A Toolkit for Coalitions to Review Services, Contexts, and Capacity at Local Rape Crisis Centers

WITH A CASE STUDY FROM NORTH CAROLINA

By

Mary Koenig

A paper presented to the faculty of The University of North Carolina at Chapel Hill in partial fulfillment of the requirements for the degree of Master of Public Health in the Department of Maternal and Child Health.
Chapel Hill, N.C.

November 14, 2017

Approved by:

_____
First Reader

_____
Second Reader

Introduction

This paper stems from an exploratory assessment project conducted at the North Carolina Coalition Against Sexual Assault (NCCASA), an inclusive, statewide alliance working to end sexual violence through education, advocacy, and legislation.[1] Among other services provided to its member programs—local rape crisis centers (RCCs) or dual domestic violence/rape crisis centers in North Carolina—NCCASA provides training and technical assistance to help these agencies bolster their sexual violence (SV) primary prevention programming.

Conversations with NCCASA staff members revealed a knowledge gap regarding SV prevention programming, contexts, and capacity at RCCs across North Carolina. In order to provide the best training and technical assistance services possible to statewide RCCs, NCCASA aims to keep a finger on the pulse of services, contexts, and capacity at each RCC. To this end, during the summer to fall of 2017, NCCASA interns assessed prevention programming at North Carolina's RCCs and prepared a report to help NCCASA better understand programs, community contexts, and capacity at RCCs regarding SV prevention programming. Overall, semi-structured phone interviews were completed with staff from 54 North Carolina RCCs, focusing on the prevention programs currently offered, goals for future programs, and barriers to meeting those goals.

Most published research articles are focused on project outcomes, and very often the implementation evaluation, along with challenges faced and course adjustments required, are not fully explored in such outcomes-based studies. Although many state coalitions have likely conducted similar assessments, few implementation guides and other related resources to help coalitions understand, plan, and carry out such large-scale and time-consuming assessment projects are publicly available. In the words of a key informant from NCCASA's Statewide Member Services Planning Initiative in 2016: **"There's tremendous wisdom… but we exist too much in silos. There is not enough collaborative work to maximize resources."**[2]

This paper is shared in the spirit of this statement, with a goal to offer a compilation of information, steps taken, and lessons learned during NCCASA's project, so others in the field who aim to conduct their own similar project may do so without reinventing the wheel, thus potentially saving time, funds, and other resources. This guide is for statewide coalitions who are working with many agencies in various counties, but may be used by individual agencies as well. Along with other assessment and evaluation activities at statewide coalitions, conducting such a project could be one important way to improve training, technical assistance, and other services for RCCs, and therefore more effectively combat sexual violence.

In summary, this paper is intended to:

1) Provide step-by-step instructions for statewide agencies such as coalitions to gather information about services, contexts, and capacity at local agencies in their state, with special focus on sexual violence prevention work;
2) Relate the work to theory/models and previous practice wisdom; and
3) Add to practice wisdom by sharing methods, findings, and lessons learned from a project conducted in North Carolina.

Table of Contents

Background information

Sexual violence (SV), defined by the Centers for Disease Control (CDC) as sexual acts committed against individuals without their freely given consent,[3] is a pervasive public health problem with immense and long-term impacts to both individuals and communities. According to an analysis of several nationwide surveys, about 1 in 5 women and 1 in 71 men in the U.S. experience rape during their lives.[4] Those most at risk for SV are those from 18 to 24 years of age.[5] Disparities also exist by race, with women who identify as multiple race or American Indian/Alaska Natives having a higher percentage of reported experiences of rape or attempted rape in their lifetimes.[5] Additionally, students who identify as transgender, genderqueer, and gender non-conforming report higher rates of SV compared to their cisgender counterparts, both female and male.[6] The high prevalence of SV throughout the country—with actual rates likely being higher due to underreporting—demonstrates the need for effective programs, interventions, and service systems to address and prevent SV.

People have mobilized against SV in various ways throughout history. Across the U.S., particularly in the past 40 years, community members have organized to support survivors by establishing rape crisis centers (RCCs), agencies whose main purpose is to support and advocate for, and with, sexual violence survivors.[7] Many of these agencies are dual sexual violence/intimate partner violence (SV/IPV) agencies, and commonly provide both violence prevention or community education and crisis response services. With increased professionalization of the RCC movement, agencies frequently serve as both social service providers offering crisis response services to survivors of violence and social change agents implementing programs to change their communities and reduce the prevalence of violence.[8]

Many U.S. states have rape crisis agencies that serve counties or other smaller areas in addition to statewide coalitions that work with county-level agencies. These statewide organizations can function as membership associations for local service providers and often coordinate statewide work; provide training, technical assistance, and guidance to member RCCs; advise on public policy issues; and/or manage contracts or funding sources for local RCCs.[7]

Because state coalitions often work with numerous local agencies and operate on little funding, it can be difficult to keep tabs on the often-changing services, community contexts, and capacity at RCCs around the state. However, it is crucial that coalitions are aware of what is happening at the local level so they can (1) provide accurate training and technical assistance to help RCCs accomplish their aims, regarding both prevention and response and (2) better advocate on behalf of individual RCCs and the anti-violence field as a whole.

Why is it important to know what's out there?

What are agencies in my state doing to prevent sexual violence in their communities? What are the unique barriers and facilitators of prevention work in different counties and communities? What are the similarities? And how can coalitions help local agencies leverage their unique strengths?

If you've asked yourself any of these questions, you may want to conduct a survey of the programs going on around your state. In addition to answering these questions, there are many reasons a state sexual assault coalition may want to conduct a survey of local RCCs in their state. Some of these reasons are:

1. **To stay aware of programming and services in your state.** Perhaps the most obvious reason that a statewide coalition may want to conduct a survey of local agencies in their state is to get an idea of the range of services that are being provided. Often, knowledge about what's happening at local agencies can fall through the cracks, particularly in more rural areas.[7] By conducting a project like this one, which intentionally includes all relevant agencies in the state, you may be able to address this disparity. Having real-time data on the state of the field as well as individual RCCs' needs allows the state coalition to educate policymakers and others, therefore serving as an effective advocate for their state's RCCs.
2. **To define state prevention goals.** By developing baseline measures, coalitions can see how programming changes over time.[9] Baseline measures can help coalitions assess whether RCCs' prevention interventions are successful in their communities so they can share effective interventions with other RCCs.[10] They can also help coalitions create SMART prevention goals for the entire state using these baseline data—for example, "reduce the prevalence of SV from baseline by 25% within two years." According to Victoria Camp, deputy director of the Texas Association Against Sexual Assault (TAASA), providing RCCs with standardized outcomes and models reduces workload and stress at RCCs.[11] Sharing standardized outcomes can also leave more time and resources for RCCs to devote to program implementation rather than evaluation.
3. **To identify knowledge gaps at RCCs.** By identifying knowledge gaps, coalitions can strategize what content to include in future training and technical assistance to close those gaps. Identifying the specific issues and barriers that need to be addressed can help save time and resources by avoiding implementing unnecessary interventions. This is crucial in a field that often works with limited funding.
4. **To strategize creative ways to engage RCCs in improving their services.** For example, you may be able to learn what presentation styles or settings are most effective for RCCs to learn new skills and brainstorm ideas for potential future work.
5. **To connect RCCs with each other and the coalition.** Contacting RCCs and opening lines of communication is useful on its own. For example, in the case study, we found that those we communicated with for the project were then more likely to reach out to the coalition again to follow up and ask more questions about how to conduct prevention

programming. You may also be able to use the information you gather to arrange cohorts based on capacity, barriers, or other factors, or share the findings with RCCs and connect them to others doing similar work. Through these collaborative engagements, positive learning communities may develop that are both inspiring and practically useful to the state and individual RCCs.

6. **To advocate for more funding from grants**. Through a statewide survey, coalitions can help agencies show that programs are working, track changes over time, and advocate for additional technical assistance funds or money to expand programming.

State coalitions are uniquely able to conduct a project like the one described in this report, as they likely already have established connections with a large number of RCCs in their state. Conducting a similar project can improve the services offered *by* RCCs, as well as services offered *to* RCCs by the state coalition.

Why focus on (primary) prevention?

Statewide assessment projects can explore any services that they identify as important, but for this guidance document a choice was made to focus on prevention for several reasons:

1. Public health underscores the importance of prevention.[12] Despite this, prevention programming is often sidelined when RCCs are faced with funding cuts in comparison to response services, which are often considered more pressing.[13] For this reason, coalitions should assess RCCs' prevention programming and contexts so they can strategize about how to increase RCCs' prevention capacity.
2. Because SV prevention interventions are difficult to assess and the field is relatively new, little is known about the effectiveness of prevention interventions in general.[14] A statewide assessment project could add to a growing body of research about what makes prevention interventions effective—particularly if you explore the role of community contexts, a major gap in this body of research.[14]
3. Though there is variation between the states on exact requirements, SV prevention education is a core standard in some form in almost every U.S. state.[11] This underlines the importance of prevention work—and therefore, the importance of measuring what prevention work is being conducted.
4. NCCASA identified a gap in their knowledge about prevention programming being offered at RCCs across the state.

How coalitions can examine rape crisis centers' prevention programming across their state

This section contains background information and a how-to guide for coalitions to conduct a project to examine RCCs' prevention programming across their state. A case study, described below and incorporated throughout each step, is used to share an example of how this process plays out in the real world and present lessons learned that could be incorporated into future work by other coalitions. The overall goal is for others in the field to use our experience and lessons learned to conduct similar projects with less effort and resources required.

Case study overview

The case study project was conducted in the summer and fall of 2017 at the North Carolina Coalition Against Sexual Assault (NCCASA), an inclusive, statewide alliance working to end sexual violence through education, advocacy, and legislation.[1] Among other services provided to local rape crisis center member organizations, NCCASA offers training and technical assistance to help RCCs bolster their prevention programming in their community. As of September 2017, there are 74 local rape crisis centers (RCCs) across North Carolina, most of which are dual programs connected to domestic violence (DV) agencies.[2] For a map of rape crisis centers in each county, see Appendix A.

Despite the importance of coalitions having an understanding of services offered at RCCs throughout their state, undertaking a project to gain such an understanding is often difficult due to funding and resources at the coalition, the often-changing nature of RCCs, and prioritization of issues that can seem more pressing. NCCASA staff identified a gap in knowledge regarding services, contexts, and capacity at North Carolina's RCCs, with particular focus on prevention. This project was conducted to close that gap with the goal of gaining a better understanding of:

1. What rape crisis centers around the state are doing to prevent SV in their communities
2. What community contexts they are doing this work in—barriers and facilitators; and
3. Their capacity to do prevention work.

NCCASA aims to use this information to get a better idea of services offered in North Carolina and tailor their training and technical assistance to the needs of RCCs in the state.

In the summer and fall of 2017, two NCCASA interns (with supervision from NCCASA's Director of Prevention and Evaluation) conducted in-depth semi-structured interviews with staff from 54 RCCs total. Interview questions centered around prevention programming and community-level work, community partnerships, barriers to conducting prevention work, and understanding of social justice issues. Interns took notes during each call and analyzed notes by extracting relevant information and identifying key themes using Google Spreadsheets. This information and key themes will be presented throughout this paper, and lessons learned from the project will be incorporated in each step of the step-by-step guide.

How can you examine programming across your state?

State coalitions and other macro-level anti-violence organizations have employed various strategies to examine programming across their state. For example, Wasco et al. (2004) worked collaboratively with the University of Illinois at Chicago and the Illinois Coalition Against Sexual Assault (ICASA) to evaluate services provided to SV victims in Illinois using interviews and self-report questionnaires at the point of service during hotline calls or counseling services.[15] Their findings provided some of the first empirical documentation of RCC service effectiveness across an entire state.[15] This study engaged directly with survivors to evaluate the quality of RCC services in a state. Engaging directly with programs' beneficiaries also has advantages: it can help you understand what works from the perspective of those most directly affected, it can empower and provide a voice for marginalized groups, and it can fit into a larger participatory effort involving grassroots and survivor-led work.[16]

However, engaging with program beneficiaries also has key disadvantages—for example, it may be difficult and time-consuming to engage beneficiaries, establish trust and buy-in, and record and report findings.[16] These disadvantages can be further exacerbated by the sensitive nature of SV service provision. In Wasco et al.'s study, 22.4-24.4% of survivors engaged at the point of contact were too upset or distressed to complete the evaluation.[15] The researchers concluded that both the validity of the data and the well-being of the participants may have been compromised, and alternative ways to explore RCC services should be explored.[15]

One such alternate way is to engage RCC workers as key informants rather than engaging with survivors. Several examples of this type of project are available in the literature. For example, Wasco and Zadnik (2013) conducted semi-structured 60-minute interviews with key informants in different campus stakeholder groups to assess campus readiness to implement SV prevention programming.[9] Townsend and Ullman (2007) interviewed key informants from RCCs in order to better understand the barriers that RCC workers may face when advocating for survivors.[17] Townsend (2012) employed key informant interviews with RCC workers as part of a national strengths and needs assessment that also utilized surveys, focus groups, and a questionnaire.[18]

Focus groups, interviews, and surveys are common methods that can be employed to identify and prioritize community needs.[12] Conducting in-depth key informant interviews—either on their own or among other methods—may be appropriate for your project if you are interested in gathering information about a community problem or issue, understanding community motivations or beliefs, discussing sensitive topics and getting candid or in-depth answers, or engaging people with diverse backgrounds and opinions.[19] Key informant interviews have been used successfully in a number of community assessment projects, often conducted via telephone.[20]

Key informant interviews can be an affordable and efficient way to gain a big picture idea of a community problem or situation.[21] The information gathered during key informant interviews will be relevant and insightful, and may allow for creative ideas or unanticipated concepts to emerge.[21] However, some limitations should be kept in mind. First, as in any interview project,

interviewers may unknowingly influence key informants' responses;[21] this can pose a particular risk when the topic of discussion is associated with stigma or strong emotions, such as SV or other types of violence. Bias can also be introduced if key informants are not selected carefully, or if informants more likely to participate are also more likely to give certain answers.[21] Qualitative data may also be time consuming to code and systematically analyze if in large amounts; and the validity of the data you collect in key informant interviews may be difficult to prove or otherwise not accepted by individuals or groups who prioritize quantitative data.[21] Key informant interviews may be the most acceptable method only in certain circumstances.

