place to live, free from violence (ranked in the top five by 97% of participants), emotional support (94% of participants), and planning for safety (75.8%). In addition, receiving violence/trauma information was ranked in the top five benefits by 64.2% of participants, and community referrals was ranked in the top five by 58.2% of participants.

Figure 6. Percentage of participants who ranked item as a high priority (1-5) for shelter services
In addition, we summarized the mean or average ranking of the service-delivery goals and present those results in Table 5. This table illustrates how the participants prioritized the benefits survivors should receive from each of the core services, from highest (1) to lowest (10) priority based on survey participants’ average rankings. This summary table also demonstrates several striking findings. Across all core services, the participants’ average rankings indicated that *emotional support* was most frequently prioritized. Average rankings for *emotional support* made it the first priority of four services: crisis, medical advocacy, support group, and counseling. Further, average rankings of *emotional support* indicated that it was the second priority for two services: legal advocacy and shelter. In addition, the item *receiving information about violence and trauma* was consistently prioritized for crisis services, support groups, and counseling. Similar to these findings, a theme emerged from participants’ open-ended responses indicating that *client safety* and *providing empathy* were among the highest priorities for the participants who provided open-ended answers in the survey. It is noteworthy that across all services, *self-care strategies* and *building social support*, consistently received (with one notable exception) average rankings that indicated these were low priorities. The notable exception was seen in rankings of benefits for support group services, where *self-care strategies* received average rankings indicating it was a higher priority benefit.

However, it was not surprising that unique items were prioritized for specific core services. For example, unique legal items such as *information about legal options*, *help with victims’ compensation*, and *accompaniment to legal proceedings* received average rankings as high priority benefits of legal advocacy. Similarly, unique medical benefits
including information about medical options and accompaniment to medical appointments received high priority rankings on average for medical advocacy. Likewise, receiving a safe place to live, violence free was received average rankings that indicated it was the highest priority for shelter services.
Table 5. Service Goals: Prioritizing Benefits Survivors Should Receive from Services, Highest (1) to Lowest (10) Based on Survey Participants’ Average Rankings

<table>
<thead>
<tr>
<th>Ranking</th>
<th>Crisis</th>
<th>Legal Advocacy</th>
<th>Medical Advocacy</th>
<th>Support Group</th>
<th>Counseling</th>
<th>Shelter</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Plan for Safety</td>
<td>Emotional Support</td>
<td>Medical Options/Information</td>
<td>Improve Self-Esteem</td>
<td>Plan for Safety</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Violence/Trauma Information</td>
<td>Victim Comp. Help</td>
<td>Medical Accompaniment</td>
<td>Violence/Trauma Information</td>
<td>Violence/Trauma Information</td>
<td>Plan for Safety</td>
</tr>
<tr>
<td>5</td>
<td>Community Referrals</td>
<td>Police/Legal Accompaniment</td>
<td>Victim Comp. Help</td>
<td>Support from Other Survivors</td>
<td>Community Referrals</td>
<td>Community Referrals</td>
</tr>
<tr>
<td>6</td>
<td>Social Support Strategies</td>
<td>Violence/Trauma Information</td>
<td>Violence/Trauma Information</td>
<td>Self-Care Strategies</td>
<td>Help with Life Problems</td>
<td>Help with Life Problems</td>
</tr>
<tr>
<td>7</td>
<td>Self-Care Strategies</td>
<td>Community Referrals</td>
<td>Community Referrals</td>
<td>Help with Life Problems</td>
<td>Self-Care Strategies</td>
<td>Improve Self-Esteem</td>
</tr>
<tr>
<td>8</td>
<td>*****</td>
<td>Social Support Strategies</td>
<td>Social Support Strategies</td>
<td>Social Support Strategies</td>
<td>Social Support Strategies</td>
<td>Support from Other Survivors</td>
</tr>
<tr>
<td>9</td>
<td>*****</td>
<td>Self-Care Strategies</td>
<td>Self-Care Strategies</td>
<td>Community Referrals</td>
<td>*****</td>
<td>Self-Care Strategies</td>
</tr>
<tr>
<td>10</td>
<td>*****</td>
<td>*****</td>
<td>*****</td>
<td>*****</td>
<td>*****</td>
<td>Social Support Strategies</td>
</tr>
</tbody>
</table>
**Service Delivery Practices**

A series of survey questions were used to assess participants’ opinions regarding service delivery practices for the core of crisis services, legal advocacy, medical advocacy, support groups, individual counseling, and shelter services, which inquired about the way these services should be delivered. Four response options were provided for each question: *strongly agree*, *agree*, *disagree*, and *strongly disagree*. The survey instructions asked participants to respond to *only* to the items for which their agencies provided that specific service. Descriptive analyses were conducted on participants’ responses, including the mean, standard deviation, mode, and range for all the items. These results can be found in Appendix A in tables 12-18. In addition, graphic representations of the participants’ responses are presented in figures 7-11.
Figure 7 depicts survey participants’ opinions regarding service delivery practices for crisis services. More than 80% of participants strongly agreed that these services should be continuously available (i.e., 24 hours a day, 7 days a week, and 365 days a year); that crisis services should be furnished by providers specifically trained in crisis services (e.g., skilled in active-listening and problem-solving, able to provide emotional support), and crisis service providers should be specifically trained in domestic violence and/or sexual assault services. Over 80% of participants either strongly agreed or agreed that crisis services best help clients when the client receives an immediate response from a crisis service provider (i.e., rather than making first contact with an answering service that relays the call to a provider). However, slightly less than half the sample strongly agreed or agreed that crisis services best help survivors when delivered by a staff member rather than a volunteer.

Figure 7. Crisis Service Delivery Practices

<table>
<thead>
<tr>
<th>How Should Crisis Services Be Delivered to Best Help Clients?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Provider</td>
</tr>
<tr>
<td>Immediate Response</td>
</tr>
<tr>
<td>Provider DV/SA Trained</td>
</tr>
<tr>
<td>Provider Crisis Trained</td>
</tr>
<tr>
<td>Available 24/7/365</td>
</tr>
</tbody>
</table>

[Bar chart showing percentages of agreement for each service delivery practice]
Figure 8 illustrates survey participants’ opinions related to service delivery practices for advocacy services. More than 80% of participants strongly agreed that medical advocacy services should be continuously available (i.e., 24 hours a day, 7 days a week, and 365 days a year). Nearly half (48.9%) of participants strongly agreed that legal advocacy services should be available at all times; and when combined with those who agreed that legal advocacy should be available 24/7, these participants comprised a sizable majority (78.4%) of the sample. In addition, more than half of the participants (57.6%) either agreed or strongly agreed that legal advocacy services best help clients when delivered by staff; however, more than half (53.8%) of the sample disagreed or strongly disagreed that medical advocacy services best help clients when delivered by staff.

Figure 8. Advocacy Service Delivery Practices
Figure 9 shows survey participants’ opinions related to service delivery practices for support groups. Overall, most participants disagreed or strongly disagreed that clients with special needs (e.g., physical disability, intellectual disability, mental illness, or substance abuse) are better helped when referred to specialized services instead of participating in agency support groups. Interestingly, in the open-ended responses, several participants stated that referrals for services should be made when necessary, but to the greatest possible extent, services should be provided on-site at the domestic violence or sexual assault agency for all clients. Specifically, these responses indicated that some participants perceived support group services as so critical for violence survivors that they are resolute in that such services should be available on-site for all clients—regardless of the client’s other problems including mental illness and substance abuse. In addition, slightly more than 75% of participants either agreed or strongly agreed that clients with special needs (e.g., physical disabilities, non-English-speakers) are best helped when they are in groups with other survivors who have similar needs and situations. However, nearly 45% of participants agreed or strongly agreed that clients with mental illnesses are better helped when referred to mental health services, and 42.5% of the sample agreed or strongly agreed that clients with substance abuse problems are better helped when referred to substance abuse services.

Interestingly, more than 80% of respondents agreed or strongly agreed that clients are best helped when support groups are comprised of survivors who have experienced similar forms of violence (i.e., sexual assault, domestic violence, adult survivors of child abuse). In addition, in excess of 80% of participants agreed or strongly agreed that clients are best helped through support groups that use an open format,
which allows clients to join the group at any time and attend as many or as few sessions as they like. Furthermore, slightly more than 63% of participants disagreed or strongly disagreed that clients are best helped by support groups using a closed format in which all clients begin the group together and attend the same number of sessions. Participant responses were evenly divided on whether support groups best help clients when led by staff rather than volunteers: 50% agreed or strongly agreed, and 50% disagreed or strongly disagreed.

Figure 9. Support Group Service Delivery Practices

![Bar chart showing percentage of responses to different service delivery practices.](image-url)
Figure 10 presents survey participants’ opinions regarding service delivery practices for counseling. Overall, most participants disagreed or strongly disagreed that clients with physical disabilities (82.8%) and intellectual disabilities (76.9%) are better helped when referred to specialized services instead of participating in counseling offered through the domestic violence or sexual assault services agency. However, 44.6% of participants agreed or strongly agreed that clients with mental illnesses are better helped when referred to mental health services, and 37.2% of the sample agreed or strongly agreed that clients with substance abuse problems are better helped when referred to specialized substance abuse services. A considerable number of the participants (71.1%) agreed or strongly agreed that counseling services best help clients when provided by staff. In addition, participants used the open-ended survey questions to explicitly state that although volunteers are valuable and able to provide many agency services to survivors, counseling services should be provided only by trained staff.

Figure 10. Counseling Service Delivery Practices
Figure 11 illustrates survey participants’ opinions about service delivery practices for shelter. Most participants disagreed or strongly disagreed that clients with physical disabilities (85.2%), intellectual disabilities (79.8%), and legal convictions (86.1%) were best helped when referred to other services. In addition, a majority of participants disagreed or strongly disagreed that clients with mental illnesses, substance abuse, and adolescent male children were better helped when referred to other services. However, it is notable that nearly one third of participants agreed or strongly agreed that clients with mental illnesses (35.3%), substance abuse (32.9%), and adolescent male children (28.4%) would be better helped if referred to other services. Interestingly, although most participants (83.3%) agreed or strongly agreed that clients who are in imminent, life-threatening danger are typically prioritized for shelter space over clients whose situations do not represent the same threat of danger, most participants (60%) also agreed or strongly agreed that clients who are in imminent, life-threatening danger should be referred elsewhere to ensure the safety of staff and other clients.

Although 47.9% of participants agreed or strongly agreed that services best help clients when providers help manage their medications, 52.1% of the sample disagreed or strongly disagreed with that scenario. However, most participants (84.9%) agreed or strongly agreed that services best help clients when the shelter has rules that require participation in activities and services. Similarly, a dominant theme that emerged among participants’ open-ended responses was even though structure and rules were perceived as necessary for shelters, client autonomy and empowerment should remain central when making and enforcing regulations.
In terms of safety, security and staffing of shelters, all participants (100%) either agreed or strongly agreed that shelters best help clients when they have a security system and security protocols in place. Moreover, 78.4% of participants agreed or strongly agreed that the shelter location should be hidden. Nearly all (96.1%) participants agreed or strongly agreed that the shelter should be staffed at all times. A slight majority (55.4%) of participants disagreed or strongly disagreed that shelter services best help clients when provided by staff rather than volunteers.
How Should Shelter Services Be Delivered to Best Help Clients?

- Refer: Disability
- Refer: Conviction
- Refer: Adolescent Males
- Refer: Intellectual Disability
- Refer: Substance Abuse
- Refer: Mental Illness
- Refer: Survivors in Danger
- Staff Manage Meds
- Staff Provider
- Location Hidden
- Require Service Participation
- Prioritize Survivors in Danger
- Staffed 24/7/365
- Security Protocol
- Security System

Strongly Agree  Agree  Disagree  Strongly Disagree
LITERATURE REVIEW, INTERVIEWS, AND SURVEY FINDINGS: A SYNTHESIS

An important benefit of using multiple research methods to investigate domestic violence and sexual assault services is that multi-method research can yield richer information about service delivery practices than is possible with any one method. Likewise, multi-method research can provide a broader range of findings than is possible with a single research method. In addition, the extent to which a result is found consistently across one or more research methods suggests the finding is particularly robust.

In light of these arguments, this investigation used three research methods to investigate domestic violence and sexual assault service delivery practices: (a) an extensive review of the research literature addressing domestic violence or sexual assault services, including a review of best practices obtained from other states’ Coalitions; (b) in-depth interviews with directors of North Carolina domestic violence and sexual assault agencies; and (c) a statewide survey of all executive directors of domestic violence and sexual assault agencies in North Carolina. This section of our report presents a synthesis of the literature review findings, the findings from the in-depth interviews, and the findings from the statewide survey.

The combined findings regarding domestic violence and sexual assault service delivery practices are presented in six tables, with one table representing each core service: crisis, legal advocacy, medical advocacy, support group, counseling, and shelter. The findings summarized in these tables were included if one of the following criteria were met: (a) the finding was a service delivery practice recommendation identified in the literature review, (b) the finding emerged from our analysis of the
director interviews, (c) the finding was a service delivery goal ranked in the top five by at least 75% of survey participants, or the finding was a service delivery practice with which a minimum of 75% of participants agreed or strongly agreed. Each table includes a column that indicates these criteria. Thus, the tables show the extent to which a specific service delivery finding was evident in one, two, or all three of the research methods. The final column in the tables indicates whether the finding was consistent across the three research methods. A service delivery finding is labeled with *Strong Consistency* if it was a finding ascertained using all three research methods, *Consistency* if it the finding was specified by two research methods, and *Endorsed* if the finding was determined by one of the methods. These integrated, synthesized findings can help inform domestic violence and sexual assault service delivery practices generally. In addition, these findings could help form the basis of recommended service guidelines for North Carolina domestic violence and sexual assault services.

However, in reviewing and interpreting these tables and in considering the potential utility of these findings to inform services and guidelines, the following caveats should be kept in mind. First, the extent to which a result is found consistently across one or more research methods suggests the finding is robust. However, because a service delivery practice was endorsed through only one of the methods does not mean that it is not an important domestic violence or sexual assault service delivery practice. Rather, the fact that the service delivery practice was not found across multiple research methods may instead reflect limitations of the particular methods or limitations in the way the method was employed by the research team.
Second, by using three research methods the research team may have specified a wider range of findings in comparison to only using one of these methods. However, there is no guarantee that the research team has determined an exhaustive, universal list of all important domestic violence and sexual assault service delivery practices.

Third, when reviewing these synthesized findings, readers should keep in mind a key finding from both the interviews and surveys: there is no one-size-fits-all approach to helping domestic violence and sexual assault survivors with safety and recovery from trauma. Although our synthesis of these findings show that some consensus exists within the field regarding which services are needed by most survivors, and how these services can be delivered most effectively, several areas of service delivery continue to be contentious. More important, however, is the fact that each survivor's needs are likely to be unique and varied. Thus, service providers must always use their training, knowledge, and expertise to respond to survivors in individualized ways.
## Table 6. Summary of Service Delivery Findings: Crisis Services

<table>
<thead>
<tr>
<th>Service Delivery Practice</th>
<th>Literature Review Finding</th>
<th>Director Interview Finding</th>
<th>Director Survey: 75% Finding</th>
<th>Consistent Finding Across Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider helps survivor plan for safety/ensures safety</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Strong Consistency</td>
</tr>
<tr>
<td>Provider gives information about violence/trauma</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Strong Consistency</td>
</tr>
<tr>
<td>Provider gives emotional support/empathy</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Strong Consistency</td>
</tr>
<tr>
<td>Provider offers referrals to other services as needed</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Strong Consistency</td>
</tr>
<tr>
<td>Continuously available (24/7/365)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Strong Consistency</td>
</tr>
<tr>
<td>Provider gives information about options</td>
<td>X</td>
<td>X</td>
<td></td>
<td>Consistency</td>
</tr>
<tr>
<td>Provider enhances survivor’s coping/ stress management/self-care</td>
<td>X</td>
<td></td>
<td></td>
<td>Consistency</td>
</tr>
<tr>
<td>Provider explores options and helps survivor with decision making</td>
<td>X</td>
<td>X</td>
<td></td>
<td>Consistency</td>
</tr>
<tr>
<td>Provider has domestic violence/sexual assault training</td>
<td>X</td>
<td></td>
<td>X</td>
<td>Consistency</td>
</tr>
<tr>
<td>Provider has crisis skills training</td>
<td>X</td>
<td></td>
<td>X</td>
<td>Consistency</td>
</tr>
<tr>
<td>Survivor receives immediate response</td>
<td>X</td>
<td></td>
<td>X</td>
<td>Consistency</td>
</tr>
<tr>
<td>Service able to handle multiple callers</td>
<td>X</td>
<td></td>
<td></td>
<td>Endorsed</td>
</tr>
<tr>
<td>Telephone service is toll-free</td>
<td>X</td>
<td></td>
<td></td>
<td>Endorsed</td>
</tr>
<tr>
<td>Provider able to respond to non-English speakers and those with hearing-impairments</td>
<td>X</td>
<td></td>
<td></td>
<td>Endorsed</td>
</tr>
<tr>
<td>Service Delivery Practice</td>
<td>Literature Review Finding</td>
<td>Director Interview Finding</td>
<td>Director Survey: 75% Finding</td>
<td>Consistent Finding Across Methods</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------------</td>
<td>--------------------------</td>
<td>---------------------------</td>
<td>-----------------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>Provider helps survivor plan for safety/ensures safety</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Strong Consistency</td>
</tr>
<tr>
<td>Provider gives emotional support/empathy</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Strong Consistency</td>
</tr>
<tr>
<td>Provider gives legal policies/procedures information, helps survivors make informed decisions</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Strong Consistency</td>
</tr>
<tr>
<td>Provider accompanies survivor to civil/criminal proceedings</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Strong Consistency</td>
</tr>
<tr>
<td>Provider gives help to survivor with crime victim compensation</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Strong Consistency</td>
</tr>
<tr>
<td>Provider help survivors obtain order of protection/legal remedies</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Strong Consistency</td>
</tr>
<tr>
<td>Providers is knowledgeable about legal policies and procedures</td>
<td>X</td>
<td>X</td>
<td></td>
<td>Consistency</td>
</tr>
<tr>
<td>Provider liaises with police/prosecutors/legal professionals on survivor’s behalf</td>
<td>X</td>
<td>X</td>
<td></td>
<td>Consistency</td>
</tr>
<tr>
<td>Provider conducts follow-up visits/phone calls to survivor for as long as needed</td>
<td>X</td>
<td>X</td>
<td></td>
<td>Consistency</td>
</tr>
<tr>
<td>Provider is mindful of providing services within expertise and role</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Consistency</td>
</tr>
<tr>
<td>Provider gives information about violence/trauma</td>
<td>X</td>
<td>X</td>
<td></td>
<td>Consistency</td>
</tr>
<tr>
<td>Provider ensures that survivor is treated sensitively, prevents secondary victimization</td>
<td>X</td>
<td>X</td>
<td></td>
<td>Consistency</td>
</tr>
<tr>
<td>Continuously available (24/7/365)</td>
<td>X</td>
<td></td>
<td>X</td>
<td>Consistency</td>
</tr>
<tr>
<td>Provider has &quot;good rapport&quot; with police/legal professionals</td>
<td></td>
<td></td>
<td>X</td>
<td>Endorsed</td>
</tr>
<tr>
<td>Provider offers referrals to other services</td>
<td>X</td>
<td></td>
<td></td>
<td>Endorsed</td>
</tr>
</tbody>
</table>
### Table 8. Summary of Service Delivery Findings: Medical Advocacy

<table>
<thead>
<tr>
<th>Service Delivery Practice</th>
<th>Literature Review Finding</th>
<th>Director Interview Finding</th>
<th>Director Survey: 75% Finding</th>
<th>Consistent Finding Across Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider gives emotional support/empathy</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Strong Consistency</td>
</tr>
<tr>
<td>Provider accompanies survivor to medical appointments</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Strong Consistency</td>
</tr>
<tr>
<td>Provider gives medical procedures information, helps survivors make informed decisions</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Strong Consistency</td>
</tr>
<tr>
<td>Continuously available (24/7/365)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Consistency</td>
</tr>
<tr>
<td>Providers is knowledgeable about medical/forensic policies and procedures</td>
<td>X</td>
<td>X</td>
<td></td>
<td>Consistency</td>
</tr>
<tr>
<td>Provider conducts follow-up visits/phone calls to survivor for as long as needed</td>
<td>X</td>
<td>X</td>
<td></td>
<td>Consistency</td>
</tr>
<tr>
<td>Provider ensures that survivor is treated sensitively, prevents secondary victimization</td>
<td>X</td>
<td>X</td>
<td></td>
<td>Consistency</td>
</tr>
<tr>
<td>Provider helps survivor manage distress/trauma from forensic medical exam</td>
<td>X</td>
<td>X</td>
<td></td>
<td>Consistency</td>
</tr>
<tr>
<td>Provider gives information about violence/trauma</td>
<td>X</td>
<td>X</td>
<td></td>
<td>Consistency</td>
</tr>
<tr>
<td>Provider offers referrals to other services as needed</td>
<td>X</td>
<td>X</td>
<td></td>
<td>Endorsed</td>
</tr>
<tr>
<td>Provider enhances survivors’ coping/ stress management/self-care</td>
<td>X</td>
<td></td>
<td></td>
<td>Endorsed</td>
</tr>
<tr>
<td>Provider helps survivor build social support</td>
<td>X</td>
<td></td>
<td></td>
<td>Endorsed</td>
</tr>
<tr>
<td>Provider assists survivor with crime victim compensation</td>
<td></td>
<td></td>
<td>X</td>
<td>Endorsed</td>
</tr>
</tbody>
</table>
Table 9. Summary of Service Delivery Findings: Support Group

<table>
<thead>
<tr>
<th>Service Delivery Practice</th>
<th>Literature Review Finding</th>
<th>Director Interview Finding</th>
<th>Director Survey: 75% Finding</th>
<th>Consistent Finding Across Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider/group gives emotional support/empathy</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Strong Consistency</td>
</tr>
<tr>
<td>Provider/group helps survivor with self-esteem/self-efficacy</td>
<td>X</td>
<td>X</td>
<td></td>
<td>Consistency</td>
</tr>
<tr>
<td>Provider/group gives information about violence/trauma</td>
<td>X</td>
<td>X</td>
<td></td>
<td>Consistency</td>
</tr>
<tr>
<td>Provider/group enhances survivors’ coping/ stress management/self-care</td>
<td>X</td>
<td></td>
<td></td>
<td>Endorsed</td>
</tr>
<tr>
<td>Provider/group helps survivor build social support</td>
<td>X</td>
<td></td>
<td></td>
<td>Endorsed</td>
</tr>
<tr>
<td>Provider offers referrals to other services as needed</td>
<td>X</td>
<td></td>
<td></td>
<td>Endorsed</td>
</tr>
<tr>
<td>Provider/group helps survivor plan for safety/ensures safety</td>
<td>X</td>
<td></td>
<td></td>
<td>Endorsed</td>
</tr>
<tr>
<td>Group has two leaders</td>
<td>X</td>
<td></td>
<td></td>
<td>Endorsed</td>
</tr>
<tr>
<td>Leaders have violence/trauma knowledge/training</td>
<td>X</td>
<td></td>
<td></td>
<td>Endorsed</td>
</tr>
<tr>
<td>Leaders ensure group members’ safety/confidentiality during group meetings</td>
<td>X</td>
<td></td>
<td></td>
<td>Endorsed</td>
</tr>
<tr>
<td>Group meetings held in accessible location (parking, public transportation available)</td>
<td>X</td>
<td></td>
<td></td>
<td>Endorsed</td>
</tr>
<tr>
<td>Childcare is offered during group meetings</td>
<td>X</td>
<td></td>
<td></td>
<td>Endorsed</td>
</tr>
<tr>
<td>Group meetings held on consistent basis</td>
<td>X</td>
<td></td>
<td></td>
<td>Endorsed</td>
</tr>
<tr>
<td>Survivors build relationships among group</td>
<td>X</td>
<td></td>
<td></td>
<td>Endorsed</td>
</tr>
<tr>
<td>Provider/group addresses survivor’s feelings of powerlessness, loss, anger</td>
<td>X</td>
<td></td>
<td></td>
<td>Endorsed</td>
</tr>
<tr>
<td>Provider/group normalize survivor’s reactions</td>
<td>X</td>
<td></td>
<td></td>
<td>Endorsed</td>
</tr>
<tr>
<td>Provider screens potential participants for group appropriateness</td>
<td></td>
<td>X</td>
<td></td>
<td>Endorsed</td>
</tr>
<tr>
<td>Provide groups for clients with special needs on-site at agency</td>
<td></td>
<td>X</td>
<td></td>
<td>Endorsed</td>
</tr>
<tr>
<td>Provide different groups for clients who have experienced different types of violence</td>
<td></td>
<td>X</td>
<td></td>
<td>Endorsed</td>
</tr>
<tr>
<td>Offer support groups in open-ended format</td>
<td></td>
<td>X</td>
<td></td>
<td>Endorsed</td>
</tr>
</tbody>
</table>
## Table 10. Summary of Service Delivery Findings: Counseling