When deciding who to collect information from in your assessment, the "research question"—or what you want to find out or assess—should determine the method you use, not the other way around.[11] Because the goal of the case study project is to understand the programs being implemented at various RCCs around North Carolina, as well as the community factors and contexts surrounding the work and each RCC's capacity regarding prevention programming, the project engages RCC workers as key informants.

The case study project also utilizes phone interviews. Phone interviews were chosen to enable those conducting the project to elicit additional information by probing and to allow us to explain questions if necessary to avoid misunderstandings that can arise in other methods like online surveys. The case study was conducted by a team of two NCCASA interns, to increase our ability to take detailed notes while leading an interview; as well as to enable us to determine interrater reliability in coding the interviews.

The case study engaged with key informants identified at each RCC. Two NCCASA interns reached out to executive directors or other points of contact that NCCASA had at each RCC and asked them to identify an individual at the agency who would be a good person to talk with about prevention programming at the agency. See Appendix C for more information about identified key informants and Appendix E for the initial contact email used to identify key informants. Key informants were engaged to complete short (~30-45 minute) semi-structured phone interviews about prevention programming at their agency. A more detailed account of this process is provided as part of the how-to guide section of this paper.

Overall, evaluation and assessment projects are best when they are based on multiple sources of information and uses multiple methods of measurement.[22] For example, a project that includes an online questionnaire, a qualitative survey, focus groups, and interviews may reveal both a breadth and depth of data that is difficult to achieve through just one method. However, maximizing the usefulness of the data you collect must be balanced with the realities of working with RCCs and of working within a coalition context. Lessons learned during the case study regarding this balance are explored in the next section of this paper.

Considerations to keep in mind when working with rape crisis centers

Several considerations should be kept in mind when reaching out to and working with RCCs in your state. Some lessons we learned while conducting this project were:

- **Keep in mind the day-to-day realities of working at an RCC.** RCCs, particularly those working with fewer resources, may not have the time or bandwidth (amongst busy schedules and the nature of crisis work) to participate in your project. In the case study, this was an important data point in itself. You may want to keep track of how many times it takes you to reach out to get a hold of someone at the RCC. Those listing out-of-date contact information may be experiencing turnover, and those who are more difficult to communicate with may be working on many other projects at once. See Appendix A for a map of RCCs contacted.
- **Meet RCC workers where they are.** Because the best data is both qualitative and quantitative,[22] we considered including both a semistructured phone interview and an online questionnaire. However, based on feedback from NCCASA staff that RCCs would be more likely to complete a phone interview than an online questionnaire, we used semistructured phone interviews only. We also had more success, particularly with rural RCCs, making the initial contact via phone rather than via email. We theorized that this could be because while not all RCCs use email regularly, almost all conduct important work over the phone.
- **Balance what you want to know with how much time RCCs can spend.** In the case study, our original list of questions to ask was pages long—since so little is known about prevention interventions, contexts, and capacity; there was so much that NCCASA wanted to know. The list of questions was pared down significantly so we could be respectful of RCC workers' time.
- **Formulate questions intentionally.** In the new and developing field of SV prevention, jargon is often used that means different things to different groups of people (such as "upstream," "primary/secondary/tertiary"). As much as you are able, formulating questions that avoid the use of jargon without defining it can help eliminate confusion and misinterpretation of questions. Further, while RCC workers whose positions solely focus on prevention may be practiced in answering questions about what prevention means to them, RCC workers who spend most of their time responding to crises may have had fewer opportunities to sit down and brainstorm prevention strategies. All RCC workers can give important insights and ideas about prevention. Formulating questions that spark interactive discussion can be one way to elicit insights from RCC workers who have less often been asked to describe their vision for prevention.

In addition, those implementing a similar project may be working with limited funding and resources at the state level coalition. For this reason, the case study project uses software that can be accessed for free online, rather than more expensive qualitative data analysis programs such as Atlas ti. Additionally, phone interviews were used rather than face-to-face interviews in order to contact as many RCCs as possible in a limited time.

Step-by-step guide

The following is a step-by-step guide to help coalitions implement projects to assess programs, contexts, and/or capacity at RCCs around their state. The specific steps taken will depend in part on the project's goals. After clear goals are defined, they can guide the planning process.[11]

For example, the case study's goals were to gain a better understanding of:

1. What rape crisis centers around the state are doing to prevent SV in their communities
2. What community contexts they are doing this work in—barriers and facilitators; and
3. Their capacity to do prevention work.

We aimed to use this information to tailor training and technical assistance services at NCCASA to the needs of RCCs in the state.

The above goals guided planning for the case study, which will be incorporated in the latter half of each step's section.

Step 1: Frame the project and get your bearings

Step one of your project should be establishing a base of understanding and formulating a strategic plan to implement the project. This includes reviewing what is already known—both at the coalition and in the literature; identifying learning goals and clarifying your purpose; identifying key informants if necessary; and creating a timeline for implementation of the project. It could start with something as informal as a conversation with others at your coalition or organization about what's well-documented, what's well-known but not yet documented, and what the coalition still has questions about.

Overall, creating a plan is crucial to ensuring that your project is carried out to achieve your goals in a way that aligns with your organization's values.[23] For example, if your coalition sets out to increase communication with and solicit input from agencies of varying capacity in various communities—not just those that are most often in contact with the agency—creating a plan can help keep them accountable to those values. A plan also creates an easy-to-follow roadmap that you can refer back to.[23]

Review what is already known

The first thing a coalition should do before implementing a project to better understand programming, contexts, and capacity across their state is to **get an idea of what is already known**. This involves discussion with staff at the coalition as well as a thorough review of previously documented contexts, needs, and strengths in the state. You may want to review:

- The results of member services surveys or focus groups
- The results of previously conducted similar projects
- Lists of agencies that have participated in coalition trainings or engaged with the coalition in other ways
- Training and program notes at the coalition
- Published research focusing on your state or area of interest
- Any other resources suggested by coalition staff

Overall, before implementing the case study, NCCASA interns reviewed:

- The results of a similar, smaller scale project conducted in 2015
- Lists of RCCs that had participated in NCCASA trainings since 2015
- The results of a 2015 member services focus group project
- Literature published on North Carolina anti-violence agencies and service providers

Interns also accessed expertise within NCCASA, communicating with various staff members to begin forming a list of questions to ask RCCs. More information on each of these information sources is provided below.

The results of a similar, smaller scale project conducted in 2015

A similar, smaller-scale project was implemented at NCCASA in 2015, which helped us to both establish a baseline and prompt conversations about what should be changed or added for the next wave of data collection.

Three questions from the 2015 phone survey related to prevention programming and were therefore of interest to us for this project:

1. What does sexual violence prevention programming look like?
    a. How long are prevention sessions?
    b. How many sessions in a full training?
    c. How often do sessions occur?
    d. Where do sessions take place?
    e. What is the content of your prevention programming?
    f. What groups/populations does your training target?
    g. Who are your community partners?
    h. How do you evaluate your prevention programming?
2. If you were asked to do a one-hour training for college students with little guidance, what would be your focus?
3. If you were asked to do a one-hour training for K-12 students with little guidance, what would be your focus?

The latter two questions were used to identify RCCs' location along a continuum of technical assistance needs. The pilot phase of our project aimed to collect information from one RCC at three different locations along this continuum to allow interns to assess the appropriateness of interview questions for RCCs with varying technical assistance needs. See Appendix B for findings from the 2015 survey and more information on how they were used to create this continuum.

Lists of RCCs that had participated in NCCASA trainings since 2015

NCCASA interns obtained lists of all registered participants in one of two Sexual Violence Primary Prevention 101 trainings held by NCCASA since the spring of 2015, when the previous project was conducted. NCCASA interns aimed to use these lists to compare the differences between RCCs that had participated in NCCASA primary prevention 101 trainings and those that

had not between the 2015 and 2017 projects. The goal was to determine whether there was a connection between participation in the primary prevention 101 training and increased knowledge of primary prevention strategies and/or increased prevention programming offered.

The results of a 2015 member services focus group project

Beginning in the fall of 2015, NCCASA conducted a series of six listening sessions with RCCs across the state.[2] 54 out of the 74 RCCs in North Carolina (73%) had at least one representative participate in a listening session. Listening sessions contained questions about what makes North Carolina RCCs strong, agencies' ideal sexual assault services, barriers to achieving this ideal, and how NCCASA can help address those barriers. NCCASA also conduced key informant interviews with Council for Women Region Directors and gathered information from NCCASA technical assistance providers and analyzed data from the listening sessions, key informant interviews, and information from technical assistance providers.

Overall, four primary themes emerged in the analysis of all three data sources:[2]

1. *Rape crisis center capacity and credibility*, including organizational structure and resources, services and programming, and a statewide network.
2. *Community partnerships*, including RCCs' partners in the community; their values, skills, and knowledge; and models for partnership such as sexual assault response teams.
3. *Funding*, including the amount of funding available, what it is allocated to, any restrictions and costs to be covered.
4. *Social/community climate*, including culture, education and engagement, and services and systems.

NCCASA extracted relevant quotes from participant RCCs with each theme and used the primary themes to identify cross-cutting strategies for NCCASA to implement in order to better help RCCs achieve their aims. Topics to address during training and technical assistance were also identified, including advocating for policy change; exploring alternatives to criminalization; volunteer recruitment, engagement, and retention; and movement-building.[2]

Reviewing the results from this project was important for the case study. NCCASA interns were able to continue to establish a baseline to compare our findings to, as well as to begin discussing potential methods for gathering related information focused on prevention programming. The results of the member services survey also highlighted the importance of using assessment findings to coordinate NCCASA services and connect RCCs across the state with others doing similar work or facing similar barriers.

This importance was clear in quotes from participants from RCCs: "Isolated interventions in each community are not going to have a collective impact on this issue. There's tremendous wisdom across our state, but we exist too much in silos. There is not enough collaborative work to maximize resources."

And quotes from technical assistance providers at NCCASA: "How can we all be on the same page more and coordinating our efforts so that it is meeting the needs of local programs and

not conflicting with each other or duplicating each others' efforts? How can we supplement and complement each others' work?"

Literature published on North Carolina anti-violence agencies and service providers

Interns used Google Scholar and UNC library resources to conduct a thorough search of the literature, focusing on SV/IPV oriented agencies located in North Carolina, their employees, and the services they offer. Articles of note are summarized below.

Macy, Giattina, Parish, and Crosby (2010) examined challenges at North Carolina domestic violence and sexual assault agencies using focus groups and interviews.[24] The researchers had three research questions:

1. What challenges do agencies face regarding their capacities to endure?
2. What challenges do agencies face regarding their capacities to focus on social change?
3. What unanticipated challenges do agencies face?

Macy et al. conducted 7 focus groups and 12 interviews with agency directors and funding staff at North Carolina domestic violence and sexual assault agencies and used an open-coding approach to identify seven challenges faced by these agencies: funding, sustainability, community norms, tension between grassroots versus professional service providers, lack of attention to sexual assault, the need for welcoming services for all survivors, and the need for comprehensive services to help survivors with co-occurring mental illnesses and substance abuse problems.[24]

Another paper by Macy, Ogbonnaya, and Martin (2015) presents the findings from a statewide survey of domestic violence and sexual assault agency directors.[25] Eighty agency directors (a 77% response rate) participated in the survey, which elicited their opinions on what information should be collected from victims to evaluate the helpfulness of services commonly provided to them, including legal advocacy, medical advocacy, group services, individual counseling, and shelter.[25] Agency directors ranked victims' satisfaction with services, their progress toward meeting their goals, and changes in their knowledge as important, as well as changes in the extent of violence and/or trauma that victims experienced.[25]

North Carolina RCCs were also included in a study conducted by Maier (2011), which investigated the extent and effects of lack of funding.[26] Maier conducted interviews with 63 rape crisis workers and volunteers with 6 RCCs located in four East Coast states, including North Carolina.[26] The researcher found that RCCs in those states continued to struggle financially and experience reductions in funding, leading to numerous challenges including elimination of staff positions, burnout of remaining staff and volunteers, reduced victim services, compromised efforts to recruit and train volunteers, and limited community education and outreach.[26]

O'Sullivan and Carlton (2011) compared 8 independent, autonomous RCCs (focused on sexual violence) to 8 multiservice centers (offering combined services in sexual violence and domestic violence) in terms of their victim services and community outreach efforts.[27] They found that dual or multiservice centers heard from far fewer sexual assault victims, did not routinely receive requests for hospital advocates, and did not provide systematic community education.[27]

The autonomous RCCs provided more comprehensive community education, were more likely to initiate community education programs targeted at young people and males, promoted more inclusive definitions of sexual assault, and incorporated cultural concerns in assessing their services and outreach.[27]

This existing body of research gave us a base from which to work and sparked questions and conversations about what information we should look for. For example, based on O'Sullivan and Carlton's (2011) findings, we decided to code for autonomous RCCs versus dual service agencies.[27] We also noted that funding was a major challenge to RCCs identified by both Maier (2011) and Macy et al. (2010).[24,26] Therefore, we made a note to pay special attention to what interviewees said regarding funding and its role as a barrier or challenge.