<table>
<thead>
<tr>
<th>Service Delivery Practice</th>
<th>Literature Review Finding</th>
<th>Director Interview Finding</th>
<th>Director Survey: 75% Finding</th>
<th>Consistent Finding Across Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider gives emotional support/empathy</td>
<td>X</td>
<td>X</td>
<td></td>
<td>Consistency</td>
</tr>
<tr>
<td>Provider helps survivor with self-esteem/self-efficacy</td>
<td>X</td>
<td>X</td>
<td></td>
<td>Consistency</td>
</tr>
<tr>
<td>Provider gives information about violence/trauma</td>
<td>X</td>
<td>X</td>
<td></td>
<td>Consistency</td>
</tr>
<tr>
<td>Provider helps survivor plan for safety/ensures safety</td>
<td>X</td>
<td>X</td>
<td></td>
<td>Consistency</td>
</tr>
<tr>
<td>Provider enhances survivors’ coping/ stress management/self-care</td>
<td>X</td>
<td></td>
<td></td>
<td>Endorsed</td>
</tr>
<tr>
<td>Provider helps survivor build social support</td>
<td>X</td>
<td></td>
<td></td>
<td>Endorsed</td>
</tr>
<tr>
<td>Provider offers referrals to other services</td>
<td>X</td>
<td></td>
<td></td>
<td>Endorsed</td>
</tr>
<tr>
<td>Provider helps survivor with problem-solving/decision-making</td>
<td>X</td>
<td></td>
<td></td>
<td>Endorsed</td>
</tr>
<tr>
<td>Provider normalize survivor’s reactions to violence</td>
<td>X</td>
<td></td>
<td></td>
<td>Endorsed</td>
</tr>
<tr>
<td>Provider ensure safety/confidentiality of survivor during counseling</td>
<td>X</td>
<td></td>
<td></td>
<td>Endorsed</td>
</tr>
<tr>
<td>Provider has knowledge about domestic violence/sexual assault, including medical/legal policies/procedures</td>
<td>X</td>
<td></td>
<td></td>
<td>Endorsed</td>
</tr>
<tr>
<td>Providers has relationships within legal and medical systems</td>
<td>X</td>
<td></td>
<td></td>
<td>Endorsed</td>
</tr>
<tr>
<td>Counseling is structured and focused</td>
<td>X</td>
<td></td>
<td></td>
<td>Endorsed</td>
</tr>
<tr>
<td>Provider helps survivor managing life problems e.g., work, parenting, school</td>
<td>X</td>
<td></td>
<td></td>
<td>Endorsed</td>
</tr>
<tr>
<td>Provider offer mental health counseling onsite and/or offer mental health referrals</td>
<td>X</td>
<td></td>
<td></td>
<td>Endorsed</td>
</tr>
<tr>
<td>Provide counseling for clients with special needs on-site at agency</td>
<td></td>
<td></td>
<td>X</td>
<td>Endorsed</td>
</tr>
</tbody>
</table>
Table 11. Summary of Service Delivery Findings: Shelter

<table>
<thead>
<tr>
<th>Service Delivery Practice</th>
<th>Literature Review Finding</th>
<th>Director Interview Finding</th>
<th>Director Survey: 75% Finding</th>
<th>Consistent Finding Across Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shelter provides survivor safe place to live</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Strong Consistency</td>
</tr>
<tr>
<td>Provider helps survivor plan for safety/ ensures safety</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Strong Consistency</td>
</tr>
<tr>
<td>Providers do not screen out survivors based on personal characteristics/needs</td>
<td>X</td>
<td>X</td>
<td></td>
<td>Strong Consistency</td>
</tr>
<tr>
<td>Provider gives information about violence/trauma</td>
<td>X</td>
<td>X</td>
<td></td>
<td>Consistency</td>
</tr>
<tr>
<td>Providers do not screen out survivors because survivor unwilling to seek protection order</td>
<td>X</td>
<td>X</td>
<td></td>
<td>Consistency</td>
</tr>
<tr>
<td>Provider works with survivor to develop an individualized plan for shelter stay</td>
<td>X</td>
<td>X</td>
<td></td>
<td>Endorsed</td>
</tr>
<tr>
<td>Shelter is staffed at all times (24/7/365)</td>
<td>X</td>
<td>X</td>
<td></td>
<td>Consistency</td>
</tr>
<tr>
<td>Shelter has rules/policies to enable communal living yet offers flexibility to adult survivor</td>
<td>X</td>
<td>X</td>
<td></td>
<td>Consistency</td>
</tr>
<tr>
<td>Provider helps survivor with self-esteem/self-efficacy</td>
<td>X</td>
<td></td>
<td></td>
<td>Endorsed</td>
</tr>
<tr>
<td>Provider offers referrals to other services as needed</td>
<td>X</td>
<td></td>
<td></td>
<td>Endorsed</td>
</tr>
<tr>
<td>Survivors build relationships with other shelter residents</td>
<td>X</td>
<td></td>
<td></td>
<td>Endorsed</td>
</tr>
<tr>
<td>Provider connects survivor to other services (support groups, counseling)</td>
<td>X</td>
<td></td>
<td></td>
<td>Endorsed</td>
</tr>
<tr>
<td>Crisis admissions available 24/7/365</td>
<td>X</td>
<td></td>
<td></td>
<td>Endorsed</td>
</tr>
<tr>
<td>Survivor receives intake assessment within 24-hours of admission</td>
<td>X</td>
<td></td>
<td></td>
<td>Endorsed</td>
</tr>
<tr>
<td>Shelter meets survivor’s basic needs</td>
<td>X</td>
<td></td>
<td></td>
<td>Endorsed</td>
</tr>
<tr>
<td>Provider gives emotional support/empathy</td>
<td></td>
<td>X</td>
<td></td>
<td>Endorsed</td>
</tr>
<tr>
<td>Shelter has security system</td>
<td>X</td>
<td></td>
<td></td>
<td>Endorsed</td>
</tr>
<tr>
<td>Shelter has security protocols/policies</td>
<td></td>
<td></td>
<td>X</td>
<td>Endorsed</td>
</tr>
</tbody>
</table>
LIMITATIONS AND FUTURE RESEARCH

Study Limitations

The overall aims of this research were to develop guidelines for domestic violence and sexual assault services, and to inform domestic violence and sexual assault service delivery practices in North Carolina. This research had several strong components and processes that helped to ensure study rigor and robustness of the overall findings. The research team used a multi-method research design to investigate domestic violence and sexual assault services delivery practices; this research design helped to provide rich findings, to produce a wide range of findings, and to ensure the robustness of the findings overall. In addition, each of the research components included rigorous aspects in the investigations. Specifically, the literature review examined a relatively large number of documents (n = 43) from a variety of sources; the in-depth interviews were conducted with participants from agencies purposefully selected to represent the diversity of agencies and of the state (i.e., service delivery focus, rural/urban, state region); and the statewide survey had an exceptionally strong response rate overall. However, as with any research study, there are important limitations that should be considered to adequately interpret the findings.

Although some of these limitations have been mentioned previously, most bear repeating here. For example, readers should remain mindful of the caveat regarding consistency of findings across research methods. Whereas consistently finding the same result across multiple research methods attests to the robustness of a particular finding, the opposite is not true. Readers should not interpret endorsement of a finding by one or two research methods as meaning that the particular practice is unimportant.
Rather, such limited endorsements of findings are likely the result of either limitations in the method or the way in which the method was used. In addition, there is no guarantee that the research team has determined an exhaustive, universal list of all important domestic violence and sexual assault service delivery practices. It is likely that other critical service delivery practices exist, even though they were not identified by this research. Furthermore, the findings from this research strongly indicate that there is no uniform approach to helping domestic violence and sexual assault survivors with safety and recovery from trauma. Although the findings from this research can provide guidance to service providers, as well as suggest recommended guidelines for domestic violence and sexual assault service delivery, each survivor’s needs are unique, varied, and warrant individualized services. Thus, service providers and agencies may want to use the findings from this research to guide and inform service delivery practices. Nevertheless, providers still must use their knowledge and expertise to tailor service delivery practices to the unique needs and problems of individual survivors.

An additional limitation was the inclusion of a relatively small number of directors representing agencies with a single focus on sexual assault services or on domestic violence services. Four single-focus sexual assault agencies were represented in the interviews, and 11 such agencies participated in the survey research. Three single-focus domestic violence agencies were represented in the interviews, and 18 such agencies participated in the survey research. In part, this limitation reflects the fact that few such agencies exist in North Carolina and that the majority of domestic violence and sexual assault services are provided by combined agencies. In addition, the research team oversampled directors of such agencies when conducting the director interviews.
to compensate for the limited number of single-focused agencies in the state. It is worth mentioning that even if with considerable effort on the part of the research team only three single-focused domestic violence agencies participated in the interviews. In light of the literature review findings, which suggested that combined agencies have less capacity to effectively provide sexual assault services compared to single-focus agencies, it is a concern and a limitation that the findings of the research overwhelmingly reflect service delivery practices conducted by combined agencies. This limitation is especially true for the survey results.

As the research team conducted this research, we quickly learned that there are significant differences in the service delivery practices among domestic violence and sexual assault agencies in North Carolina. Even within the type of agencies (i.e., single-focus domestic violence, single-focus sexual assault, or combined services), considerable differences were identified in how the agencies deliver core services. For example, a support group may be delivered very differently by a domestic violence agency in one community as compared to how a domestic violence agency in another community delivers support group services. Some of these service delivery differences are reflected in the variability of responses to the survey questions related to support groups, counseling, and shelter services. However, these differences may have also been reflected in the way survey participants responded to the survey questions. Although the research team attempted to help address possible differences by defining each core service in the survey instrument (see appendix D), it is possible that participants’ survey responses, which were based on their varying service delivery
practices, were influenced in significant ways that cannot be fully capture by the research methods used in this project.

A further limitation of the survey instrument was the section ranking the importance of service delivery goals. Several survey participants, who completed the other sections of the survey, did not complete the service delivery goal section. Some of these participants indicated that they could not rank order these items because they felt all items were equally important. Although the research team had anticipated this concern when developing the survey and addressed the concern in the survey instructions, these efforts proved inadequate, and some important information may have been lost from participants who did not complete this part of the survey. (See Appendix A for detailed information about the number of participants who completed the relevant parts of the survey).

Another limit of this research is that the sampling frame included only directors of domestic violence and/or sexual assault agencies. The research findings show that directors represent a rich resource regarding both the services and delivery strategies that have worked well for the violence survivors in their communities. However, the findings highlight opinions from only one group of service providers. The descriptive information regarding both the interview and survey participants shows overall that participants had considerable experience delivering domestic violence and sexual assault services, and thus likely had extensive knowledge about services. Nevertheless, it is likely that the directors’ opinions about service delivery practices differ considerably from other knowledgeable groups, such as violence survivors and front-life staff. Future
research efforts regarding service delivery practices should aim to include diverse viewpoints from other important groups of providers and survivors.

Finally, the overall aim of this research was to develop guidelines for domestic violence and sexual assault services based on a synthesis of the existing research literature and the opinions, knowledge, and experience of the directors of North Carolina agencies. As such, these findings are based on expert opinion and consensus, which is useful and important in developing recommended practice guidelines when little evidence exists regarding efficacious interventions. However, readers should keep in mind that these service delivery practices have not yet been empirically validated or tested. Therefore, to determine if these service delivery practices are effective in improving domestic violence and sexual assault survivors’ safety and well-being, intervention and outcome research must be conducted with these service delivery practices.

Implications for Future Research

Service delivery practices differences. The limitations discussed above also point toward the next steps for research in this area. First, in the immediate future, the research team will examine the differences in service delivery practices among North Carolina agencies based on key characteristics including service delivery focus, agency size, region, and rural/urban/suburban location. Using the data collected in this research, the research team will determine how service delivery practices vary based on these important agency characteristics. In addition, such research will help determine the extent to which service delivery practices vary between single-focus agencies and combined agencies. The literature review findings specifically showed a
lack of clarity about how to best to offer both domestic violence and sexual assault services within a combined agency. Given that the majority of North Carolina agencies are combined agencies, this, too, is a critical area for further investigation to ensure that survivors receive the best services available.

Although the grant funding for this research has ended, the research team will continue to work on this aspect of the research, as well as other facets of the research that were beyond the scope of the research project and funding period. The efforts of the research team over the past two years have yielded voluminous data that have considerable potential to inform domestic violence and sexual assault services in North Carolina. The research team plans to continue analyzing the data, exploring the meaning and implications of the data, and disseminating our findings. All manuscripts and reports from these future research efforts will be shared with the funder, the North Carolina Governor’s Crime Commission.

*Developing outcome tools/Intervention research.* A secondary aim of this research was to develop preliminary outcome guidelines for use by North Carolina agencies in evaluating the efficacy of their interventions. In the course of collecting data on agencies’ current evaluation practices and outcomes tools, we found that many agencies did not have the capacity to evaluate their services, or to collect outcome information from their clients regarding the impact of the agencies’ services. However, this lack of evaluation was not an indication that the directors did not value such tools, because many participants stated that evaluating their services and collecting service outcomes were important endeavors that could help their agencies’ service delivery and sustainability. One agency director commented,
I’m a huge proponent of [evaluation] outcomes because I need to be able to tell the community what we’re doing... That’s been one of our struggles with that whole [agency] name recognition [in the community], is we can tell them how many people we saw, but we really haven’t been able to tell them what difference we’ve made in their lives.

Therefore, the development of outcome tools to evaluate services and to capture the efficacy of domestic violence and sexual assault services is a critical next step for research.

The current research project made important efforts toward the development of outcome guidelines through the identification of service delivery goals. However, in the course of conducting this research, it also became clear that meaningful, effective outcome guidelines would require additional input from a broad range of resources including survivors who have received domestic violence and/or sexual assault services, and a broad range of funders including potential funders. In addition, the research team acknowledged outcome guidelines would only be useful if they met the following criteria:

- acceptable to clients,
- feasible for use in busy agencies,
- designed to collect data helpful to service providers, funders, and policy makers,
- and designed to collect data useful to the agency in securing funding for sustainability.

Therefore, the research team recommends four steps as the focus for future research: (a) to build on the data collected in this current research, (b) to collect additional data from key domestic violence and sexual assault stakeholders to ensure that the outcome tools collect information that is meaningful for all stakeholders, (c) to develop specific
outcome tools that can be effectively used in a demanding service environment, and (d) to pilot test these tools with North Carolina domestic violence and sexual assault services agencies.

The development of effective tools for evaluating service outcomes will address a serious limitation of the current research. As previously mentioned the service delivery practices presented in this report have not yet been empirically validated or tested. Thus, intervention and outcome research must be conducted on these service delivery practices to determine if they are effective in improving the safety and well-being of violence survivors. Furthermore, the development of such outcome tools will help build knowledge regarding which service delivery practices best help survivors achieve safety and recover from the trauma of violence.

New Questions for Future Research

This research also raised new questions that warrant attention in future research. Specifically, our investigation revealed areas of service delivery where there is considerable controversy, confusion, and little guidance regarding how best to deliver services to survivors.

Serving survivors with both victimizations. The literature review findings show that these survivors need specialized legal and medical advocacy services to ensure that both forms of violence are properly investigated and documented. In addition, these survivors need specialized advocacy, counseling, support group, and shelter services to ensure that their complex victimizations experiences are appropriately and adequately addressed. Given the number of survivors who have experienced multiple forms of violent victimization, this issue is likely to continue as a challenge for providers of
domestic violence and sexual assault services. The research findings thus suggest the need for domestic violence and sexual assault service delivery practices specific to survivors with both forms of victimization and thus are a recommended next step for future research.

_Mental illness and substance abuse._ Another example of a question raised by this research includes how best to provide violence services to survivors who are also struggling with mental illness and/or substance abuse. On the one hand, the findings show that research participants are clearly concerned with and uncertain about how best to provide services to survivors with mental illnesses and substance abuse problems. On the other hand, the findings also show among participants a strong commitment to offer services to all survivors regardless of their substance abuse and mental health problems. These contradictory findings suggest a significant challenge and a potential crisis for service providers. As domestic violence and sexual assault agencies continue to offer services to survivors with serious mental illnesses and substance abuse problems without the resources, support, and expertise to help survivors manage these problems, a significant toll is likely to be taken on providers and agencies. Evidence of this toll may be seen in the 30% of participants (and more for some items) who indicated in the survey that they agreed or strongly agreed that survivors with these problems would be better helped with a referral to substance abuse and mental health services. In light of ongoing mental health reform, these findings suggest the need for greater policy attention to the challenges of serving survivors with co-occurring mental illness and/or substance abuse problems.
Such findings also suggest the need for domestic violence and sexual assault service delivery practices specific to survivors with substance abuse problems and mental illnesses and are a recommended next step for future research. Domestic violence and sexual assault service delivery practices for survivors with mental illnesses and substance abuse could build from the growing evidence regarding the efficacy of cognitive-behavioral therapies for addressing mental illness and/or substance abuse along with co-occurring domestic violence and sexual assault (see for example: Jaycox, Zoellner,& Foa, 2002; Kubany, Hill, & Owens, 2003; Najavits, 2002), as well as the research on trauma-informed mental health and substance abuse treatments (see for example, Elliott, Bjelajac, Fallot, Markoff, & Reed, 2005).

*Shelter location knowledge.* Furthermore, our research revealed conflicting findings regarding managing community knowledge about the location of a domestic violence shelter. Although the interview findings indicated that some directors hold strong philosophical beliefs that a public location, which is well-protected with security and community support, is the best protection for survivors and staff, the survey results showed that, in practice, most directors agreed that a shelter’s location should be hidden. Unfortunately, to our knowledge, no empirical research exists to help address the importance of a hidden location of ensuring survivor and staff safety from violent perpetrators. Thus researchers, in collaboration with shelter service providers, could provide important information about domestic violence shelter services by conducting studies on the value of a hidden shelter location for survivors and staff safety.
REFERENCES


California Coalition Against Sexual Assault. (n.d.). *Proposed revisions to service standards for the operation of rape crisis centers.* (Available from the California Coalition Against Sexual Assault, 1215 K St Suite 1100, Esquire Plaza, Sacramento, CA 95814).


Council Against Sexual Violence, 1311 N Paul Russell Road, Suite A204, Tallahassee, FL 32301).


Texas Association Against Sexual Assault. (2004). *Sexual Assault Advocate Training Manual*. (Available from the Texas Association Against Sexual Assault, PO Box 684813, Austin, TX 78768).


### APPENDIX A

Table 12. Crisis: Service Goals and Practices Sample Descriptive Statistics

<table>
<thead>
<tr>
<th>Goals (n= 87-86)(^a)</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Mode</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receive Emotional Support</td>
<td>1.99</td>
<td>1.56</td>
<td>1</td>
<td>1-7</td>
</tr>
<tr>
<td>Plan for Safety</td>
<td>2.37</td>
<td>1.51</td>
<td>2</td>
<td>1-7</td>
</tr>
<tr>
<td>Violence/Trauma Information</td>
<td>3.91</td>
<td>1.40</td>
<td>3</td>
<td>1-7</td>
</tr>
<tr>
<td>Agency Information</td>
<td>4.30</td>
<td>1.83</td>
<td>7</td>
<td>1-7</td>
</tr>
<tr>
<td>Community Referrals</td>
<td>4.44</td>
<td>1.38</td>
<td>5</td>
<td>1-7</td>
</tr>
<tr>
<td>Social Support Strategies</td>
<td>5.09</td>
<td>1.50</td>
<td>6</td>
<td>2-7</td>
</tr>
<tr>
<td>Self-Care Strategies</td>
<td>5.83</td>
<td>1.55</td>
<td>7</td>
<td>1-7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Practices (n= 95-94)(^a)</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Mode</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Available 24/7/365</td>
<td>3.89</td>
<td>0.31</td>
<td>Strongly Agree</td>
<td>3-4</td>
</tr>
<tr>
<td>Provider Crisis Trained</td>
<td>3.89</td>
<td>0.31</td>
<td>Strongly Agree</td>
<td>3-4</td>
</tr>
<tr>
<td>Provider DV/SA Trained</td>
<td>3.89</td>
<td>0.34</td>
<td>Strongly Agree</td>
<td>2-4</td>
</tr>
<tr>
<td>Immediate Staff Response</td>
<td>3.52</td>
<td>0.71</td>
<td>Strongly Agree</td>
<td>2-4</td>
</tr>
<tr>
<td>Staff Provider</td>
<td>2.63</td>
<td>0.88</td>
<td>Disagree</td>
<td>1-4</td>
</tr>
</tbody>
</table>

\(^a\)Sample range reflects both the number of participants at agencies that provide this service and missing values
Table 13. Legal Advocacy: Service Goals and Practices Sample Descriptive Statistics

<table>
<thead>
<tr>
<th>Goals (n= 82-80)</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Mode</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal Options/Information</td>
<td>2.94</td>
<td>1.62</td>
<td>2</td>
<td>1-9</td>
</tr>
<tr>
<td>Receive Emotional Support</td>
<td>3.05</td>
<td>2.43</td>
<td>1</td>
<td>1-9</td>
</tr>
<tr>
<td>Victims’ Comp Help</td>
<td>3.33</td>
<td>1.61</td>
<td>3</td>
<td>1-9</td>
</tr>
<tr>
<td>Plan for Safety</td>
<td>3.80</td>
<td>2.14</td>
<td>5</td>
<td>1-9</td>
</tr>
<tr>
<td>Police/Legal Accompaniment</td>
<td>3.90</td>
<td>1.73</td>
<td>4</td>
<td>1-9</td>
</tr>
<tr>
<td>Violence/Trauma Information</td>
<td>6.11</td>
<td>1.71</td>
<td>6</td>
<td>1-9</td>
</tr>
<tr>
<td>Community Referrals</td>
<td>6.43</td>
<td>1.64</td>
<td>7</td>
<td>2-9</td>
</tr>
<tr>
<td>Social Support Strategies</td>
<td>7.34</td>
<td>1.53</td>
<td>8</td>
<td>1-9</td>
</tr>
<tr>
<td>Self-Care Strategies</td>
<td>7.78</td>
<td>1.85</td>
<td>9</td>
<td>1-9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Practices (n= 92-88)</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Mode</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Available 24/7/365</td>
<td>3.24</td>
<td>0.87</td>
<td>Strongly Agree</td>
<td>1-4</td>
</tr>
<tr>
<td>Staff Provider</td>
<td>2.80</td>
<td>0.92</td>
<td>Disagree</td>
<td>1-4</td>
</tr>
</tbody>
</table>

*aSample range reflects both the number of participants at agencies that provide this service and missing values*
Table 14. Medical Advocacy: Service Goals and Practices Sample Descriptive Statistics

<table>
<thead>
<tr>
<th>Goals (n=69-66)\textsuperscript{a}</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Mode</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receive Emotional Support</td>
<td>2.41</td>
<td>1.99</td>
<td>1</td>
<td>1-9</td>
</tr>
<tr>
<td>Medical Options/Information</td>
<td>2.84</td>
<td>1.37</td>
<td>2</td>
<td>1-8</td>
</tr>
<tr>
<td>Medical Accompaniment</td>
<td>2.90</td>
<td>2.02</td>
<td>2</td>
<td>1-9</td>
</tr>
<tr>
<td>Plan for Safety</td>
<td>4.18</td>
<td>2.09</td>
<td>4</td>
<td>1-9</td>
</tr>
<tr>
<td>Victims’ Comp Help</td>
<td>5.60</td>
<td>2.14</td>
<td>4</td>
<td>1-9</td>
</tr>
<tr>
<td>Violence/Trauma Information</td>
<td>5.96</td>
<td>1.57</td>
<td>6</td>
<td>2-9</td>
</tr>
<tr>
<td>Community Referrals</td>
<td>6.38</td>
<td>1.75</td>
<td>6</td>
<td>2-9</td>
</tr>
<tr>
<td>Social Support Strategies</td>
<td>7.00</td>
<td>1.53</td>
<td>8</td>
<td>3-9</td>
</tr>
<tr>
<td>Self-Care Strategies</td>
<td>7.36</td>
<td>1.98</td>
<td>9</td>
<td>1-9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Practices (n=80-78)\textsuperscript{a}</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Mode</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Available 24/7/365</td>
<td>3.82</td>
<td>0.42</td>
<td>Strongly Agree</td>
<td>2-4</td>
</tr>
<tr>
<td>Staff Provider</td>
<td>2.64</td>
<td>0.83</td>
<td>Disagree</td>
<td>1-4</td>
</tr>
</tbody>
</table>

\textsuperscript{a}Sample range reflects both the number of participants at agencies that provide this service and missing values
Table 15. Support Group: Service Goals and Practices Sample Descriptive Statistics