Identify your learning goals and clarify your purpose

After gathering and reviewing existing data, determine what additional information you want to collect. You may want to brainstorm a long list of questions, select and highlight those that aren't answered by existing data and then further refine the list based on feedback from others at your agency. What should emerge is a thorough list of questions and learning goals, in addition to a clarified purpose for your project.

Questions will depend on your specific area of interest, but our final list of questions included:

- What are North Carolina agencies doing to prevent sexual violence in their communities? Are the programs offered effective?
- What are the unique barriers and facilitators of prevention work in different counties and communities? What are the similarities?
- How can the coalition help local agencies leverage their unique strengths?

In turn, the list of questions you have should determine your methods of inquiry—in other words, the type of project you will undertake.[11]

Type of project	When it may be appropriate
Online questionnaire	If most of your questions are preliminary in nature or only require reporting of lists or numbers, you may want to use an online questionnaire, particularly if anonymity may be important to participants.
Paper and pencil questionnaire	If you are interested in collecting straightforward information at the point of service or after a training, a paper and pencil questionnaire may be an appropriate method.
Focus group	If you would like participants to be able to expand on each others' ideas and perspectives and get an idea of group consensus, focus groups may be an appropriate method. Focus groups afford a great deal of flexibility, as they often spark debate and conversation.[28]

In-person interview	If you are able to arrange in-person interviews logistically, they may be a good method to ask in-depth questions, probe for more information, and make note of nonverbal cues and responses.[28] You may also be able to use a more complex questionnaire and have more flexibility in what you can ask and how.[28]
Telephone interview	Telephone interviews may be a good method if you are interested in asking in-depth questions and probing for more information, along with the significant cost advantage that telephone interviews bring in comparison with in-person interviews.[29] Telephone interviews may be used when in-person interviews are impractical.[28]

Based on the questions we had, we knew that we wanted to be able to elicit additional information through probing, as well as explaining any questions if necessary to avoid misunderstandings. We also wanted to be able to build rapport with participants to potentially elicit more honest responses about their agencies' services. Finally, we knew that given the nature of crisis work, RCC workers may only have a limited time to participate in our project, so we chose to utilize a single method rather than a mix. Therefore, we narrowed the type of project to one qualitative method. We chose interviews rather than focus groups for two reasons: first, that we felt we may be able to get more honest responses about communities' and agencies' shortcomings in a one-on-one setting and second, our own schedules and project timeline—as well as potential schedule limitations of participants—limited our ability to get a diverse group of RCC workers together in one place. Ultimately, we chose to conduct phone interviews rather than face-to-face interviews so we could contact as many RCCs as possible and eliminate any barriers to meeting created by funding or transportation issues.

By using a semi-structured telephone interview approach, we could include a mix of both closed-ended and open-ended questions, an approach recommended by a number of experts.[30] While closed-ended questions provide data that is relatively easy to score, analyze, and understand, open-ended questions supplement that data with rich information and stories that make that data meaningful.[30]

Identify key informants

Select key informants important to your project. To do so, reference the primary questions you would like to answer and what type of data is needed to answer those questions.[19] Key informants should be individuals with valuable first-hand knowledge about your state, county, or other community of interest—individuals who are able to give unique insight into the information you are aiming to collect.[19]

The number of key informants you choose to interview will depend on your project goals. Coalitions can decide how many key informants from which agencies to include in their project based on these goals. For example, if the goal is to understand common community contexts and dynamics in the state, key informant interviews should be conducted as necessary if inconsistencies are found "until the interviewer is confident they have enough understanding of the community dynamics."[31] If the goal is primarily to measure readiness using the Community

Readiness Model, this model's creators assert that interviews with as few as three to four key informants may be sufficient.[20,32] However coalitions narrow down their list of key informants, they should ensure that there is as much diversity as possible in terms of background, identity, or group membership in the group.[19]

For the case study, we chose to contact as many RCCs we could, since a goal of this project was to collect information we could use to tailor training and technical assistance to each individual RCC in North Carolina. See Appendix C for more information on identified key informants in the case study, including their positions within participating RCCs.

Create a timeline

A project timeline creates benchmarks so you know you are on track to complete the project as you envisioned it.[23] Coalitions can take as long as they need to implement a similar project. One consideration to take into account when building a project timeline is that participants in the project will likely be interested in seeing its results within a reasonable timeframe. See Appendix D for more information and resources from the case study.

Step 2: Create a plan for inquiry and/or interview guide

Step two is to create a plan for inquiry—in our case, an interview guide. This includes referring back to your goals from step one, developing questions based on those goals, and assembling those questions into a meaningful list. Then, solicit feedback from others at the coalition or organization to ensure that the questions are designed to elicit feedback from RCCs and

Our interview guide included questions intended to elicit more straightforward information (such as "What does sexual violence prevention programming look like at your agency?" and "Are there any paid staff at your agency who spend 100% of their time on prevention work?") and questions designed to facilitate more in-depth conversation (such as "If you lived in an ideal world, what would your prevention programming look like?").

Interns also included questions that we hoped would elicit answers about communities and other contextual factors, since previous research indicates that contextual factors exert a powerful influence on agencies' ability to support the implementation of prevention programs and policies.[51,52] That is, **prevention programming must be sensitive to context in order to be successful.** Therefore, it is important to determine community context in addition to the straightforward details of RCC programming in order to get an idea of programs' effectiveness. See Appendix F for the finalized interview guide and script.

Lessons learned

- We put a lot of work into the interview guide on the front end so we could be sure to balance the amount of time we asked busy RCC staff to spend on the phone with getting sufficient information. Even so, we could have solicited more feedback from NCCASA staff to confirm the information we collected would be practical and useful.
- It took us a few phone calls to familiarize ourselves with the script and deliver it in a way that felt natural. We could have benefited from running through the script aloud and making these changes in delivery before beginning calls.

member agencies that will be helpful in improving staff members' understanding of the state of the field, as well as their ability to strategize ways to improve the coalition's services.

After putting together your interview guide, preparing as much as possible by familiarizing yourself with the questions can help you make the most of key informants' valuable time and get the best information you can.[9] Read through the guide ahead of time, adjusting the wording so it feels more natural to you (while keeping in mind that the questions asked should remain relatively consistent across time and different interviewers).

Contact and schedule key informants

Next, contact your identified key informants and schedule interviews with them. It's useful to have an estimate of how much time the interview will take, approach scheduling with flexibility, and be ready to name a few open time slots in the upcoming days or weeks. In addition, be sure to thank participants for agreeing to work with you and be clear about the purpose of the project and any risks or benefits of participation if applicable.

First, we contacted the executive director or other primary contact at all 74 RCCs in North Carolina using contact information from NCCASA's member services initiative, which keeps an up to date directory of primary contacts at each RCC. See Appendix E for resources for the initial contact email and follow-ups.

Because the two interns working together on this project were not always in the office at the same times, we found Google Spreadsheets useful for keeping an up-to-date schedule of interview times. In a calendar template for Google Spreadsheets, the NCCASA intern who made the call appointment noted the time and date, as well as any notes to keep in mind.

Lessons learned

- We noted that the time or amount of initial contact emails/calls it took to get in touch with a key informant to interview was a valuable data point in itself, so we began to track this information.
- We also learned to reach out to schedule key informant interviews early, but not too early. Because of scheduling conflicts, we sent an initial email in July and a follow up in late August. We found this length of time was too long as we lost momentum, and some RCCs experienced turnover during that time, so our initial contact was no longer at the RCC.
- Finally, because interns were both in the office on Thursdays and Fridays, we initially aimed to schedule all calls on one of those days. However, many RCC staff we talked with seemed to have more time and flexibility (and were more likely to remember we had scheduled a call) at the beginning of the week. We adjusted our plan accordingly.

After contacting and scheduling key informants, prepare to implement your plan. At this point, be sure to continue familiarizing yourself with your interview guide, as well as reviewing any relevant guidance from experts for conducting your project. For example, because our project utilized semi-structured key informant interviews, NCCASA interns reviewed strategies for

conducting interviews, building rapport with key informants, and probing to get more detailed information.[28]

Step 3: Implement your plan

The next step is to implement your plan. You may choose to begin your project with a pilot stage, in order to determine the feasibility of the project, the process of recruiting participants, and the appropriateness of your method and questions for the range of different agencies that will be participating in the project.[33]

For example, in the case study, interns chose to begin with a pilot stage including three RCCs total—each determined (using previous data from a survey conducted in 2015) to be at a certain point in a continuum of technical assistance needs. See Appendix B for more information on how interns used data from the 2015 survey to create this continuum.

Incorporating lessons learned from the pilot stage

Before conducting the main qualitative semi-structured interviews, we piloted to two RCCs, selected purposely in order to have a mix of centers with differing technical assistance needs, among a group of RCCs that answered an initial email request to participate in the project. Although we intended to pilot with three RCCs, one was unreachable on the day of the scheduled interview.

The pilot stage gave interviewers practice conducting interviews and taking notes, and confirmed that the set of questions was appropriate for RCCs with differing technical assistance needs. It also provided an important lesson learned: When working with RCCs, it's best to send a reminder/confirmation email in the days approaching the interview and be flexible, since the nature of crisis work means that crises may come up and interfere with the interview time.

We also learned that, although many of our questions were straightforward and relatively concrete, developing rapport with key informants remained an important part of the interview process. Interviewers detected a note of hesitancy in both pilot stage key informant interviews, potentially because interviewees may have felt they were being 'tested' for funding or otherwise being judged. Interviewers made a note to begin the conversation with a warm, clear explanation of the purpose of the project and thank interviewees for helping enable NCCASA to improve their services. The explanation of the project would serve as both rapport building and an overview of what would be discussed so interviewees could begin thinking through potential answers.

Finally, interviewers noted that there were valuable observations to be made in the call that were not recorded in the call notes—such as background noise, pauses or silences, and overall tone of the call. Therefore, interviewers planned to debrief and make detailed notes on their reactions and perceptions of the call and any details not recorded in the notes

After the pilot stage, NCCASA interns continued scheduling and completing interviews. At the beginning of the project, one intern took the lead on asking questions while the other primarily focused on note-taking. However, as we became more familiar with the questions and ways to gather the information we needed, we began to use a more collaborative approach for both interviewing and note-taking, allowing one to fill in any gaps that the other missed. This helped us create a more complete set of notes as well as be sure to cover all of the questions.

We began a preliminary codebook after the two pilot interviews and three additional interviews (five interviews total). Both NCCASA interns independently went through notes taken during the five calls and began extracting relevant codes. The two codebooks were then compared and combined to create an initial coding scheme.

Step 4: Review and process the information you gathered

Finally, after gathering all the information they set out to gather, coalitions can begin to review and process this information. If you collected qualitative information and want to analyze the content, you may want to create a codebook—a collection of "tags or labels for assigning units of meaning to the descriptive or inferential information compiled during a study."[34]

Your coding process may differ based on the types of questions you asked. For example, for more closed-ended questions, information may be more easily extracted from the transcript or notes by identifying which category from a limited set of potential categories that answer falls into. Therefore, your codebook will contain a set of possible responses (such as yes/no or an option from a limited list) and brief criteria for inclusion or exclusion in those categories.

You may also want to analyze your data to identify larger themes or examine answers to more open-ended questions, which are less easily extracted from the notes or transcript. To identify larger themes, the types of codes you choose to use to extract meaning from your data depend on the type of data and your goals for the project and are explored below:

Types of codes and how they are developed	
Theory-driven	Developed a priori from existing theory or concepts
Data-driven	Developed after data collection from the raw data
Structural	Developed from the specific project's research goals and questions

DeCuir-Gunby, Marshall, & McCulloch, 2011.[35]

Developing codes to extract meaning from your data is an iterative process: that is, it requires cyclical re-examination and revisiting of either theory and concepts, research goals, or the raw data.[35] Operationalizing your set of codes into a codebook with clear rules about when to use which code helps to increase consistency between coders and distinguish between different categories in the data.[35]

A codebook includes at least three main components: (1) a code name or label, (2) a full definition of inclusion and/or exclusion criteria, and (3) and example.[35] Some suggest additional components—such as a brief definition in addition to a full definition—or expansion of the second component into a definition, inclusion criteria, and exclusion criteria separately.[35] However, which components you use depend on what you feel will be the most useful way to communicate how your information was coded and why.

Coding in the case study project

For the case study project, we utilized an open-coding approach. Most codes were data-driven; although some were theory-driven (see Appendix G for data- and theory-driven codes). Because we asked both closed-ended and open-ended questions, we chose to separate the data analysis into two phases: sorting and thematic coding. The first phase included reading through the call notes and email correspondences and extracting information from participants' answers to closed-ended questions, such as "How many paid staff spend 100% of their time on prevention work?" and "Who does your prevention programming—staff or volunteers?". We also categorized the answers to some open-ended questions, such as "What are some major barriers your agency faces to implementing prevention programming?". See Appendix G for the codebook used for this phase.

In the second phase, two NCCASA interns independently read through call notes and completed a list of salient overall themes. The interns discussed to come to a consensus of a list of 28 themes: 11 applying to the call in general, 11 applying to specific questions, and 6 to capture interviewers' perceptions. Both interns coded one third of the dataset (18 calls) independently, then met to discuss codes for that portion of the dataset and roughly estimate interrater reliability. Of the 18 calls, interns agreed on all codes for 13 (72.2%). There was particularly high interrater reliability for the question focused on how prevention programs incorporated systems of oppression: interns were in agreement on 17 of 18 calls, or 94.4%. Interns discussed inconsistencies in their chosen themes and definitions for inclusion or exclusion were refined to address those inconsistencies. Two general codes were added. See Appendix H for thematic codebook.

What now? Putting the information you collected to use, developing strategies, and disseminating knowledge

Presenting findings in a useful, accessible format

After all of your information is collected and processing it has begun, it is crucial to present your findings in a useful, accessible format so it can be shared with stakeholders and so you can avoid a pitfall that coalitions and agencies too often experience—letting rich, useful information sit on a shelf.