<table>
<thead>
<tr>
<th>Goals (n=80-77)a</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Mode</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receive Emotional Support</td>
<td>2.54</td>
<td>2.35</td>
<td>1</td>
<td>1-9</td>
</tr>
<tr>
<td>Improve Self-Esteem</td>
<td>3.76</td>
<td>1.94</td>
<td>2</td>
<td>1-9</td>
</tr>
<tr>
<td>Violence/Trauma Information</td>
<td>4.52</td>
<td>2.11</td>
<td>3</td>
<td>1-9</td>
</tr>
<tr>
<td>Plan for Safety</td>
<td>4.68</td>
<td>2.84</td>
<td>2</td>
<td>1-9</td>
</tr>
<tr>
<td>Support from Other Survivors Self-Care Strategies</td>
<td>5.19</td>
<td>2.68</td>
<td>3</td>
<td>1-9</td>
</tr>
<tr>
<td>Help with Life Problems</td>
<td>6.06</td>
<td>2.27</td>
<td>9</td>
<td>1-9</td>
</tr>
<tr>
<td>Social Support Strategies</td>
<td>6.27</td>
<td>2.11</td>
<td>7</td>
<td>1-9</td>
</tr>
<tr>
<td>Community Referrals</td>
<td>6.47</td>
<td>1.93</td>
<td>5/8/9b</td>
<td>3-9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Practices (n=90-86)a</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Mode</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Open Group Format</td>
<td>3.28</td>
<td>0.92</td>
<td>Strongly Agree</td>
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</tr>
<tr>
<td>Specific Violence Group</td>
<td>3.11</td>
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<td>1-4</td>
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<tr>
<td>Specific Need Groups</td>
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<td>0.65</td>
<td>Agree</td>
<td>1-4</td>
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<tr>
<td>Staff Provider</td>
<td>2.57</td>
<td>0.86</td>
<td>Disagree</td>
<td>1-4</td>
</tr>
<tr>
<td>Refer: Mental Illness</td>
<td>2.54</td>
<td>0.82</td>
<td>Disagree</td>
<td>1-4</td>
</tr>
<tr>
<td>Closed Group Format</td>
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<td>0.90</td>
<td>Disagree</td>
<td>1-4</td>
</tr>
<tr>
<td>Refer: Substance Abuse</td>
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<td>0.68</td>
<td>Disagree</td>
<td>1-4</td>
</tr>
<tr>
<td>Refer: Intellectual Disability</td>
<td>2.24</td>
<td>0.66</td>
<td>Disagree</td>
<td>1-4</td>
</tr>
<tr>
<td>Refer: Disability</td>
<td>2.09</td>
<td>0.67</td>
<td>Disagree</td>
<td>1-4</td>
</tr>
</tbody>
</table>

aSample range reflects both the number of participants at agencies that provide this service and missing values; bIndicates bi- or multimodal item
### Table 16. Counseling: Service Goals and Practices Sample Descriptive Statistics

<table>
<thead>
<tr>
<th>Goals (n= 83-82)^a</th>
<th>Mean</th>
<th>SD</th>
<th>Mode</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receive Emotional Support</td>
<td>2.34</td>
<td>2.17</td>
<td>1</td>
<td>1-8</td>
</tr>
<tr>
<td>Plan for Safety</td>
<td>3.48</td>
<td>2.35</td>
<td>2</td>
<td>1-8</td>
</tr>
<tr>
<td>Violence/Trauma Information</td>
<td>3.89</td>
<td>1.79</td>
<td>3</td>
<td>1-8</td>
</tr>
<tr>
<td>Improve Self-Esteem</td>
<td>4.17</td>
<td>1.77</td>
<td>4</td>
<td>1-8</td>
</tr>
<tr>
<td>Community Referrals</td>
<td>5.10</td>
<td>1.86</td>
<td>4</td>
<td>2-8</td>
</tr>
<tr>
<td>Help with Life Problems</td>
<td>5.55</td>
<td>1.90</td>
<td>5/7^b</td>
<td>1-8</td>
</tr>
<tr>
<td>Self-Care Strategies</td>
<td>5.55</td>
<td>2.18</td>
<td>8</td>
<td>1-8</td>
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<tr>
<td>Social Support Strategies</td>
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<td>1.83</td>
<td>7</td>
<td>1-8</td>
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</table>

<table>
<thead>
<tr>
<th>Practices (n= 94-90)^a</th>
<th>Mean</th>
<th>SD</th>
<th>Mode</th>
<th>Range</th>
</tr>
</thead>
<tbody>
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<td>Staff Provider</td>
<td>3.00</td>
<td>0.87</td>
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</tr>
<tr>
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<td>0.86</td>
<td>Disagree</td>
<td>1-4</td>
</tr>
<tr>
<td>Refer: Mental Illness</td>
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<td>0.73</td>
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<td>1-4</td>
</tr>
<tr>
<td>Refer: Intellectual Disability</td>
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<td>0.56</td>
<td>Disagree</td>
<td>1-4</td>
</tr>
<tr>
<td>Refer: Disability</td>
<td>2.03</td>
<td>0.60</td>
<td>Disagree</td>
<td>1-4</td>
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</table>

^aSample range reflects both the number of participants at agencies that provide this service and missing values. ^bIndicates bi- or multimodal item
### Table 17. Shelter: Service Goals Sample Descriptive Statistics

<table>
<thead>
<tr>
<th>Goals (n=67-64)(^a)</th>
<th>Mean</th>
<th>SD</th>
<th>Mode</th>
<th>Range</th>
</tr>
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<tbody>
<tr>
<td>Safety, Live Violence-Free</td>
<td>1.67</td>
<td>1.44</td>
<td>1</td>
<td>1-10</td>
</tr>
<tr>
<td>Receive Emotional Support</td>
<td>2.40</td>
<td>1.92</td>
<td>1</td>
<td>1-10</td>
</tr>
<tr>
<td>Plan for Safety</td>
<td>4.14</td>
<td>2.44</td>
<td>3</td>
<td>1-10</td>
</tr>
<tr>
<td>Violence/Trauma Information</td>
<td>5.31</td>
<td>2.02</td>
<td>4</td>
<td>2-10</td>
</tr>
<tr>
<td>Community Referrals</td>
<td>5.54</td>
<td>1.96</td>
<td>4</td>
<td>2-10</td>
</tr>
<tr>
<td>Help with Life Problems</td>
<td>6.40</td>
<td>2.08</td>
<td>5/6(^a)</td>
<td>2-10</td>
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<tr>
<td>Improve Self-Esteem</td>
<td>6.42</td>
<td>1.81</td>
<td>7</td>
<td>2-10</td>
</tr>
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<td>Support from Other Survivors</td>
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<td>1-10</td>
</tr>
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<td>Self-Care Strategies</td>
<td>7.62</td>
<td>2.04</td>
<td>9</td>
<td>2-10</td>
</tr>
<tr>
<td>Social Support Strategies</td>
<td>8.03</td>
<td>1.79</td>
<td>9</td>
<td>2-10</td>
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Table 18. Shelter: Service Practices Sample Descriptive Statistics

<table>
<thead>
<tr>
<th>Practices (n=76-70)</th>
<th>Mean</th>
<th>SD</th>
<th>Mode</th>
<th>Range</th>
</tr>
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<td>Has Security System</td>
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<tr>
<td>Has Security Protocol</td>
<td>3.86</td>
<td>0.35</td>
<td>Strongly Agree</td>
<td>3-4</td>
</tr>
<tr>
<td>Staffed 24/7/365</td>
<td>3.71</td>
<td>0.54</td>
<td>Strongly Agree</td>
<td>2-4</td>
</tr>
<tr>
<td>Prioritize Survivors in Danger</td>
<td>3.15</td>
<td>0.76</td>
<td>Agree</td>
<td>1-4</td>
</tr>
<tr>
<td>Require Service Participation</td>
<td>3.25</td>
<td>0.81</td>
<td>Agree</td>
<td>1-4</td>
</tr>
<tr>
<td>Location Hidden</td>
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<td>0.84</td>
<td>Agree</td>
<td>1-4</td>
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<td>Staff Provider</td>
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<td>Agree/Disagree</td>
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<td>Staff Manage Medications</td>
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<td>0.82</td>
<td>Disagree</td>
<td>1-4</td>
</tr>
<tr>
<td>Refer: Mental Illness</td>
<td>2.34</td>
<td>0.77</td>
<td>Disagree</td>
<td>1-4</td>
</tr>
<tr>
<td>Refer: Substance Abuse</td>
<td>2.30</td>
<td>0.78</td>
<td>Disagree</td>
<td>1-4</td>
</tr>
<tr>
<td>Refer: Intellectual Disability</td>
<td>2.09</td>
<td>0.69</td>
<td>Disagree</td>
<td>1-4</td>
</tr>
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<td>Refer: Adolescent Males</td>
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<td>Disagree</td>
<td>1-4</td>
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<td>Disagree</td>
<td>1-4</td>
</tr>
<tr>
<td>Refer: Disability</td>
<td>1.99</td>
<td>0.69</td>
<td>Disagree</td>
<td>1-4</td>
</tr>
</tbody>
</table>

\(^{a}\)Sample range reflects both the number of participants at agencies that provide this service and missing values; \(^{b}\)Indicates bi- or multimodal item
APPENDIX B
Understanding Domestic Violence and Sexual Assault Services
In-Depth Interview Guide

Instructions Interviewer Will Give to the Participants Before Beginning Interview:
Your answers to the questions in this interview will be very valuable to this research and will help us better understand how sexual assault and/or domestic violence services (interviewer to use appropriate terms based on depending on type of agency) are delivered in North Carolina. When you answer the questions, please answer in a way that is true for you and for [name of agency here]. Please remember there are no right or wrong answers to the questions. There is very little research about what services are most effective for victims and survivors for violence, and there is very little information about what services help to make families and communities safe. Information on your perspectives, opinions, and experiences will be very helpful to this research.

I’d like to record your interview as a way to help my note taking. I don’t want to take chance of relying just on written notes and somehow miss something that you say or inadvertently change your words. So if you don’t mind, I’d like to use the tape recorder. If, at any time during the interview, you would like to turn the tape recorder off, all you need to do is press this button or let me know, and I’ll turn it off.

I also want to make certain that we understand one another as fully as possible. I realize that the fields of domestic violence and/or sexual assault are broad and people sometimes use very different words to describe similar things. Before we get started, I want to make certain we are using the same words in the same way. For example, what do you call the activities that are provided and delivered here at [name of agency here]: services, programs, interventions, or something else? Also, sometimes in the domestic violence/sexual assault fields we call the people who seek help from us different things. What term do you use? Clients, consumers, or something else? What term do you use to describe people who have experienced violence: victims, survivors, or both, or something different? (Interviewer will try to match terms to the interviewee’s terms throughout the interview.)

Are there any other words or terms we should clarify before we get started? If a word comes up during the interview and you are not sure what I mean by that word, please stop me and let me know. If you have any questions or concerns as we go through the interview, please stop me and ask me your question or tell me your concern. Please let me know if you want to take a break at any point in the interview. Before we get started, let’s test the tape recorder to make certain it’s working properly.
Appendix B

Interview Questions

Before I begin my other questions, it would be helpful to get some background information about [name of agency here].

• How many staff work for your agency? Full-time? Part-time?
• Please describe the training that staff receives.
• How many volunteers work for your agency?
• Please describe the training that volunteers receive.
• Please describe how your board operates.
• Is your agency an independent/stand-alone agency or are you affiliated/part of another organization?
• What is the geographical area that [name of agency] serves? Would you describe this area as mostly rural, urban, or suburban?

What accomplishment of [name of agency] are you most proud?

What is the biggest challenge [name of agency] is facing right now?

• Possible probes as necessary:
• Does [name of agency] have challenges with:
  • Infrastructure, your office space?
  • Service delivery?
  • Obtaining funding?
  • Administration capacity?
  • Developing staff skills?
  • Recruiting volunteers?
  • Developing your board?

It will also be helpful to my research to learn more about your opinions of program evaluation and research. Please think about research or program evaluations in which your program participated or conducted. What was your experience with research? With program evaluation?

• Interviewer may need to define the terms, research or/program evaluation.
• Possible follow-up questions if necessary (particularly if participant’s program has not conducted program evaluations or research):
  • How do you think research be helpful to you? To your program? How about program evaluation? Can it be helpful? How so? What concerns and worries do you have about research or program evaluation?

If you feel comfortable sharing this information, it will be helpful to my research if I know more about you and your experiences and background. What led you to work in the area of domestic violence/sexual assault? Could you tell me a bit about your background and experiences?

• Possible follow-up questions if necessary:
• How long have you worked in domestic violence/sexual assault services?
• How long have you worked for [name of agency here]?
• How long have you worked as agency/program/executive director (use appropriate title) of [name of agency here]?
• What kinds of education/training/experiences do you have?
I realize that domestic violence/sexual assault programs often want to provide more services and/or a broader range of services. Some programs struggle with funding, may not have enough office space, have problems with infrastructure, may not have enough administration support, or may not have enough support from their board. This may or may not be the case for your program. Given the challenges and resources that [name of agency here] currently has, I would like to have an understanding of what services your program can realistically provide. Please tell me, in as much detail as possible, about each kind of service/program that [name of agency here] offers.

- Interviewer will ask about each of the type/category of services that the interviewee listed in question two, e.g., hotline, counseling, advocacy, housing/shelter.
- Possible follow-up questions, as appropriate for each service:
  - Can you tell me about the different aspects or components of this service/program?
  - Who provides this service/program (e.g., volunteers, full-time staff, part-time staff)?
  - How do clients/people access this service/program?
  - Where are these services/programs offered?
  - How often/long is this service/program offered?
  - How frequently can clients/people come back for this service?
    - If clients/people return, how do you know if they have been here? To another program/agency for help?
  - How long can clients/people access this service? Is there a cut-off of how much/how often a person can receive this service?
  - How are the programs/services evaluated?
  - What skills/traits/experiences do staff/volunteers need to have to deliver these services effectively?

Of all the services/programs you have told me about, which do you feel are a priority to provide?

- Follow-up if necessary:
  - What services should be a first priority?
  - What services do you find are most important for victims/survivors?
  - Do service priorities differ for victims/survivors of sexual violence compared to victims/survivors of domestic violence? Or are the service priorities the same?

Sometimes program directors know the history of how their program decided what services to deliver. Sometimes program directors do not have this information, particularly if they have not been at a program for long. If you have this information, please tell me about how [name of agency here] decided to provide the services you just described.

- Possible follow-up questions/statements:
  - Sometimes service providers decide to offer certain services or programs because of their training or experiences, or because there is a critical need for that service in the community, or because a funding agency requires that service. What were the reasons [name of agency here] decided to provide the [name of specific service here] you told me about?

Does [name of agency here] have a philosophy about how and what services are delivered?

- Possible follow-up prompting statements as necessary:
• For example, some domestic violence/sexual assault programs say that they have a feminist philosophy, others say that they have an empowerment philosophy, and others may not have an identified philosophy. What would you say about [name of agency here]?
• Sometimes these philosophies mean different things to different people. Could you describe what [stated philosophy here] means for you? For [name of agency here]?
• Please tell me about how [stated philosophy here] helps [name of agency here] decide what services to provide and how to provide these services? Please give me an example of how [stated philosophy here] helped [name of agency here] decide on what services and programs to provide.
• Please tell me about how [stated philosophy here] helps [name of agency here] decide what services to prioritize.
• Does [stated philosophy here] help [name of agency here] decide who/what people to provide services for?

Please tell me about the ways that a person may contact your program for help. For example, what happens after a person makes contact with the crisis line, the shelter, or walks in the door? What I especially would like to know is: how do you and your staff decide if this is the best place for the person/client to get help? How do you or your staff decide which service/programs the person/client most needs?

• Follow-up if necessary:
  • Does [name of agency here] have an assessment form or assessment guidelines? Please describe the form/guidelines to me?

Because of varied reasons such as limited resources or staff expertise, domestic violence/sexual assault programs sometimes need to make decisions about who they can and cannot serve. Does [name of agency here] have guidelines about who can receive services here?

• Possible follow-up statement if necessary:
  • For example, some domestic violence/sexual assault programs focus their services for women only or some agencies have policies about not working with clients/people with substance abuse problems. Does [name of agency here] have any policies or informal guidelines like these?
  • Could you tell me about what led [name of agency here] to have these policies and guidelines?
  • Does [name of agency here] have policies to prioritize and decide who should receive services? How about informal guidelines or unwritten understandings?

What are the changes you hope you will see for people/clients who come here because of the services?

• Follow-up if necessary:
  • What do you think will be different for people/clients because they came here for help compared to someone who experienced the same thing (provide examples if necessary, e.g., sexual assault, domestic violence) but did not come here for help?

Could you tell me how you/the staff/the volunteers at [name of agency here] know if these services have worked? Have made a difference? Have been successful?

• Possible follow-up questions, if necessary:
• Does [name of agency here] track or record the changes in people/families/the community after they received services from [name of agency here]. For example, do you use client satisfaction surveys, track the number of clients/people who take out protection orders, or have a safety plan?
  • If yes: How does [name of agency here] use this information?
  • If yes: How does [name of agency here] share this information among your staff (files, written records, databases, log journal, other ways?)
  • Possible follow-up questions, if appropriate:
  • Does your program have different ways of tracking changes for victims/survivors of sexual violence compared to victims/survivors of domestic violence?

Information may come out of above question. Follow-up question if necessary.
You’ve told me about some of the information that [name of agency here] collects. I realize that you may be required to collect additional information for funding sources. Can you tell me about what other kinds of information you are currently required to collect about services, programs, or people served? I know about most of the information that the GCC and the NC Council on Women requires programs to track. How about other funding sources?

Now I would like you to think about an ideal world. If money and resources were not an issue—if your agency had unlimited funding and resources—what services/program would you most like to provide to victims and survivors? To families? To the community?
  • Follow-up questions/probes if necessary:
  • This may not be a traditional domestic violence/sexual assault service/program. Perhaps you have an idea that you feel is innovative, creative, or really out of the box. It would be helpful to me to know about these ideas, too.
  • Why do you think it would be ideal for these programs and services to be provided? Why these particular services and programs?
  • Still thinking of an ideal world where funding and resources are not a problem, please describe how each of these services/programs should be provided.

If money and resources were not an issue—if your agency had unlimited funding and resources—what program/service evaluations would you like to do? What research?

What would [name of agency here] need in order to provide these ideal services in the way you described? How about the evaluations and research? What kinds of resources? What kind of funding? What else besides additional resources or funding?
  • Follow-up questions/probes if necessary: Does your program have a strategic plan to guide decisions about what resources you need?

It would be helpful know more about your ideas about funding priorities for domestic violence/sexual assault programs/agencies. How do you think funds should be allocated to help programs develop? Grow? Be sustainable? Provide the best services possible to victims/survivors? Let’s imagine that you got a wonderful new grant that paid for one additional staff position. What would you have that person do?
As you know, part of the aim of this research study is to develop a set of service guidelines for domestic violence and sexual assault programs. In what ways could a set of service guidelines be helpful to you? What are your concerns and worries about possible service guidelines?

- *Follow-up if necessary*: How might having one set of service guidelines for all domestic violence, sexual assault, and combined agencies be helpful? be a problem?
- Are you currently using any service guidelines or manuals for any of your programs or services?
  - *If yes*: How do these work? How are they helpful to [name of agency here]?
  - *If yes*: Where did the guidelines come from? Developed here? Found in a book?

The next phase in this research is to conduct a statewide survey of all the domestic violence, sexual assault, and combined agencies in North Carolina about their services and programs. What are two or three key questions that you think should be asked in this statewide survey?

Is there anything I should have asked you, but I did not? Is there anything more that you would like me to know?

**Thank you for spending time with me today and for answering all of these questions. Your participation is very important to this research!**
APPENDIX C
Understanding Domestic Violence and Sexual Assault Services:
Focus Group Guide

Instructions Interviewer Will Give to the Participants Before Beginning Interview and Following Informed Consent:
Your answers to the questions in this interview will be very valuable to this research and will help us better understand how sexual assault and domestic violence services are delivered in North Carolina. When you answer the questions, please answer in a way that is true for you and for [name of organization here]. Remember, there are no right or wrong answers to the questions. There is very little research about which services are most effective for victims and survivors for violence, and there is very little information about which services help to make families and communities safe. Your perspectives, opinions, and experiences will be very helpful to this research.

We are conducting this research because there is little research and no clear evidence about which domestic violence and sexual assault services work well for victims and survivors. In addition, there is some disagreement among domestic violence and sexual assault service providers about which services are most important and how best to deliver these services. During our discussion today, there may be different ideas and disagreement about which services are important and how these services should be delivered. I would like to learn about as many different ideas and perspectives today as possible because becoming familiar with a diversity of ideas will strengthen the results of this research. So, even if you disagree with one another, I would like to hear your different perspectives and opinions.

I also want to point out that you may know most of the people who fund, provide, lobby for, and give trainings for domestic violence and sexual assault services in North Carolina. So, everything that is said in our group discussion today must be held in confidence and you must agree not to reveal anything you learn from the group discussion or the names of the other participants. In addition, I want to keep our discussion at a general level because the people who work to prevent and help with domestic violence and sexual assault are a small community. When giving examples during our discussion, please use general terms to describe a person, program, or organization instead of stating a name of a specific person, program, or organization. For example, rather than saying: “the domestic violence program in Pleasantville has an innovative prevention program,” please say something like, “One innovative prevention program includes these services . . .” If you use a specific name, I will stop the discussion and remind you to make your point in a more general way.

I would like to record our group discussion today because it facilitates our note taking and I don’t want to miss something that you say or inadvertently change anyone’s words. So, with your permission, I’d like to use the tape recorder. If, at any time during the group discussion, you want the tape recorder turned off, just say so, and I’ll turn it off. Also, you do not have to answer any question that you do not wish to answer. If I ask a question and no one responds, I will move on to the next question.

I want to make certain that we understand one another as fully as possible. I realize that the fields of domestic violence and sexual assault are broad and people sometimes use very different words to describe similar things. Before we get started, I want to make certain we are using the same words in the same way. For example, what do you call the activities that domestic violence and sexual
assault programs do: services, programs, interventions, or something else? Also, sometimes in the domestic violence and sexual assault fields we call the people who seek help from us different things. What term do you all use? Clients, consumers, or something else? What term do you use to describe people who have experienced violence: victims, survivors, or both, or something different? (PI will try to match terms the terms throughout the interview.) Are there any other words or terms we should clarify before we get started?

Before we get started, does everyone feel comfortable with the instructions and guidelines for our group discussion? I am wondering if everyone can agree to keep what is said in our discussion confidential and to keep our discussion general. Is everyone comfortable with these instructions? Does anyone have any concerns or worries about these instructions? (PI will provide time for a brief discussion about the instructions at this point and will ensure that everyone agrees to group confidentiality.) If you have any questions or concerns as we go through the group discussion, please stop me and ask your question or tell me your concern.

Let’s test the tape recorder to make certain it’s working properly before we begin.

**FOCUS GROUP QUESTIONS**

**Achievements**
What has been the most significant achievement of North Carolina domestic violence programs, sexual assault programs, and combination domestic violence and sexual assault programs to-date?

**Challenges**
What is the biggest challenge facing these programs right now?

**Service Priorities: What and How**
Please consider the current system of domestic violence and sexual assault services. Given the current state of services and funding for these programs, which services should be the first priority for North Carolina domestic violence, sexual assault, and combination programs to provide to victims-survivors? to families? to their respective communities?

- Possible follow-up question if necessary:
- Please describe in as much detail as possible how you think these priority services should be provided.

**Service Priorities: Who**
Again, please consider the current system of domestic violence and sexual assault services. Given the current state of services and funding for these programs, who should programs prioritize serving?

**Differences in Service Priorities**
Do the service priorities differ for victims-survivors of sexual violence compared to victims-survivors of domestic violence? Or are the service priorities the same?

**Outcomes**
Should these programs track and measure service outcomes?

- Possible follow-up question if necessary:
If yes, why? If no, why not?
What service outcomes should these programs measure?
How should programs measure these service outcomes?

Ideal Services
Now I would like you to think about an ideal world. If money and resources were not an issue, what services would you most like North Carolina programs to provide to victims-survivors? to families? to their respective communities?
- Possible follow-up question if necessary:
- Why do you think it would be ideal for these services to be provided?
- Ideal services may or may not be a traditional domestic violence or sexual assault services. Please also describe ideas that are innovative, creative, or “outside the box.”
- Please describe in as much detail as possible how you think these ideal services should be provided.

Philosophy
Should programs have a philosophy to guide service delivery?
- Possible follow-up question if necessary:
- If yes, what should that philosophy be (and please describe this philosophy in as much detail as possible)?
- If no, what should guide program’s service delivery practices?

Funding Priorities
How do you think funds should be allocated to programs?
- Possible follow-up question if necessary:
- Please describe in as much detail as possible how funds could best be allocated.

Changing Funding Priorities
If you could change only one thing about how funds are currently allocated, what would you change?

Service Guidelines
One goal of this research study is to develop a set of service guidelines for domestic violence, sexual assault, and combination programs. In what ways could a set of service guidelines be helpful to you? to your organization? What are your concerns and worries about these possible service guidelines?

Survey Questions
The next phase in this research is to conduct a statewide survey of all the domestic violence, sexual assault, and combined agencies in North Carolina about their services and programs. What are the three key questions that you think should be asked in this statewide survey?

Additional Comments
Is there anything more that you would like to tell us? Is there a question we should have asked you but did not?
Thank you for taking the time to answer our questions. Your participation is very important to this research!
APPENDIX D
North Carolina Domestic Violence and Sexual Assault Services

In this survey, we ask for both your opinions about how domestic violence and sexual assault services should be delivered to best help clients and questions about how services are delivered in your agency right now. We ask that for all questions you be completely honest and candid in your answers. For the opinion questions, there are no right or wrong answers. We are truly interested in your opinions about these services. For the questions about how your agency provides services now, forthright responses will give us the most realistic picture of North Carolina domestic violence and sexual assault services.

WHAT SERVICES YOUR AGENCY PROVIDES
Both domestic violence and sexual assault agencies are being asked to complete this survey. Also, agencies in different communities often provide different services. Because of this, we want to understand what services your agency provides. Your agency may or may not provide all the services listed here. Please let us know which services your agency does provide.