Due to the nature of qualitative data collection, you will likely have a rich data source, from which myriad themes and results can be extracted. What and how you choose to present findings will depend on the coalition's priorities and knowledge gaps. For example, you may want to look at RCCs' programming or capacity in relation to the population size of counties, counties served, budgets, or grant information.

Interns used Google Spreadsheets to create graphic depictions of descriptive data so both coalition staff and stakeholders could visualize our results. See Appendix I for descriptive results. We also used Google Drive and Google Spreadsheets to prepare a report of the qualitative themes that emerged from our dataset. See Appendix J for a summary of qualitative themes.

You can also present your findings using a map to depict trends. There are many examples of this in the literature: For example, Ruback and Menard (2001) mapped differences in SV reporting and incidence rates in RCCs located in urban versus rural counties.[36] We used this approach in the case study and found an interesting trend: RCCs that we were unable to contact for an interview tended to be clustered in certain areas, particularly in the western part of the state. See Appendix A for a map of the counties contacted.

Applying theories, models, and previous research

One way to get an even better grasp of what your results mean is to apply previously developed and/or validated theories, models, or conceptual frameworks about your topic of interest (in our case, SV prevention). A number of such theories, which may be useful for your project, are explored below.

Social ecological model (ecological systems theory)

The social ecological model is accepted by the Centers for Disease Control and Prevention (CDC) as a theory to explore the root causes, as well as risk and protective factors, of SV.[37] The four-level social ecological model pictured below can help us better understand violence and the effect of prevention strategies implemented on various layers of the model—that is, targeted toward individuals, their relationships, communities, or larger societal factors.[38] This model helps categorize risk and protective factors, understand how those factors interact, and strategize ways to intervene to prevent SV along the spectrum of factors affecting individuals and communities' experiences of violence.[38]

CDC, 2015

This model is useful because research suggests that work across multiple levels of the model is most likely to be sustained than any single intervention. For example, individual-level change in knowledge, beliefs, or behaviors can be supported by strategies that target the relationship and

community level factors that support SV.[39] By applying the social ecological model, coalitions can examine the level to which agencies are targeting their prevention work. This can help coalitions estimate the effectiveness of interventions and target future training and technical assistance to help RCCs expand prevention to other levels and support interventions with a multi-layer strategy.

Levels of prevention

This framework focuses on the question of *when* individuals, RCCs, communities, and coalitions can intervene to prevent public health problems like SV.[12] According to the Pennsylvania Coalition Against Rape:

- **Primary prevention** takes place before SV occurs to prevent violent behavior;
- **Secondary prevention** takes place immediately after SV occurs to prevent negative short-term effects; and
- **Tertiary prevention** takes place after SV occurs to either prevent perpetrators from recidivism or reduce long-term negative effects for survivors.[12]

Primary prevention, rather than awareness raising or risk reduction, is emphasized by most public health experts and anti-violence organizations.[12] The further "upstream" an intervention is, the more likely it is that the intervention will be effective.[40]

The levels of prevention framework can be applied to assess what level of prevention RCCs are focusing on and enable coalitions to strategize ways to increase the number and effectiveness of primary prevention programs being implemented across their state. Increasing the number

Primary prevention vs. awareness, response, and risk reduction

Because public health identifies primary prevention as the approach most likely to impact rates of SV in communities,[12] NCCASA interns were also interested in whether agencies were including content in their prevention programming that could prevent SV before it happens. Overall, 23 RCCs (43.4%) included content interns coded as "primary prevention-oriented", while 30 RCCs (56.7%) did not include such content, instead focusing on awareness, reporting or response, or risk reduction. For context, below are quotes from RCC key informants: two coded as "primary prevention" and two coded as "risk reduction."

Primary prevention:

⇒ *"Educate about how messages [about masculinity] can be harmful without alienating the community members."*

⇒ *"Explain how all these 'isms' end up going up the ladder and create unsafe spaces and marginalized groups and oppression."*

Risk reduction:

⇒ *"I want them [youth] to know what to do to make sure they aren't a target… make sure you're doing everything on your end to make sure you don't get victimized."*

⇒ *"[about a poster they put up] No one is exempt from sexual assault and these are the ways to help protect yourself… not leaving your drink uncovered, safety plans… having someone with you, not leaving your friend."*

of RCCs implementing primary prevention programs, and increasing funding allocated to primary prevention work, could have a significant effect on rates of SV in the state.[12]

Community readiness model

The community readiness model, first developed at the Tri-ethnic Center for Prevention Research at Colorado State University, is another framework that can be applied in a statewide exploratory assessment project. Donnermeyer et al. (1997) define this model as "the relative level of acceptance of a program, action, or other form of decision-making activity that is locality-based" and introduce nine stages of readiness, ranging from "No awareness" to "High level of community ownership" as depicted below.[41]

Stage of readiness[42]	Definition
1. No awareness	The issue is not generally recognized as a problem by the community or community leaders.
2. Denial/resistance	At least some community members recognize the issue as a concern, but there is little recognition of it as a concern locally.
3. Vague awareness	Most in the community feel it is a local concern, but there is no immediate motivation to do anything about it.
4. Preplanning	There is clear recognition that something must be done; maybe even with a group addressing it. However, efforts are not focused or detailed.
5. Preparation	Active leaders begin planning in earnest. The community offers modest support of their efforts.
6. Initiation	Enough information is available to justify efforts. Activities are underway.
7. Stabilization	Activities are supported by administrators or community decision-makers. Staff are trained and experienced.
8. Confirmation/ expansion	Efforts are in place; community members feel comfortable using services, and they support expansions. Local data are regularly obtained.
9. High level of community ownership	Detailed and sophisticated knowledge exists about prevalence, causes, and consequences. Effective evaluation guides new directions; community-based solutions are implemented.

The Community Tool Box, Chapter 2 Section 9.[43]

Complexity can be added to the model by splitting readiness into six dimensions:[20]

1. The community's knowledge of the problem;
2. Current efforts aimed at addressing the problem;
3. The community's knowledge of current efforts;
4. Leadership taken in those efforts;
5. Community climate; and
6. Resources that have been put toward the efforts.

Each of these dimensions can be rated at one of the nine stages of readiness, enabling the model to take into account the possibility that a community's readiness in terms of one

dimension—for example, resources put toward efforts—may be at a different stage than another dimension, such as knowledge of efforts.[32]

This model is important because a lack of readiness for programming among community members can thwart a program's effectiveness.[41] The model assumes that prevention efforts are most effective when strategies are tailored to a community's current level of readiness. Once RCCs assess which stage of readiness best describes their specific community, they can set appropriate goals for their SV prevention initiatives. Conducting a community readiness assessment, sharing its findings, and building partnerships are highly interrelated activities that reinforce one another and serve the same purpose: laying the groundwork for the success and sustainability of future activities.[20]

Applying this model can help coalitions understand and address any resistance RCCs may encounter in their communities when implementing prevention programming. It can also help coalitions examine the differences and similarities between different community contexts in different counties across their state in terms of their readiness for prevention programming. The coalition can then target training and technical assistance according to the stage of readiness found in RCCs' communities, and move the community to greater readiness, one level at a time.[43] Strategies to increase community readiness vary depending on the stage that the community is in and are explored in several papers by Edwards, Jumper-Thurman, Plested, Oetting, and Swanson.[20,42]

The community readiness model is especially useful to apply to SV prevention work, since it is often used to assess readiness around needs that may not be readily acknowledged as problems.[44] Additionally, applying the community readiness model can help you create prevention goals based on the stage of readiness you find in each RCC's community.[9]

Case study example: Estimating community readiness

In the case study, although we did not ask any questions specifically aimed to assess community readiness, many interviewees' responses about community norms or attitudes—particularly as a barrier to implementing prevention programming—hinted at where the community may fall on the community readiness model. Despite interviewers not asking any specific community context-oriented questions, 35 RCCs (64.8%) brought up community norms and contexts when asked about their programming or any barriers they faced to implementing prevention. Some examples of those responses are given below:

- ⇒ *"Whenever we do put on presentations, they're not very well attended… targeting the regular community is hard because of the mill history. People are afraid to come out to meetings and organize because we had organizing beaten out of us."*
- ⇒ *"One thing I've noticed, I wouldn't say it's a barrier per se, our name is rape crisis center when I go out in the community to do awareness, it says rape crisis center, some people look at it and are taken aback and walk away… People worry that if they work with us, they will be assumed to be a victim."*

In addition to this preliminary assessment, further investigation would be required in each community of interest to adequately assess the community's readiness for prevention programming.

However, we did use the idea of stages of readiness to create a coding scheme for our question about how RCCs incorporated an understanding of the multiple levels and types of oppression into their programming. Similar to the community readiness model, these codes roughly align to our perceptions of an RCC's readiness to engage with, and active engagement in, anti-oppression work. We added one additional category as we developed our codebook for interviewees who did not recognize oppression as a part of anti-violence work. Our coding scheme, resembling the levels of the community readiness model, is described below.

Code	Definition
0. Not interested	Interviewee does not recognize anti-oppression work as necessary to anti-violence work.
1. Not recognized as a problem	Systems of oppression, such as homophobia, transphobia, or racism, are not recognized as problems in the community or within the RCC.
2. Awareness, but no action	Interviewee indicates that RCC is aware that systems of oppression should be addressed, but does not know where to start.
3. Preplanning	The RCC recognizes that something must be done about systems of oppression and has taken some steps to do so, but efforts are not clear or focused.
4. Working on it, but experiencing barriers	The RCC recognizes something must be done and has ideas about how to do it, but experiences the community or other stakeholders' reactions as barriers to the work.
5. Active incorporation in programming	The RCC is actively incorporating a discussion of systems of oppression into prevention programming, either in schools or in the community.

Previous research on effective prevention strategies

Previous research on effective interventions to address the coalition's topic of interest for the assessment can also be applied. A base of knowledge about effective programming can enable you to compare the results of your assessment with what has been demonstrated to work. It can help you answer questions like:

Are the programs agencies are implementing effective? Are they implemented with fidelity, and if so, do they work to reduce the incidence of SV in the community?

For example, the case study focuses on SV prevention programming, so a literature review on effective SV prevention programs was completed before data collection. A systematic review by

DeGue et al. (2014) found only two primary prevention programs shown to be effective in reducing SV perpetration in a rigorous evaluation: *Safe Dates* and *Shifting Boundaries*.[45]

Safe Dates consists of a 10-session curriculum focused on "consequences of dating violence, gender stereotyping, conflict management skills, and attributions for violence" and a student theater production and poster contest.[45,46] This intervention has been evaluated in a randomized controlled trial of 14 public schools in a predominantly rural North Carolina county.[46] As compared with baseline and control schools, the students at schools that received *Safe Dates* reported less sexual violence perpetrated against their current dating partner.[46] Foshee et al. followed up on intervention schools in 2004 to determine postintervention effects four years after receiving *Safe Dates*.[47] They found that adolescents receiving *Safe Dates* reported significantly less sexual dating violence perpetration and victimization four years after the program,[47] indicating *Safe Dates* could have lasting effects to prevent SV.

Shifting Boundaries is a multi-level program that combines multiple approaches, utilizing a whole-school building-based intervention component as well as classroom lessons addressing sexual harassment, gender roles, and other precursors to teen dating violence.[48] The program's classroom component is implemented over six 45-minute long sessions with a mixed-gender 6th- and 7th-grade audience; the building-based component includes the use of building-based restraining orders, higher levels of faculty or security presence in "hot spots" mapped by students, and posters to increase teen dating violence awareness and reporting.[48] A 2013 randomized controlled study of 117 classrooms found that the building-only and combined interventions were effective in reducing peer SV perpetration and victimization at six months post-intervention.[48]

Case study example: Applying previous research on effective interventions
With this base of knowledge, NCCASA interns could apply the findings of previous research in order to better understand the programs RCCs were using and estimate their effectiveness.

In our sample of 54 RCCs, 13 RCCs (24.1%) reported using *Safe Dates* and 6 RCCs (11.1%) reported using *Shifting Boundaries*. However, more information is needed to determine whether the RCCs were implementing these evidence-based programs with fidelity. Many who reported using *Shifting Boundaries* did not mention a building-based component in addition to the classroom lessons. In addition, of those RCCs that reported using *Safe Dates* and *Shifting*

- ⇒ *"We added some stuff… bits and pieces of this program and that program… [we] tweak a few things so we don't make the superintendent unhappy."*
- ⇒ *"Safe Dates is really structured, however, I do add some things in because it's a little dated."*
- ⇒ *About a curriculum that pulls from both Safe Dates and Shifting Boundaries: "[The curriculum is] a compilation of things we found online and things we wrote; it changes year to year depending on the dynamics of the class and depends on what I think would work."*

Boundaries, many were adapting them, either to better fit perceived needs of the community, offer more relevant programming for students, or adhere to constraints placed on them by schools or school boards.

Frameworks about effective prevention strategies

However, because the anti-violence field is relatively new, little research has been conducted on programs and interventions that work to prevent SV.[14] In the absence of research, coalitions and RCCs can use frameworks and principles identified by experts, researchers, and survivors. For example, Breiding et al. (2011) write that, because research indicates that a substantial portion of violence is experienced at a young age, effective prevention interventions must begin early.[4]

A paper from Nation et al. (2003) often referenced as a "classic citation on primary prevention" identifies and defines principles of effective prevention programs.[9,49] Referencing these principles may be key to understanding why prevention strategies *aren't* working, according to DeGue et al. (2014): **"The dearth of effective prevention strategies available to date may reflect a lack of fit between the design of many of the existing programs and the principles of effective prevention identified by Nation et al. (2003)."**[45] These principles are:[49]

- *Comprehensive services*—that is, strategies should include multiple components, provide activities in multiple settings, and address a wide range of risk and protective factors.
- *Varied and multiple teaching methods*, including some type of active, skills-based component.
- *Sufficient dosage* that exposes participants to enough of the activity for it to have an effect.
- *Theory driven*; having a scientific justification or logical rationale.
- Fostering *positive, strong, stable relationships* between children and adults.
- *Appropriately timed* with regards to development in order to have maximum impact in participants' lives.
- *Socioculturally relevant*, tailored to fit within target groups' cultural beliefs and practices as well as local community norms.
- Including an *outcome evaluation* to determine whether the program worked.
- *Well-trained, sensitive, and competent staff* to implement the program. These staff should receive sufficient training, support, and supervision to implement the program, including follow-up training and technical assistance.