1. Does your agency provide domestic violence services, sexual assault services or both? Please check one answer below.
   a. _____ domestic violence
   b. _____ sexual assault
   c. _____ both domestic violence and sexual assault

2. Please check each type of service that your agency provides (check all that apply):
   a) _____ crisis (crisis telephone line and/or crisis walk-in services)
   b) _____ legal advocacy (help with law enforcement, courts, attorneys, and legal aid)
   c) _____ medical advocacy (help with health care providers, support during medical procedures)
   d) _____ support group
   e) _____ individual counseling (information, education, support provided by agency staff/volunteers)
   f) _____ shelter
   g) _____ mental health treatment provided by mental health professional
   h) _____ substance abuse treatment provided by substance abuse professional
   i) _____ community education
   j) _____ prevention education
   k) _____ other, please describe here:
**SERVICE DELIVERY**

This section focuses on six types of domestic violence and sexual assault services: crisis services, legal advocacy, medical advocacy, support groups, individual counseling, and shelter services. The questions ask for your **opinions** about the **way** services should be delivered to **best help clients**. For these questions, you will be able to choose between four responses: 1) strongly agree, 2) agree, 3) disagree, and 4) strongly disagree.

Please only answer questions for the services that are provided by your agency. For example, if your agency provides crisis services, answer those questions. However, if your agency does not provide crisis services, skip those questions and go on to the next set of questions.

<table>
<thead>
<tr>
<th>3. CRISIS SERVICES (CRISIS LINE and CRISIS WALK-IN SERVICES)</th>
<th>If your agency does not provide crisis services, please skip to question 4.</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Crisis services best help clients when available 24-hours a day, 7-days a week, 365-days a year:</td>
<td>Strongly Agree</td>
</tr>
<tr>
<td>b) Crisis services best help clients when provided by someone trained in crisis intervention, including active listening, how to provide emotional support, and helping clients to problem-solve:</td>
<td>Strongly Agree</td>
</tr>
<tr>
<td>c) Crisis services best help clients when provided by someone trained in domestic violence and/or sexual assault:</td>
<td>Strongly Agree</td>
</tr>
<tr>
<td>d) Crisis services best help clients when agency staff/volunteers respond to clients’ requests for help, rather than an answering service who then relays the call to staff/volunteers:</td>
<td>Strongly Agree</td>
</tr>
<tr>
<td>e) Crisis services best help clients when they are provided by staff rather than volunteers:</td>
<td>Strongly Agree</td>
</tr>
</tbody>
</table>
4. LEGAL ADVOCACY SERVICES (HELP WITH LAW ENFORCEMENT AND COURTS)
If your agency does not provide legal advocacy services, please skip to question 5.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Legal advocacy services best help clients when available 24-hours a day, 7-days a week, 365-days a year. For example staff/volunteers are available to meet survivor at police station or with attorneys at night and on weekends:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>Agree</td>
<td>Disagree</td>
<td>Strongly Disagree</td>
</tr>
<tr>
<td>b) Legal advocacy services best help clients when services are provided by staff rather than volunteers:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. MEDICAL ADVOCACY SERVICES (HELP WITH HEALTH CARE PROVIDERS AND SUPPORT DURING MEDICAL PROCEDURES)
If your agency does not provide medical advocacy services, please skip to question 6.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Medical advocacy services best help clients when available 24-hours a day, 7-days a week, 365-days a year. For example, staff/volunteers are available to meet survivor at hospital at night and on weekends.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>Agree</td>
<td>Disagree</td>
<td>Strongly Disagree</td>
</tr>
<tr>
<td>b) Medical advocacy services best help clients when provided by staff rather than volunteers:</td>
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</tbody>
</table>

6. SUPPORT GROUP SERVICES
If your agency does not provide support group services, please skip to question 7.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Support group services best help clients when open and ongoing (clients are welcome to join the group any time that they like and attend as many or as few sessions as they would like):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>Agree</td>
<td>Disagree</td>
<td>Strongly Disagree</td>
</tr>
</tbody>
</table>
b) Support group services best help clients when time limited and closed (clients all begin the
group together and attend the same number of group meeting together) to maintain client
confidentiality and help group cohesion:

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

c) Support group services best help clients when those with specific violence experiences are
helped to form their own group with members with similar experiences. For example, sexual
assault survivors, domestic violence survivors, adult survivors of child sexual abuse would form
separate support groups:

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

d) Support group services best help clients when those with a variety of violence experiences,
including sexual assault survivors, domestic violence survivors, and adult survivors of child sexual
abuse form support groups together:

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

e) Support group services best help clients when those with specific needs are helped to form their
own group with other members with similar needs. For example, clients with mental health
problems, substance abuse problems, clients who are hearing impaired, clients who speak
Spanish would form separate support groups:

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

f) Support group services best help clients when clients with substance abuse problems are
referred to substance abuse services instead of participating in the support group:

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

g) Support group services best help clients when clients with mental illnesses (e.g., schizophrenia,
bipolar disorder) are referred to mental health services instead of participating in the support group:

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

h) Support group services best help clients when clients with disabilities, including deafness,
blindness, wheelchair user, are referred to disability services instead of participating in the support
group:

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>
### Appendix D

#### 7. INDIVIDUAL COUNSELING SERVICES (INFORMATION, SUPPORT, EDUCATION PROVIDED BY AGENCY STAFF OR VOLUNTEERS IN INDIVIDUAL MEETINGS)

If your agency does not provide individual counseling services, please skip to question 8.

| a) Individual counseling services best help clients when clients with substance abuse problems are referred to substance abuse services instead of participating in counseling: |
|---|---|---|---|
| Strongly Agree | Agree | Disagree | Strongly Disagree |

| b) Individual counseling services best help clients when those with mental illnesses (e.g., schizophrenia, bipolar disorder) are referred to mental health services instead of participating in counseling: |
|---|---|---|---|
| Strongly Agree | Agree | Disagree | Strongly Disagree |

| c) Individual counseling best help clients when clients with disabilities, including deafness, blindness, wheelchair user, are referred to disability services instead of participating in counseling: |
|---|---|---|---|
| Strongly Agree | Agree | Disagree | Strongly Disagree |

| d) Individual counseling best help clients when clients with intellectual disabilities are referred to disability services instead of participating in counseling: |
|---|---|---|---|
| Strongly Agree | Agree | Disagree | Strongly Disagree |

| e) Individual counseling services best help clients when provided by staff rather than volunteers: |
|---|---|---|---|
| Strongly Agree | Agree | Disagree | Strongly Disagree |
# 8. SHELTER SERVICES
If your agency does not provide shelter services, please skip to question 9.

a) Shelter services best help clients when the shelter is staffed 24-hours a day, 7-days a week, 365-days a year:

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

b) Shelter services best help clients when the shelter has a security system such as an alarm system, automatic police response, or monitoring system:

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
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</thead>
<tbody>
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<td></td>
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</table>

c) Shelter services best help clients when the shelter has a security protocol. For example, there is a written policy about how volunteers/staff respond if a perpetrator comes to the shelter:

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
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<tbody>
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<td></td>
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</table>

d) Shelter services best help clients when the shelter-staff help clients manage their medications (staff keep medications and help clients take medication as prescribed):

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

e) Shelter services best help clients when the shelter location is hidden from most in the community:

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

f) Shelter services best help clients when the shelter has rules that require client participation in shelter activities and services (for example, assigned chores, clients required to attend support groups):

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

g) Shelter services best help clients when clients with adolescent male children are referred elsewhere:

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
h) Shelter services best help clients when clients with substance abuse problems are referred to substance abuse services instead of participating in shelter services:

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

i) Shelter services best help clients when clients with mental illnesses (e.g., schizophrenia, bipolar disorder) are referred to mental health services instead of participating in shelter services:

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

j) Shelter services best help clients when clients with disabilities, including deafness, blindness, and wheelchair user, are referred to disability services instead of participating in shelter services:

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

k) Shelter services best help clients when clients with intellectual disabilities are referred to disability services instead of participating in shelter services:

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

l) Shelter services best help clients when clients with criminal/legal convictions are referred elsewhere:

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

m) Shelter service best help clients when clients who are in imminent, life-threatening danger are prioritized for shelter space over clients who are not in as serious danger:

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

n) Shelter service best help clients when clients who are in imminent, life-threatening danger are referred elsewhere to ensure the safety of the other clients and staff:

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

q) Shelter services best help clients when provided by staff rather than volunteers:

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>
9. OTHER INFORMATION: Is there other information you would like us to know about how crisis, advocacy, group, counseling or shelter services should be provided to best help clients? Please write your answer below.
**WHAT CLIENTS SHOULD RECEIVE FROM SERVICES**

This section contains *opinion* questions about *what clients should receive* from crisis, legal advocacy, medical advocacy, support groups, individual counseling, or shelter services. There is a set of questions for each type of service. Your agency may not offer all of these services. **Only answer the questions for the services provided by your agency.** For example, if your agency provides crisis services, answer those questions. However, if your agency does not provide crisis services, skip those questions and go on to the next set of questions.

For each service that your agency provides, and **based on your opinions**, please rank the services in order of importance of what services should do for clients. For example, give the ranking of 1 to the item you feel is the most important thing for a client to receive from that service, 2 for the second important, 3 for the third important, and so on. For each set of service items, please read through all choices before you begin ranking.

As you read the questions, you may feel that all of the items are important. However, we want to understand what you feel are the most important parts of these services for clients. So please use each rank only once and rank each item by its importance for helping clients in your community.

<table>
<thead>
<tr>
<th>10. CRISIS SERVICES (CRISIS LINE AND CRISIS WALK-IN SERVICES)</th>
<th>Rank from 1-7</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your agency does not provide crisis services, please skip to question 11</td>
<td></td>
</tr>
<tr>
<td>Please rank in order of importance what crisis services should do for clients: 1= most important through 7= least important.</td>
<td></td>
</tr>
<tr>
<td>a) Client received emotional support, such as kindness, caring, and empathy from agency staff/volunteer</td>
<td></td>
</tr>
<tr>
<td>b) Client received help with planning for safety such as vary routine, plan for what to do if perpetrator becomes violent again, memorize emergency numbers</td>
<td></td>
</tr>
<tr>
<td>c) Client received help with identifying and building social support such as support from family and friends</td>
<td></td>
</tr>
<tr>
<td>d) Client received information about violence and trauma such as power and control, cycles of violence, assault/violence is not survivor’s fault, or offender typology</td>
<td></td>
</tr>
<tr>
<td>e) Client received help with referrals to other community services if needed, including health care, mental health, substance abuse, disability, and social services</td>
<td></td>
</tr>
<tr>
<td>f) Client received help with self-care such as strategies to manage stress, making plans to get plenty of sleep and exercise, or making plans to do something nice for herself/himself</td>
<td></td>
</tr>
<tr>
<td>g) Client received information about your agency’s services</td>
<td></td>
</tr>
</tbody>
</table>

**OTHER INFORMATION:** Is there other information you would like us to know about what clients should receive from crisis services? Please write your answer below and on the back of this page if space is needed.
### 11. LEGAL ADVOCACY SERVICES (HELP WITH LAW ENFORCEMENT, COURTS, ATTORNEYS, AND LEGAL AID)

If your agency does not provide legal advocacy services, please skip to question 12

Please rank in order of importance what legal advocacy should do for clients: 1= most important through 9= least important.

<table>
<thead>
<tr>
<th>Rank from 1-9</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Client received emotional support such as kindness, caring, and empathy from agency staff/volunteer</td>
<td></td>
</tr>
<tr>
<td>b) Client received help with planning for safety such as vary routine, plan for what to do if perpetrator becomes violent again, and memorize emergency numbers</td>
<td></td>
</tr>
<tr>
<td>c) Client received help with identifying and building social support such as support from family and friends</td>
<td></td>
</tr>
<tr>
<td>d) Client received information about violence and trauma such as power and control, cycles of violence, assault/violence is not survivor’s fault, or offender typology</td>
<td></td>
</tr>
<tr>
<td>e) Client received help with referrals to other community services if needed, including health care, mental health, substance abuse, disability, and social services</td>
<td></td>
</tr>
<tr>
<td>f) Client received help with self-care such as strategies to manage stress, making plans to get plenty of sleep and exercise, or making plans to do something nice for herself/himself</td>
<td></td>
</tr>
<tr>
<td>g) Client received help completing legal paperwork, including victims’ compensation forms</td>
<td></td>
</tr>
<tr>
<td>h) Client received information about legal options as appropriate to advocacy role and not in conflict with legal professionals’ advice</td>
<td></td>
</tr>
<tr>
<td>i) Client was accompanied to court, trials, and legal meetings</td>
<td></td>
</tr>
</tbody>
</table>

**OTHER INFORMATION:** Is there other information you would like us to know about what clients should receive from legal advocacy services? Please write your answer below and on the back of this page if space is needed.
**12. MEDICAL ADVOCACY SERVICES (HELP WITH HEALTH CARE PROVIDERS AND SUPPORT DURING MEDICAL PROCEDURES)** If your agency does not provide medical advocacy services, please skip to question 13

Please rank in order of importance what medical advocacy should do for clients: 1= most important through 9= least important.