Similarly, Vladutiu, Martin, & Macy (2011) examined eight literature reviews of published articles and/or dissertations evaluating the effectiveness of college or university SV prevention programs between 1993 and 2005. Through systematic review, they identified characteristics of SV prevention programs that are effective at changing attitudes on college and university campuses.[50] These characteristics are:

- Professionally facilitated
- Targeted at single-gender audiences
- Offered at various times throughout students' tenure at college

- Workshop-based or offered as classroom courses with frequent and long sessions
- Supplemented with campus-wide mass media and public service announcements

The researchers also identified content areas covered in effective sexual assault prevention programs, including content on gender-role socialization, risk education, rape myths, rape attitudes, rape avoidance, men's motivation to rape, victim empathy, dating communication, and controlled drinking and/or relapse prevention.[50]

After conducting a review of what experts have identified about effective prevention interventions, coalitions can also assess the programs that RCCs are offering for how well they align with these principles and therefore, how effective they may be.

Case study example: Applying principles of effective prevention

We were interested in examining how well RCCs' programs and/or key informants' responses aligned with principles of effective prevention. For example, in our analysis of qualitative themes, we found that 14 RCCs (25.9%) brought up the importance of beginning to conduct prevention programming at a young age, a principle of effective prevention supported by SV prevention experts and researchers including Breiding et al. (2011).[4] Selected quotes are provided below.

⇒ *"We can't get in, we can't get to young people, we can't get to schools then we don't have a prayer at prevention."*

⇒ *"I start young because that's where prevention happens."*

We also found that 31 RCCs (57.4%) brought up the importance of targeting prevention programming according to age and/or explained that the RCC offered different prevention programs according to participants' developmental stage. This finding suggests that the majority of RCCs understand that prevention programming must be *appropriately timed*, a principle of effective prevention identified by Nation et al. (2003).[49]

All of the RCCs that reported offering prevention programming stated that professionals on staff implemented at least part of the programming, a principle identified by Vladutiu, Martin, & Macy (2011) as effective on college campuses.[50] However, it is worth noting that only 3 RCCs reported delivering programs on college or university campuses. Programming was most often implemented in K-12 schools (46 RCCs, 85.2%) or community spaces (40 RCCs, 74.1%), which may have different implications for what can make prevention programming effective.

Finally, 10 RCCs (18.5%) were perceived by interviewers to be implementing programming that somehow aligned with principles of effective prevention, without connecting that work to public health theories or SV prevention jargon (such as "upstream approaches," "levels of prevention," "social ecological model," etc.). This indicates that effective, competent work can be done and is being done by RCC professionals with and without formalized training in public health frameworks or SV prevention jargon.

Developing strategies

Your findings about the programs offered, RCC capacity, challenges and barriers faced, and/or community contexts should also be used to inform efforts to improve coalition services and advance the anti-violence movement. The barriers that emerge from your dataset can indicate potential strategies coalitions can employ to help RCCs bolster their prevention programming.

Case study example: Understanding barriers to implementing programming

For example, our project revealed a number of barriers that RCCs face in implementing prevention in their communities. One significant barrier, identified by 15 RCCs (27.8%), was limited funding:

- ⇒ *"When you work in this field you're not used to thinking like that, you're used to 'I have a nickel, that needs to last me the rest of the year… I have a nickel and two kids that will listen to me, let's do this.'"*

Funding streams also often came with their own limitations:

- ⇒ *"There's not a strong value put on that function [prevention]—funding in this field is very grant-driven, you do what your grant says you can do."*
- ⇒ *"We can't say 'prevention' for the grant—we can say 'education.'"*

Securing funding specifically for prevention was a challenge:

- ⇒ *"When you don't have a person [who has] been in the job long enough where they can do all the basic stuff they need to do… prevention is an advanced function. It's a more advanced thing to do prevention and look at how to get funding for that. You can't get ahead when that happens, you're lucky to not fall behind."*
- ⇒ *"The people who do RPE work have been doing it for a long time… this doesn't leave room for small up-and-coming programs and counties."*

These results indicate several potential strategies the coalition could employ to help RCCs bolster their prevention programming: (1) Providing technical assistance to coalitions on writing grants as well as securing alternative sources of funding; (2) advising RCCs on the requirements of different grants and the pros and cons of different funding streams; and (3) advocating to funders for more prevention-specific funding.

The results and raw data you collected can be shared within the coalition and used to inform future training and technical assistance strategies and target training and technical assistance to individual rape crisis centers. Aggregated, deidentified results can also be shared at the RCC level to better understand how barriers can be overcome and strengths can be leveraged. RCCs facing similar barriers or implementing similar programs can be connected to share their strategies with each other. Finally, coalitions can use information collected about community attitudes, norms, and belief systems to both (1) share relevant resources with RCCs that are tailored to addressing problematic community norms, and (2) help RCCs engage with their communities in ways that are relevant to community members.

Sharing your results and disseminating knowledge

Sharing the project's results with the RCCs or other local agencies who participated can help you keep lines of communication open, further develop trust and relationship between the coalition and local agencies, and thank agencies for their participation. Additionally, sharing the results with RCCs can help them make connections with other RCCs who are facing similar barriers or strategizing around similar programs or approaches.

Case study example: Tailoring training to knowledge gaps

Coalitions can help RCCs build capacity and leadership by providing relevant training that is tailored to knowledge gaps that you find. For example, the case study revealed several emerging topics for training and technical assistance, including:

- How to successfully apply for prevention-oriented grants such as the North Carolina Department of Health and Human Services' Rape Prevention Education grant
- How to incorporate an understanding of the multiple systems of oppression that enable violence (such as transphobia, homophobia, and racism) into prevention programming
- How to train and retain staff members and volunteers
- How to build relationships with schools, churches, and other potential sites for prevention programming

Results can also be shared with funders to help RCCs advocate for additional funding, convince funders of the importance of setting aside funds for prevention specialists, or increase the amount or quality of SV services at both autonomous and dual agencies.

Case study example: Advocating for prevention-specific funding

The most commonly identified barrier to implementing prevention programming was a lack of staff time to focus on prevention programming (compared to response or direct service work). 28 RCCs (51.9%) referred to a lack of staff time to spend on prevention when asked about barriers that the RCC faces in implementing prevention programming. 75.9% of RCCs had zero staff members who spent 100% of their time on prevention programming, and 14.8% of RCCs brought up prioritization of response services at some point in their interview. Several quotes illustrate this barrier:

⇒ *(Talking about working on prevention) "We have in our mind what we want to do and then we're hit with clients and all the sudden a month has gone by, and that's the real challenge."*

⇒ *"Funding is huge because we need somebody dedicated to that. A victim advocate is not going to be able to focus their time specifically on prevention and being out in the schools and being available and all that."*

⇒ *"When you start blurring the lines, the person in crisis is always going to take priority so it's important for RPE folks… so they're not constantly being pulled away."*

Finally, your results can also be shared more widely—for example, with coalition resource sharing projects such as the National Sexual Assault Coalition Resource Sharing Project—in order to help other coalitions and larger organizations design and implement similar projects.

Overall, conducting a statewide preliminary assessment project often yields a rich dataset that can help coalitions explore and understand programming, contexts, and capacities across their state. With this information, coalitions can continue to improve their training and technical assistance services, helping RCCs address SV in their own communities.

References

1. North Carolina Coalition Against Sexual Assault. About | NCCASA. http://www.nccasa.org/about. Published 2017. Accessed October 10, 2017.
2. North Carolina Coalition Against Sexual Assault. NCCASA Statewide Member Services Planning Initiative 2016 Summary of Results. 2016.
3. Centers for Disease Control and Prevention. Sexual Violence: Definitions. https://www.cdc.gov/violenceprevention/sexualviolence/definitions.html. Published 2016. Accessed October 10, 2017.
4. Breiding MJ, Smith SG, Basile KC, Walters ML, Chen J MM. Prevalence and characteristics of sexual violence, stalking and intimate partner violence victimization – National Intimate Partner and Sexual Violence Survey, United States. *Morb Mortal Wkly Rep*. 2011;63(No. SS08):1-18.
5. Centers for Disease Control and Prevention. Sexual Violence Factsheet. https://www.cdc.gov/ViolencePrevention/pdf/SV-DataSheet-a.pdf.
6. Rape Abuse and Incest National Network. Victims of Sexual Violence: Statistics | RAINN. https://www.rainn.org/statistics/victims-sexual-violence.
7. Bein K. *Core Services and Characteristics of Rape Crisis Centers: A Review of State Service Standards*.; 2008.
8. Campbell R, Baker CK, Mazurek TL. Remaining Radical? Organizational Predictors of Rape Crisis Centers' Social Change. *Am J Community Psychol*. 1998;26(3).
9. Wasco SM, Zadnik L. *Assessing Campus Readiness for Prevention: Supporting Campuses in Creating Safe and Respectful Communities*. Enola, PA; 2013.
10. Hampton C, Berkowitz B, Nagy K. Community Tool Box: Section 9. Developing Baseline Measures. http://ctb.ku.edu/en/table-of-contents/assessment/assessing-community-needs-and-resources/developing-baseline-measures/main. Published 2017. Accessed October 10, 2017.
11. Bein K. *Program Evaluation: Knowing Is Half the Battle*.; 2011.
12. Townsend SM. *Primary Prevention and Evaluation Resource Kit (Vol. 1)*. Vol 1. Enola, PA; 2014.
13. National Alliance to End Sexual Violence. The Need for Funding at Rape Crisis Centers. http://endsexualviolence.org/files/NAESVFundingInfographic.pdf. Published 2015.
14. Morrison S, Hardison J, Neil JO. *An Evidence-Based Review of Sexual Assault Technical Report*. Washington, D.C; 2004.
15. Wasco SM, Campbell R, Howard A, et al. A Statewide Evaluation of Services Provided to Rape Survivors. *J Interpers Violence*. 2004;19(2):252-263. doi:10.1177/0886260503260246.
16. Rabinowitz P. Community Tool Box: Section 6. Participatory Evaluation. Community Tool Box.
17. Ullman SE, Townsend SM. Barriers to Working With Sexual Assault Survivors: A Qualitative Study of Rape Crisis Center Workers. *Violence Against Women*. 2007;13(4):412-443.
18. Townsend SM. *Year 3 Report and Synthesis: National Strengths and Needs Assessment*. Enola, PA; 2012.
19. UCLA Center for Health Policy Research. Using Key Informant Interviews. *UCLA Cent Heal Policy Res*. 2016:10.
20. Edwards RW, Jumper-Thurman P, Plested BA, Oetting ER, Swanson L. Community Readiness: Research to Practice. *J Community Psychol*. 2000;28(3):291-307.
21. Macfarlan A. BetterEvaluation: Key Informant Interviews. http://www.betterevaluation.org/en/evaluation-options/key_informant_interviews. Published 2014. Accessed October 17, 2017.
22. Townsend SM. *Year 2 Report: Innovations in Prevention*. Enola, PA; 2012.
23. Heaven K. Community Tool Box Chapter 3: Developing a plan for assessing local needs and resources. Community Tool Box. http://ctb.ku.edu/en/table-of-contents/assessment/assessing-

community-needs-and-resources/develop-a-plan/main. Published 2017. Accessed October 10, 2017.
24. Macy RJ, Giattina MC, Parish SL, Crosby C. Domestic Violence and Sexual Assault Services. *J Interpers Violence*. 2010;25(3550):3-32. doi:10.1177/0886260508329128.
25. Macy RJ, Ogbonnaya IN, Martin SL. Providers' Perspectives About Helpful Information for Evaluating Domestic Violence and Sexual Assault Services: A Practice Note. *Violence Against Women*. 2015;21(3):416-429. doi:10.1177/1077801214568030.
26. Maier SL. Rape crisis centers and programs: "Doing amazing, wonderful things on peanuts." *Women Crim Justice*. 2011;21(2):141-169. doi:10.1080/08974454.2011.558802.
27. O'Sullivan E, Carlton A. Victim Services, Community Outreach, and Contemporary Rape Crisis Centers: A Comparison of Independent and Multiservice Centers. *J Interpers Violence*. 2001;16(4):343-360.
28. Vilela M. Chapter 3: Conducting interviews. Community Tool Box. http://ctb.ku.edu/en/table-of-contents/assessment/assessing-community-needs-and-resources/conduct-interviews/main. Published 2017. Accessed October 10, 2017.
29. Rahman R. Comparison of telephone and in-person interviews. *Interdiscip Undergrad Res J*. 2015;1(1):10-13. http://knowledge.e.southern.edu/jiur/.
30. Burke LA, Miller MK. Phone interviewing as a means of data collection: Lessons learned and practical recommendations. *Forum Qual Soc Res*. 2001;2(2):2-7.
31. Plested BA, Jumper-Thurman P, Edwards RW, Oetting ER. Community Readiness: A Tool for Effective Community-Based Prevention. *Prev Res*. 1998;5(2):5-7.
32. Jarpe-Ratner E, Fagen M, Day J, et al. Using the Community Readiness Model as an Approach to Formative Evaluation. *Eval Pract*. 2013;14(5). doi:10.1177/1524839913487538.
33. Abu Hassan Z, Schattner P, Mazza D. Doing a Pilot Study: Why Is It Essential? *Malaysian Fam Physician*. 2006;1(3):170-173.
34. Miles MB, Huberman AM. *Qualitative Data Analysis*.; 1994. doi:10.1136/ebnurs.2011.100352.
35. DeCuir-Gunby JT, Marshall PL, McCulloch AW. Developing and Using a Codebook for the Analysis of Interview Data: An Example from a Professional Development Research Project. *Field methods*. 2011;23(2):136-155. doi:10.1177/1525822X10388468.
36. Ruback RB, Menard KS. Rural-Urban Differences in Sexual Victimization and Reporting: Analyses Using UCR and Crisis Center Data. *Crim Justice Behav*. 2001;28(2):131-155.
37. Centers for Disease Control and Prevention. The Social-Ecological Model: A Framework for Prevention. https://www.cdc.gov/violenceprevention/overview/social-ecologicalmodel.html. Published 2015. Accessed October 10, 2017.
38. Krug EG, Mercy JA, Dahlberg LL, Zwi AB. The world report on violence and health. *Lancet*. 2002;360(9339):1083-1088. doi:10.1016/S0140-6736(02)11133-0.
39. Casey EA, Lindhorst TP. Toward a Multi-Level, Ecological Approach to the Primary Prevention of Sexual Assault: Prevention in Peer and Community Contexts. *Trauma, Violence, Abus*. 2009;10(2):91-114. doi:10.1177/1524838009334129.
40. Institute for Work & Health. What Researchers Mean By... Primary, Secondary and Tertiary Prevention. *Work*. 2015;(80):2.
41. Donnermeyer JF, Plested B a., Edwards RW, Oetting G, Littlethunder L. Community Readiness and Prevention Programs. *Community Dev Soc J*. 1997;28(1):65-83. doi:10.1080/15575339709489795.
42. Plested B a, Edwards RW, Jumper-Thurman P. Community Readiness: A handbook for successful change. *Am J Community Psychol*. 2006:1-42. http://www.triethniccenter.colostate.edu/CRhandbook.shtml.
43. Community Tool Box Chapter 2: Other Models for Promoting Community Health and

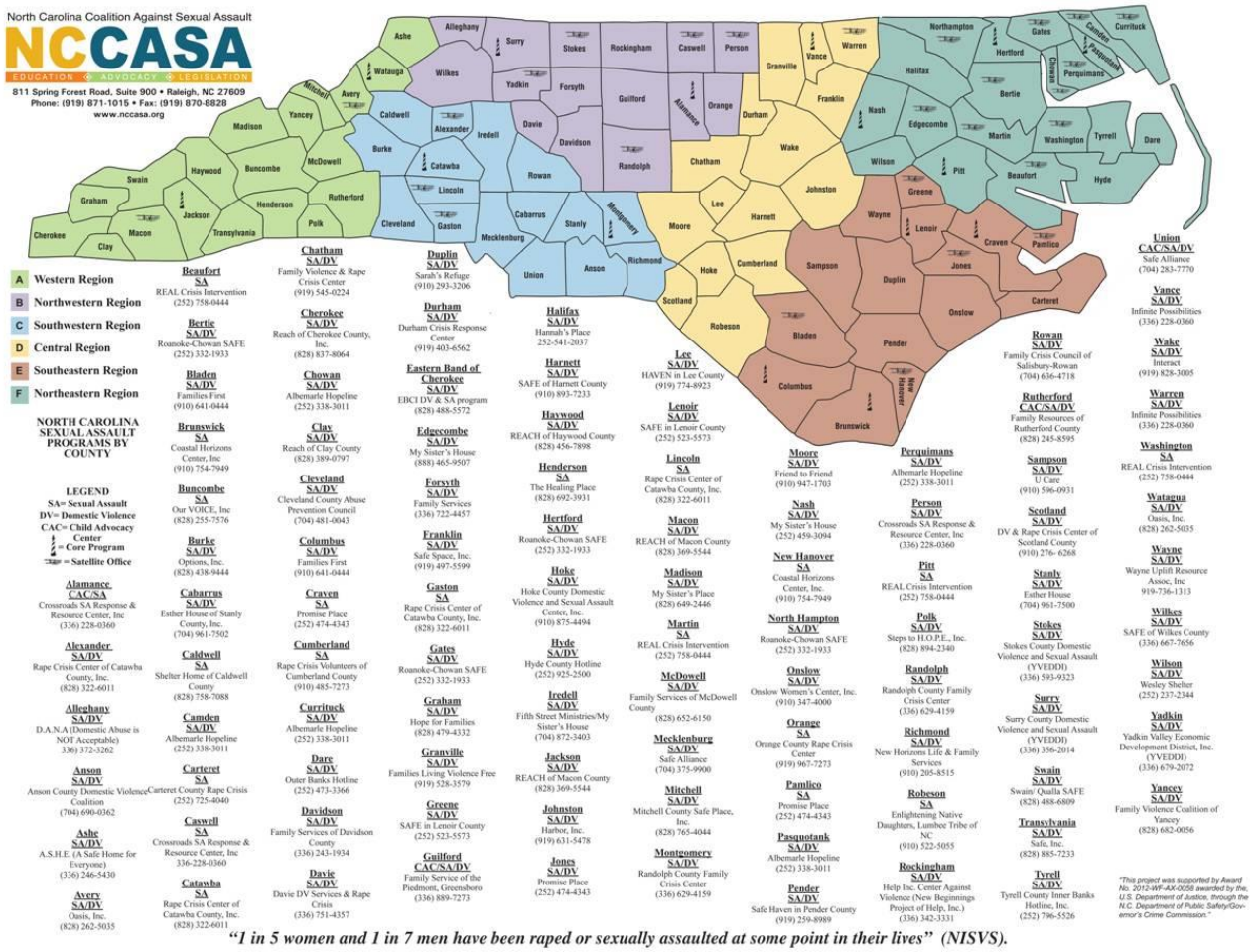
Development. Community Tool Box.
44. Oetting E., Plested B., Edwards R., Thurman P., Kelly K., Beauvis F. Community Readiness for Community Changes. *Prev Reasearch*. 1995. doi:10.1300/J125v11n03_04.
45. DeGue S, Valle LA, Holt MK, Massetti GM, Matjasko JL, Tharp AT. A systematic review of primary prevention strategies for sexual violence perpetration ☆. *Aggress Violent Behav*. 2014;19(4):346-362. doi:10.1016/j.avb.2014.05.004.
46. Foshee V, Bauman KE, Arriaga XB, Helms RW, Koch GG, Linder GF. An evaluation of safe dates, an adolescent dating violence prevention program. *Am J Public Health*. 1998;88(1):45-50. doi:10.2105/ajph.88.1.45.
47. Foshee VA, Bauman KE, Ennett ST, Linder GF, Benefield T, Suchindran C. Assessing the Long-Term Effects of the Safe Dates Program and a Booster in Preventing and Reducing Adolescent Dating Violence Victimization and Perpetration. *Am J Public Health*. 2004;94(4):619-624. doi:10.2105/AJPH.94.4.619.
48. Taylor BG, Stein ND, Mumford EA, Woods D. Shifting Boundaries: An Experimental Evaluation of a Dating Violence Prevention Program in Middle Schools. *Prev Sci*. 2013;14(1):64-76. doi:10.1007/s11121-012-0293-2.
49. Nation M, Crusto C, Wandersman A, Kumpfer KL, Morrissey-kane E, Davino K. What Works in Prevention: Principles of Effective Prevention Programs. *Am Psychol*. 2003;58(6):449-456. doi:10.1037/0003-066X.58.6-7.449.
50. Vladutiu CJ, Martin SL, Macy RJ. College- or University-Based Sexual Assault Prevention Programs: A Review of Program Outcomes, Characteristics, and Recommendations. *Trauma, Violence, Abus*. 2011;12(2):67-86. doi:10.1177/1524838010390708.
51. Brown LD, Feinberg ME, Greenberg MT. Determinants of community coalition ability to support evidence-based programs. *Prev Sci*. 2010;11(3):287-297. doi:10.1007/s11121-010-0173-6.
52. Brown LD, Feinberg ME, Shapiro VB, Greenberg MT. Reciprocal relations between coalition functioning and the provision of implementation support. *Prev Sci*. 2015;16(1):101-109. doi:10.1007/s11121-013-0447-x.

Appendices: Resources and results from the case study project

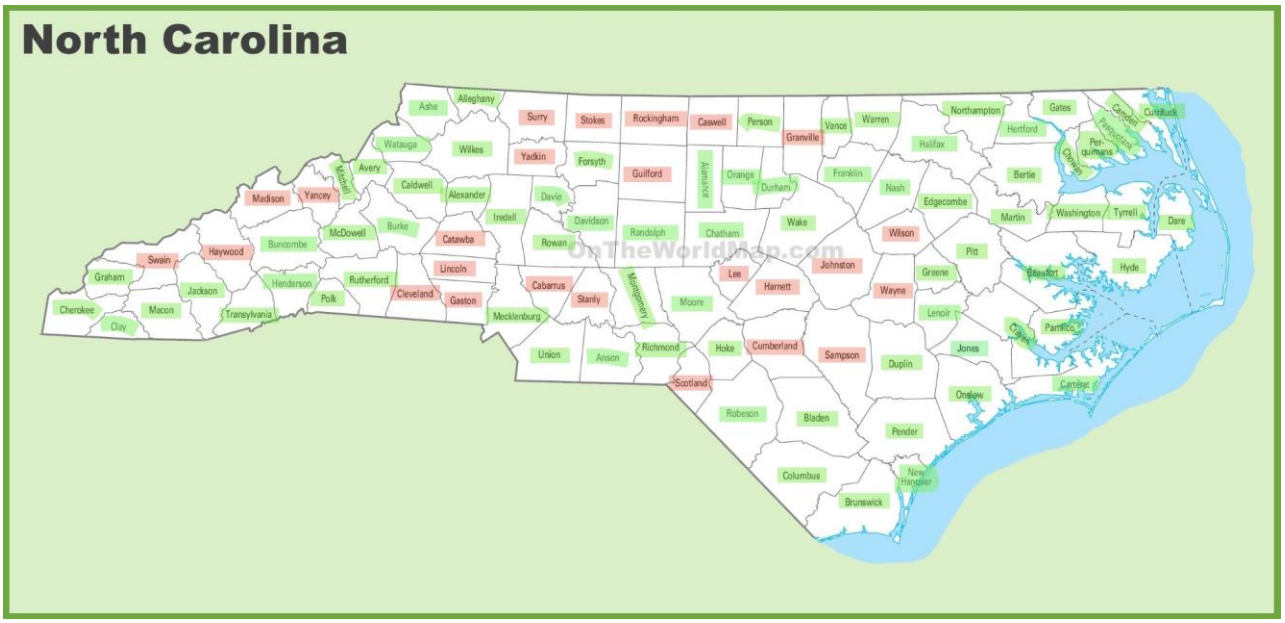
Appendix A: Maps of RCCs contacted

For the case study project, NCCASA interns contacted the executive director or other main point of contact for RCCs serving all counties in North Carolina, plus one serving the Eastern Band of Cherokee, via email asking them to connect NCCASA to the appropriate person at that RCC to answer questions about prevention programming. If they did not respond, another follow-up reminder email was sent 1-2 weeks after the initial email. If they did not respond to that email, others at the agency were emailed and/or NCCASA interns reached out by phone until they were able to speak to someone at the RCC. Overall, each RCC in North Carolina was contacted at least twice via email and at least once via phone to request that someone at the RCC participate in the project. NCCASA interns were able to successfully complete interviews with 54 of 74 RCCs, a response rate of about 73%.

The map and list below shows all of the RCCs in North Carolina by county, including satellite offices and core programs.



In the map below, counties served by RCCs who responded to our request (either via email or phone) for a short phone interview about their prevention programming are highlighted in green. Counties served by RCCs who we were unable to successfully contact are highlighted in red. 73% of the RCCs contacted completed interviews with NCCASA interns.