<table>
<thead>
<tr>
<th>Rank from 1-9</th>
<th>a) Client received emotional support such as kindness, caring, and empathy from agency staff/volunteer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>b) Client received help with planning for safety such as vary routine, plan for what to do if perpetrator becomes violent again, and memorize emergency numbers</td>
</tr>
<tr>
<td></td>
<td>c) Client received help with identifying and building social support such as support from family and friends</td>
</tr>
<tr>
<td></td>
<td>d) Client received information about violence and trauma such as power and control, cycles of violence, assault/violence is not survivor’s fault, or offender typology</td>
</tr>
<tr>
<td></td>
<td>e) Client received help with referrals to other community services as needed, including legal, mental health, substance abuse, disability, and social services</td>
</tr>
<tr>
<td></td>
<td>f) Client received help with self-care such as strategies to manage stress, making plans to get plenty of sleep and exercise, making plans to do something nice for herself/himself</td>
</tr>
<tr>
<td></td>
<td>g) Client received help completing victims’ compensation forms</td>
</tr>
<tr>
<td></td>
<td>h) Client received information about medical options, as appropriate to advocacy role and not in conflict with advice of medical professionals</td>
</tr>
<tr>
<td></td>
<td>i) Client was accompanied to medical appointments as necessary such as first-response medical appointment</td>
</tr>
</tbody>
</table>

**OTHER INFORMATION:** Is there other information you would like us to know about what clients should receive from medical advocacy services? Please write your answer below and on the back of this page if space is needed.
13. SUPPORT GROUP SERVICES
If your agency does not provide support group services, please skip to question 14.
Please rank in order of importance what support group services should do for clients:
1= most important through 9= least important.

<table>
<thead>
<tr>
<th>Rank from 1-9</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>a) Client received emotional support such as kindness, caring, and empathy from agency staff/volunteer</td>
</tr>
<tr>
<td>b) Client received help with planning for safety such as vary routine, plan for what to do if perpetrator becomes violent again, and memorize emergency numbers</td>
</tr>
<tr>
<td>c) Client received help with identifying and building social support such as support from family and friends</td>
</tr>
<tr>
<td>d) Client received information about violence and trauma such as power and control, cycles of violence, assault/violence is not survivor’s fault, or offender typology</td>
</tr>
<tr>
<td>e) Client received help with referrals to other community services as needed, including legal, health care, mental health, substance abuse, disability, and social services</td>
</tr>
<tr>
<td>f) Client received help with life problems other than violence, such as education, employment, finances, housing, or parenting</td>
</tr>
<tr>
<td>g) Client received help with self-esteem including increased positive feelings about self, and recognized personal strengths and resources</td>
</tr>
<tr>
<td>h) Client received help with self-care such as strategies to manage stress, making plans to get plenty of sleep and exercise, making plans to do something nice for herself/himself</td>
</tr>
<tr>
<td>i) Client formed positive relationships with other clients, that is, developed friendships, found support from other survivors</td>
</tr>
</tbody>
</table>

**OTHER INFORMATION:** Is there other information you would like us to know about what clients should receive from support group services? Please write your answer below and on the back of this page if space is needed.
**14. INDIVIDUAL COUNSELING SERVICES (INFORMATION, SUPPORT, EDUCATION PROVIDED BY AGENCY STAFF OR VOLUNTEERS IN INDIVIDUAL MEETINGS)**

If your agency does not provide individual counseling services, please skip to question 15

Please rank in order of importance what individual counseling services should do for clients: 1= most important through 8= least important.

<table>
<thead>
<tr>
<th>Rank from 1-8</th>
<th>a) Client received emotional support such as kindness, caring, and empathy from agency staff/volunteer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>b) Client received help with planning for safety such as vary routine, plan for what to do if perpetrator becomes violent again, and memorize emergency numbers</td>
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<td></td>
<td>c) Client received help with identifying and building social support such as support from family and friends</td>
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<td>d) Client received information about violence and trauma such as power and control, cycles of violence, assault/violence is not survivor’s fault, or offender typology</td>
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<td>e) Client received help with referrals to other community services as needed, including legal, health care, mental health, substance abuse, disability, and social services</td>
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<td></td>
<td>f) Client received help with life problems other than violence, such as education, employment, finances, housing, or parenting</td>
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<tr>
<td></td>
<td>g) Client received help with self-esteem, including increased positive feelings about self, recognized personal strengths and resources</td>
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<tr>
<td></td>
<td>h) Client received help with self-care such as strategies to manage stress, making plans to get plenty of sleep and exercise, making plans to do something nice for herself/himself</td>
</tr>
</tbody>
</table>

**OTHER INFORMATION:** Is there other information you would like us to know about what clients should receive from support group services? Please write your answer below and on the back of this page if space is needed.
**15. SHELTER SERVICES**  
If your agency does not provide shelter services, please skip to question 16.  
Please rank in order of importance what shelter services should do for clients: 1= most important through 10= least important.

<table>
<thead>
<tr>
<th>Rank from 1-10</th>
<th>a) Client received emotional support such as kindness, caring, and empathy from agency staff/volunteer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>b) Client received help with planning for safety such as vary routine, plan for what to do if perpetrator becomes violent again, and memorize emergency numbers</td>
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<tr>
<td></td>
<td>c) Client received help with identifying and building social support such as support from family and friends</td>
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<td>d) Client received information about violence and trauma such as power and control, cycles of violence, assault/violence is not survivor’s fault, or offender typology</td>
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<td></td>
<td>e) Client received help with referrals to other community services as needed, including legal, health care, mental health, substance abuse, disability, and social services</td>
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<tr>
<td></td>
<td>f) Client received help with life problems other than violence, such as education, employment, finances, housing, parenting</td>
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<tr>
<td></td>
<td>g) Client received help with self-esteem, including increased positive feelings about self, recognize personal strengths and resources</td>
</tr>
<tr>
<td></td>
<td>h) Client received help with self-care such as strategies to manage stress, making plans to get plenty of sleep and exercise, making plans to do something nice for herself/himself</td>
</tr>
<tr>
<td></td>
<td>i) Client formed positive relationships with other clients, that is, developed friendships, found support from other survivors</td>
</tr>
<tr>
<td></td>
<td>j) Client received a safe place to live free from violence</td>
</tr>
</tbody>
</table>

**OTHER INFORMATION:** Is there other information you would like us to know about what clients should receive from shelter services? Please write your answer below and on the back of this page if space is needed.
**SERVICE ACCESSIBILITY**

These questions ask about how services are delivered at your agency right now. When answering these questions, please think about all the services your agency provides.

For these questions, you will be able to choose between five responses: 1) All of the time, 2) Most of the time, 3) Some of the time, 4) Never, and 5) Not applicable. Please respond by circling the answer that best reflects how your agency provides this service right now. Respond in the following way:

- **All of the time**: My agency provides this service in this way 100% of the time
- **Most of the time**: My agency provides this service in this way more than half (50%) of the time
- **Some of the time**: My agency provides this service in this way less than half (50%) of the time
- **Never**: My agency never provides this service in this way
- **Not applicable**: At my agency, we find that it is not important if we provide this service in this way (clients or community does not need the service provided in this way)

<table>
<thead>
<tr>
<th></th>
<th>All of the time</th>
<th>Most of the time</th>
<th>Some of the time</th>
<th>Never</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>16) Services are accessible to clients with a range of disabilities. Examples include: service provided by staff/volunteers with disability training including training on intellectual disabilities, sign language interpreter available when needed, shelter can accommodate service animals and personal care attendants:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17) Services are accessible to clients whose primary language is not English. Examples include: staff/volunteers who provide services are bilingual or multilingual, interpreters are available when needed:</td>
<td></td>
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<tr>
<td>18) Services are multicultural. Examples include an environment that is welcoming to survivors from various racial-ethnic backgrounds and cultural heritages, and services are provided by multicultural staff/volunteers and staff/volunteers who have cross-cultural training:</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>19) Services are welcoming to lesbian/gay/bisexual/ transgender (LGBT) people. Examples include services provided by staff/volunteers with LGBT training, and staff/volunteers do not assume gender of client or client's perpetrator:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
20) Services are provided by staff/volunteer with mental health expertise (i.e., know how to identify mental illnesses and provide domestic violence/sexual assault services to a client with mental illnesses, such as schizophrenia and bipolar disorder), and clients with these problems are referred to appropriate mental health services:

<table>
<thead>
<tr>
<th>All of the time</th>
<th>Most of the time</th>
<th>Some of the time</th>
<th>Never</th>
<th>Not Applicable</th>
</tr>
</thead>
</table>

21) Services are provided by staff/volunteer with substance abuse expertise (i.e., know how to identify substance abuse problems and provide domestic violence/sexual assault services to a client with an addiction), and clients with these problems are referred to appropriate substance abuse services:

<table>
<thead>
<tr>
<th>All of the time</th>
<th>Most of the time</th>
<th>Some of the time</th>
<th>Never</th>
<th>Not Applicable</th>
</tr>
</thead>
</table>

22. OTHER INFORMATION: Is there other information you would like us to know about how crisis, advocacy, group, counseling or shelter services are provided at your agency? Please write your answer below.
## YOUR AGENCY AND YOU

23. Please check all answers that describes your agency:

a. _____ My agency is a stand-alone domestic violence program
b. _____ My agency is a stand-alone sexual assault program
c. _____ My agency is a stand-alone domestic violence and sexual assault program
d. _____ My agency is a domestic violence and/or sexual assault program that is a satellite office of larger domestic violence and/or sexual assault agency
e. _____ My agency is a domestic violence and/or sexual assault program within an umbrella organization that provides other human health and services
f. _____ My agency is a domestic violence and/or sexual assault program at a university
g. _____ Other, please describe:

24. How many full- and part-time staff members work at your agency? Please write a number in the space provided (if part of an umbrella organization, please tell us how many staff members provide domestic violence and/or sexual assault services):

___ full-time ___ part-time

25. Does your agency have a staff member with a master’s degree in counseling, marriage and family therapy, psychology, or social work who provides domestic violence and/or sexual assault services to clients? Please check the answer that best describes your agency.

a. _____ no
b. _____ yes, my agency has one such staff member
c. _____ yes, my agency has more than one such staff member

26. Approximately, how many volunteers, including those that provide services to clients and those that provide other help (e.g., clerical, work in thrift store), work with your agency? Please write a number in the space provided:
27. In your opinion, does your agency serve a rural, suburban, or urban area? Please check all answers that apply for your agency.

a. ______ rural
b. ______ suburban
c. ______ urban

28. Please provide the title that best describes your current position (for example: executive director, associate/assistant director, program director, advocate):

29. How long have you held your current position?

a. ______ less than one year
b. ______ 1-5 years
c. ______ 6-10 years
d. ______ 11-15 years
e. ______ 16-20 years
f. ______ more than 20 years

30. How many years in total have you provided domestic violence services, as a staff member (not volunteer), at this agency or at any agency? Please check the answer that best fits for you.

a. ______ I’ve never provided domestic violence services
b. ______ less than one year
c. ______ 1-5 years
d. ______ 6-10 years
e. ______ 11-15 years
f. ______ 16-20 years
g. ______ more than 20 years
31. How many years in total have you provided sexual assault services, as a staff member (not volunteer), at this agency and any agency? Please check the answer that best fits for you.

a. _____ I've never provided sexual assault services
b. _____ less than one year
c. _____ 1-5 years
d. _____ 6-10 years
e. _____ 11-15 years
f. _____ 16-20 years
g. _____ more than 20 years

32. Please estimate what percentage of your time is spent providing direct services to clients (i.e., directly providing crisis, advocacy, counseling, and other services to clients). Please check the answer that best fits for you.

a. _____ 25% or less
b. _____ 25-50%
c. _____ 50-75%
d. _____ more than 75%

33. Please tell us the highest level of education you completed. Please check the answer that best fits for you.

a. _____ some high school
b. _____ high school/GED
c. _____ some college
d. _____ completed community college/associate degree
e. _____ completed 4-year university/college degree
f. _____ completed graduate education (i.e., masters or doctoral degree)
34. If you have completed an associate, college, or graduate degree, is your degree in a human service field such as counseling, marriage and family therapy, psychology, or social work?

a. ______ no
b. ______ yes
c. _______ this question does not apply to me

35. Is there more you would like to tell us about your agency or yourself? Please write any comments below.

THANK YOU FOR COMPLETING THIS SURVEY. YOUR ANSWERS AND TIME ARE VERY IMPORTANT TO THIS RESEARCH!