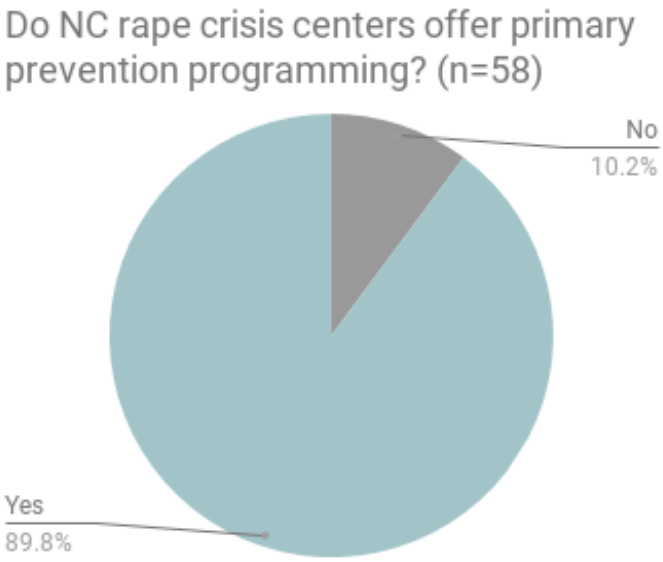


Map from OnTheWorldMap.com, edited using Preview for Mac

Appendix B: Findings from NCCASA's 2015 phone survey

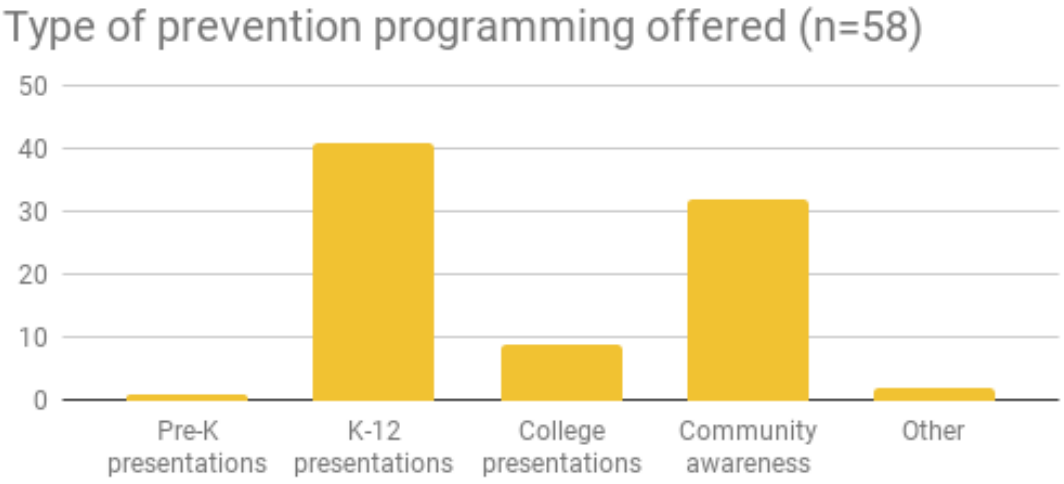
Below are our selected findings from a similar project conducted at NCCASA in 2015. In contrast to the case study conducted in 2017, this project contained only three questions focused specifically on prevention programming. Three questions from the 2015 phone survey related to prevention programming and were therefore of interest to us:

1) What does sexual violence prevention programming look like?
2) If you were asked to do a one-hour training for college students with little guidance, what would be your focus?
3) If you were asked to do a one-hour training for K-12 students with little guidance, what would be your focus?

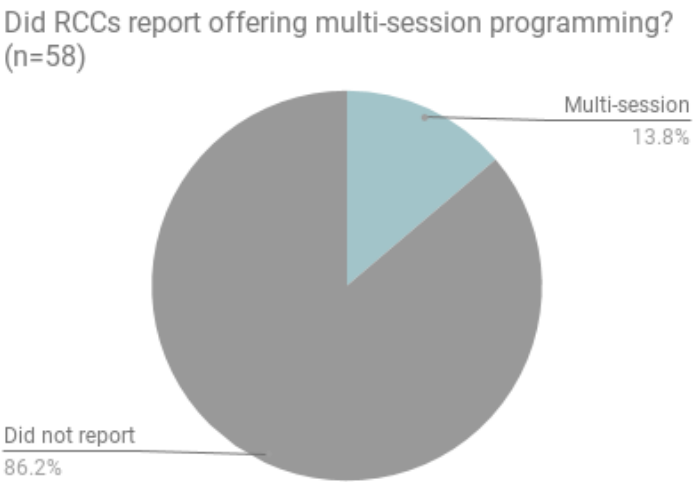


Despite focusing less on prevention specifically, this dataset was an important source that helped us establish a baseline that we could compare our findings to. Therefore, NCCASA interns analyzed findings from this survey project before implementing the case study in order to get an initial idea of the state of prevention programming at North Carolina RCCs.

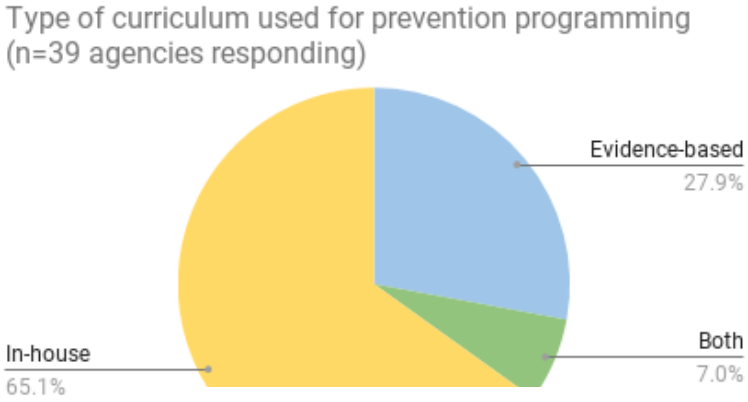
In 2015, 89.8% of North Carolina RCCs reported that they offered primary prevention programming, while 10.2% said they were currently offering no primary prevention programming.



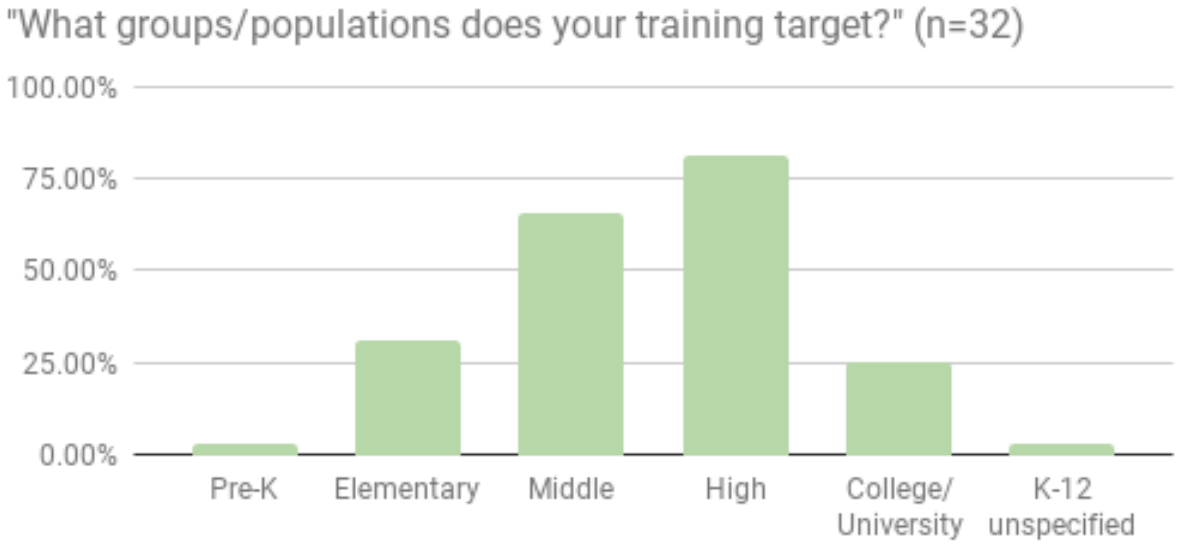
The majority of RCCs that conducted prevention programming reported offering presentations in K-12 schools, followed by community awareness presentations, in 2015.



When asked "what does your sexual violence prevention programming look like?" 13.8% of RCCs reported that they offered multi-session programming. 86.2% did not report that they offered multi-session programming. These results were of interest to us because sufficient dosage and frequent sessions have been named as principles of effective prevention.[49,50]



RCCs also reported the type of curriculum—if any—they used for prevention programming. 27.9% of agencies reported using an evidence-based programs, such as Safe Dates or Shifting Boundaries. Most agencies (65.1%) were using a curriculum they created in-house. 7.0% were using both an evidence-based program and an in-house curriculum.



Most RCCs targeted their prevention training programs to high school students, followed by middle school students. Fewer RCCs targeted programs to college/university or pre-K.

If you were asked to do a one-hour training with little guidance, what would be your focus?

Findings from the latter two questions were used to organize RCCs onto a continuum of technical assistance needs for the pilot phase of the project, which aimed to collect information from RCCs at varying points along the continuum.

An NCCASA intern sorted each question into one of three categories:

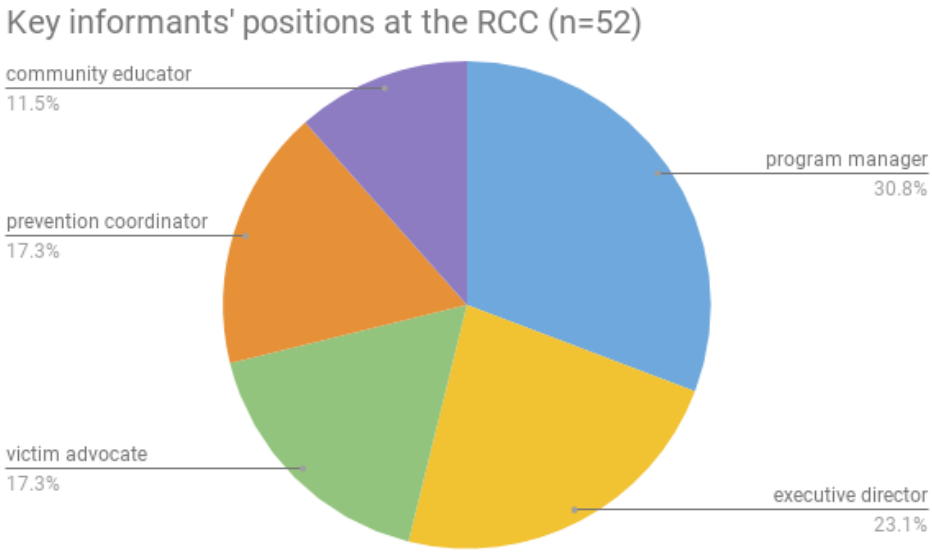
1) Answers contained mentions of strategies and content related to best practices in primary prevention; for example, rape culture/rape myths, bystander intervention, consent, boundaries and communication.
2) Answers focused on DV/SA 101 level content; focused on response rather than prevention; or focused solely on relationship violence rather than sexual violence.
3) Answers focused on risk reduction strategies or sharing information about available community services; or participants said they were unsure what they would focus on.

Technical assistance needs	**A**	**B**	**C**
Definition	RCCs' answers to both questions were sorted into category 3	RCCs' answers to both questions were sorted into category 2, or a mixture of category 2 and 3	RCCs' answer to at least one of two questions was sorted into category 1
Number of RCCs from 2015 survey in each category	28	26	4

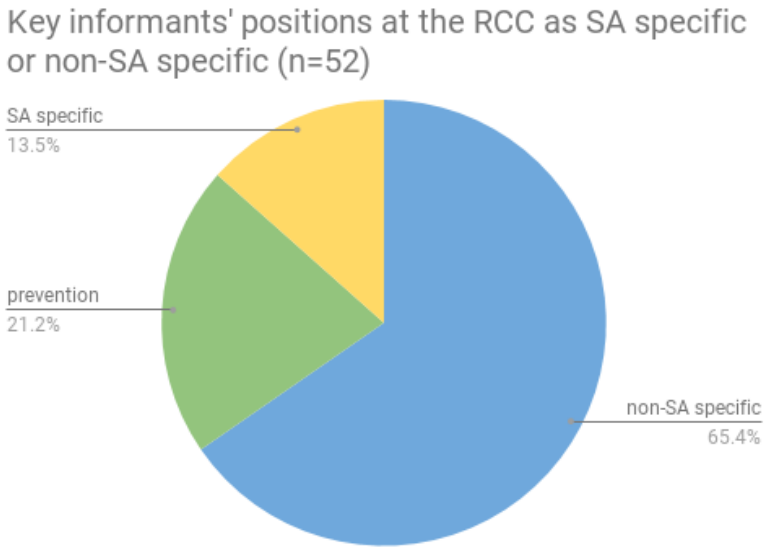
For the pilot stage of the project, one RCC from each category of technical assistance needs was selected to participate to allow interns to assess the appropriateness of interview questions for RCCs with different needs.

Appendix C: More information on identified key informants

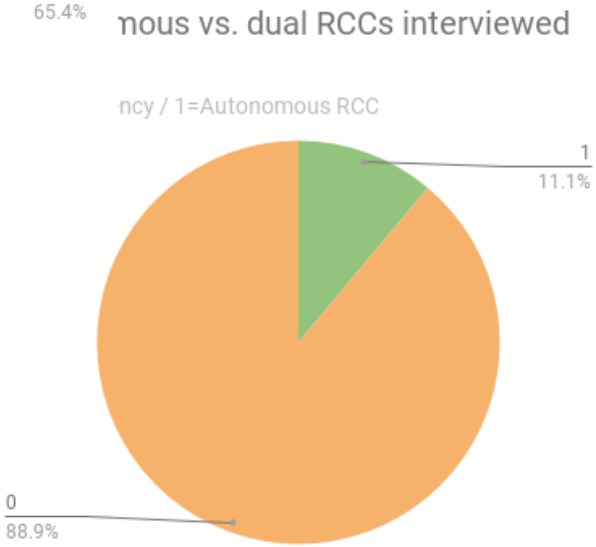
Key informants working at 54 North Carolina RCCs were interviewed for the case study project. Executive directors or other main points of contact at each RCC identified these key informants as the individual who would best be able to discuss prevention programming at that RCC. Some RCCs employed an individual who spent 100% of their time on prevention programming. Others employed one person to provide both SV prevention and response services; still others identified the executive director as the most knowledgeable about prevention programming at the RCC. We found that the scope of responsibilities of the key informant was an important data point that could tell us a lot about prevention capacity at RCCs. Below are graphs depicting the positions of the key informants we spoke with.



This graph depicts the positions that 52 key informants held at the RCC, sorted into five categories: executive director (including executive directors, interim EDs, and acting directors), program manager (including program managers, program coordinators, and directors of specific programs in the RCC/agency), community educator, victim advocate (those who worked specifically with victims of sexual violence and other forms of violence), and prevention coordinator. Most of the key informants we spoke with (30.8%) were program managers, closely followed by EDs (23.1%).



Most (65.4%) key informants we spoke with held positions that were neither prevention-specific nor sexual assault-specific; these individuals either served as executive directors or project managers of programs that addressed more than one different type of violence, such as DV/IPV and human trafficking.



Of the 54 RCCs interviewed, 6 (11.1%) were autonomous RCCs providing prevention and response services centered specifically around sexual violence. 28 (88.9%) of RCCs interviewed provided services relating to multiple forms of violence, such as sexual violence, intimate partner violence/ domestic violence, human trafficking, or child abuse.

Appendix D: Project timeline

Due to an abbreviated field placement timeline for the NCCASA intern primarily conducting this project, the case study was conducted from May 2017 to November 2017. Coalitions can take as long as they need to implement a similar project, as long as information is collected and analyzed within a timeframe that is helpful for the coalition and participants. For example, a consideration to take into account when building your timeline is that participants in the project will likely be interested in seeing its results within a reasonable timeframe so they can take action on the findings.

Below is the timeline used for the case study, along with notes and lessons learned.

May		June		July		August		September		October		November	
Step 1													
Identify informants													
	Write interview guide												
		Contact & schedule											
				Conduct interviews									
			Coding & analysis					Apply theories					
										Draft results			
												Share results	

Month 1 (May):

- Step 1: Get bearings on the project; find out what the agency already knows
- Conduct a literature review to get an idea of what is already known about the state
- Begin brainstorming a list of questions to focus on that have not been answered in previous projects or that need updating

Month 1 (June)

- Draft questions and consult about them with others at the coalition
- Locate and/or assemble an updated list of primary contacts (such as executive directors) at RCCs in the state
- Begin contacting primary contacts at each RCC to connect NCCASA with a key informant

Month 2 (July)

- Send follow-up emails to those who have not responded
- Assemble a list of key informants recommended by primary contacts
- Finalize questions and familiarize yourself with interview guide
- Identify RCCs for pilot phase

Note: We identified three RCCs to interview for our pilot phase with the goal of interviewing RCCs with differing technical assistance needs. However, one RCC was unreachable on the day of the scheduled interview. You may want to identify more than the number you want to interview in case any are unreachable.

Month 3 (August)

- Continue following up with contacts and key informants who have not responded
- Conduct pilot phase and change interview guide or plan as necessary
- Begin interviewing key informants at each RCC
- Check in with co-investigator regularly

Month 4 (September)

- Continue interviewing key informants at each RCC
- Begin extracting qualitative codes of interest and highlight salient quotes and notes
- Check in with co-investigator regularly

Month 5 (October)

- Complete interviews
- Complete a draft codebook and begin exploring qualitative codes

Note: We had planned to have interviews completed in September, but extended our timeline to get participation from RCCs that had been more difficult to contact. Even after extending our timeline, there were 20 remaining RCCs that we were unable to contact. Completing the project in a reasonable timeframe must be balanced with getting a "complete" dataset.

Month 6 (November)

- Share results internally at NCCASA and solicit feedback
- Share guides, planning documents, and any resources that may help another at NCCASA implement a similar project in the future
- With NCCASA, formulate a plan for dissemination of findings to member RCCs

Appendix E: Initial contact email messages

Initial email:

Hi (contact name),

Hope you're well. I'm emailing on behalf of NCCASA, where I'm working with (supervisor) on a project that's looking to help local rape crisis programs bolster their prevention programming.

I'm wondering who, if anyone, is the main contact at your agency for the prevention or awareness raising work that you conduct in the community--whether that is working in K-12 schools or on college campuses, doing community awareness raising events, partnering with other agencies, or anything else prevention-related.

Would you feel comfortable giving me the contact information for whoever would best be able to answer questions about prevention programming at your agency?

Thank you for your time, and I look forward to hearing from you!

Reminder email:

Hi (contact name),

I just wanted to follow up on this email so the opportunity to talk with you didn't fall through the cracks. I'm wondering if someone at (agency name) might find 20 or 30 minutes to chat with us about prevention programming at (agency name) at some point in the upcoming weeks—maybe (suggested date and time)? Let me know!

Thank you for your time!

Appendix F: Phone interview guide/script

Hi (NAME), thanks for taking some time to talk with us today. How are you?

(IF PARTICIPANT FROM 2015:) We talked to you back in 2015 about the services offered at (RCC NAME). Now, we are revisiting your old responses and collecting some new information from you so we at NCCASA can be sure to provide you with the best, most accurate technical assistance that you deserve. For this call, I'd like to learn more about your sexual violence prevention services specifically.

First, I'm going to ask some follow-up questions to the information that you gave us in 2015, then I have some new questions that will be a deeper dive into what you all are doing specifically in terms of prevention at (RCC NAME). Is that okay with you?

When we talked with you all in 2015, you all reported that _____. **Is this still correct?**

- If no → Okay. **Can you describe how your prevention programming has changed since 2015?**
- If yes → Okay, great. Thanks for letting us know. **Is there anything else that you are doing additionally or anything more you want to tell me about that that might be different than when we talked to you back in 2015?**

Those are all of the questions I have from reviewing from 2015. I have a few more questions about your prevention programming. Is that okay with you?

- Who does your prevention programming? (Is it staff, volunteers, a mix of both?)
    - Are there any paid staff who spend 100% of their time on sexual violence prevention work?
        - If yes → How many?
        - If no → Are there any paid staff who spend 50% or more of their time on prevention work?
- Do you have any relationships with community partners that help you do any prevention work?
    - If yes → who and how have those relationships been successful?
    - If no → what have the barriers been to building relationships with community partners?
- Individual-level education like classroom-based programming is one important way to prevent SV; prevention can also be policy work, building partnerships, or working on related issues in your community. Is your agency doing any of this other community-level work outside of the classroom? How do you conduct this work?
- Sexual violence and survivors' experiences are impacted by homophobia, transphobia, racism, and other forms of marginalization/oppression. How does your prevention programming incorporate or address this?

- Okay, I want to go back to the barriers we talked about earlier. You mentioned ___(Acknowledge barriers that have already been mentioned if applicable). What are some other major barriers that your agency faces in implementing prevention programming?
- (Recap barriers from community partner question and earlier question) -- If you lived in an ideal world without these barriers, what would your prevention programming look like?
- We have just one more question. We saw in our records that your agency hasn't (or has, but was not granted) applied for the North Carolina Department of Health and Human Services Rape Prevention Education grant in the funding cycles since 2009.
    - If a grantee since 2009, SKIP QUESTION
    - If no or did not receive funding → What would you need in order to be a strong applicant?

Those are all of the questions I have for you today, do you have any questions for me?

I appreciate you taking the time to answer my questions. This information will help us get a better idea of what sexual violence prevention efforts look like in North Carolina, and how we can best support you all. Thank you very much!

Appendix G: Sorting codebook

CODE NAME	
RCC info: Autonomous or dual?	
Autonomous	RCC primarily provides services to survivors of sexual violence, and refers to another agency for those who have experienced other forms of violence.
Dual	RCC provides services to survivors of multiple forms of violence, including sexual violence, intimate partner violence/domestic violence, human trafficking, or child abuse.
What does SV prevention programming look like?	
Community education	RCC reports delivering educational presentations in the larger community or in spaces open to community members in general (such as churches and civic groups) covering a wide variety of topics applicable to SV
School presentations	RCC reports delivering presentations in elementary, middle, or high schools as part of a prevention or outreach strategy.
College presentations	RCC reports delivering presentations in colleges or universities and part of a prevention or outreach strategy.
Brochures/materials	RCC reports sharing brochures and materials as part of a prevention or outreach strategy: including disseminating materials to hospitals or other community partners and/or tabling with materials at community events.
Awareness raising	RCC reports implementing programs primarily aimed to raise awareness of SV as an issue
Scheduled programs or responding to requests?	
As requested	RCC reports that they deliver programs as requested by groups, organizations, schools, or other community partners
Scheduled	RCC reports that they deliver programs on a regular, predetermined schedule (often but not always because they have an MOU with one or more schools/organizations)
About how many do they do in a year?	
#	#
Where do sessions take place?	
Schools	RCC reports delivering presentations or other programs in elementary, middle, or high schools.
Campus	RCC reports delivering presentations or other programs on college or university campuses.
Community	RCC reports delivering presentations or other programs in community spaces such as churches, civic groups, youth organizations, etc.

How do you evaluate your prevention programming?	
Pre- and post-test	RCC reports using a pre-test and post-test of participants to evaluate their prevention programming, either created in-house or by a program such as Safe Dates or Shifting Boundaries
Post-test only	RCC reports using a post-test of participants only to evaluate their prevention programming
Teacher/administrator feedback-survey	RCC reports soliciting feedback from teachers through a survey (via pen and paper or email) to evaluate their prevention programming
Teacher/administrator feedback-informal	RCC reports soliciting informal feedback from teachers, counselors, or administrators; such as checking in after a presentation to ask how they think it went.
What is the content of your prevention programming?	
Awareness/101	RCC reports including basic information about sexual violence (such as the definition of sexual violence, statistics about prevalence, where/when/to whom SV can happen), or mentions raising awareness, when asked about their prevention programming.
Bullying	RCC reports that they address bullying behaviors in their prevention programming.
Bystander intervention	RCC reports that they focus on building bystander intervention knowledge, skills, and/or behaviors as part of their prevention programming.
Consent	RCC explicitly reports including consent (definition of consent, law and/or policy, etc.) in their prevention programming.
EBP	RCC reports using an evidence-based or evidence-informed prevention program such as Safe Dates or Shifting Boundaries.
Good touch/bad touch	RCC reports teaching "good touch" vs. "bad touch" as part of their prevention programming.
Healthy relationships	RCC reports discussing healthy relationships, healthy friendships, safe dating, and/or the differences between healthy and unhealthy relationships, as part of SV prevention programming.
Policy	RCC reports discussing policy, such as Title IX, as part of prevention programming.
Reporting/response	RCC discusses sharing resources for reporting and/or response when asked about prevention programming.
Risk reduction	RCC reports teaching risk reduction strategies (such as self-defense, safety planning, or "ways to stay out of danger") when asked about prevention programming.
Structural contributors	RCC reports addressing structural/theoretical contributors to SV in their prevention programming, such as masculinity or gender norms/stereotypes, through activities such as media/pop culture literacy or engaging men and boys.

Who does your prevention programming? (not mutually exclusive)	
Staff	RCC reports that paid part-time or full-time staff members implement prevention or community education/awareness programming.
Volunteers	RCC reports that unpaid volunteers implement prevention or community education/awareness programming.
How many paid staff spend 100% of their time on SV prevention work?	
#	#
How many paid staff spend 50% or more of their time on SV prevention work?	
#	#
Do they have community partners?	
Yes	RCC reports having community partnerships that help them implement or deliver prevention/community awareness raising programming.
Working on it	RCC reports having trouble building community partnerships or is unable to name any community partners that help them implement or deliver prevention or community awareness raising programming.
Who are community partners?	
Advocacy org	RCC works with other advocacy-oriented organizations or agencies such as child advocacy centers, domestic violence shelters or agencies, or nonprofit organizations.
Churches	RCC works with community churches or other religious organizations to implement prevention or community awareness programming.
Civic groups	RCC works with non-youth-oriented community civic groups to implement prevention or community awareness programming.
Healthcare	RCC works with hospitals, wellness center, mental health clinic, or other healthcare-oriented organizations to implement prevention or community awareness programming.
Law enforcement	RCC works with law enforcement in community, school resource officers in schools, or juvenile justice system to implement prevention or community awareness programming.
Schools	RCC works with elementary, middle, or high school teachers, administrators, and/or students to implement prevention or community awareness programming.

University	RCC works with college or university staff and/or students to implement prevention or community awareness programming.
Youth organizations	RCC works with youth-oriented community organizations to implement prevention or community awareness programming, including youth activist organizations, after-school programs, college readiness programs, etc.
Barriers to building relationships with community partners	
Community attitudes	RCC reports that a major barrier to building relationships with potential community partners is community attitudes; for example, about SV, gender norms, or sex.
Community knowledge	RCC reports that a major barrier to building partnerships with potential community partners is that the community is unaware of the agency or the services that the agency offers.
Community partners unwilling	RCC reports that a major barrier to building relationships with potential community partners is that they are perceived as unwilling, because SV prevention work is deprioritized, because of personal differences, because they are not invested or not "used to" the partnership, or for some either reason.
Schools: parent/admin pushback	RCC reports that a major barrier to building relationships with K-12 schools is pushback on the content from parents and/or school administration.
Schools: trouble getting in	RCC reports that a major barrier to building relationships with K-12 schools is that they have trouble getting into schools, potentially because of school board or state requirements.
Staff time	RCC reports that a major barrier to building relationships with potential community partners is a lack of staff time to spend on building these partnerships; RCC may also mention that it takes a long time to build sustainable community relationships.
Turnover at RCC	RCC reports that a major barrier to building relationships with potential community partners is turnover at the RCC.
Turnover in community partners	RCC reports that a major barrier to building relationships with potential community partners is turnover in the community partner agency/organization.
Barriers to implementing prevention programming	
Community attitudes	RCC reports that a major barrier to implementing prevention programming is community attitudes; for example, about SV, gender norms, or sex.
Funding	RCC reports that a major barrier to implementing prevention programming is a lack of funding, either for transportation, program supplies, or salary.
Lack of attendance/interest	RCC reports that a major barrier to implementing prevention programming is a lack of community or student interest, attendance, or participation in prevention programming.
Lack of curriculum/content	RCC reports that a major barrier to implementing prevention programming is a lack of an appropriate curriculum or content; for example, because it is not

	evidence-based or evidence-informed or because it is not accessible/applicable to certain groups of potential participants.
Lack of staff/time for prevention	RCC reports that a major barrier to implementing prevention programming is a lack of protected time to plan, schedule, and implement prevention programming (especially in contrast to response work), or a lack of staff specifically working on prevention.
Political climate	RCC reports that a major barrier to implementing prevention programming is hostility toward SV prevention programming in the current political climate.
RCC turnover	RCC reports that a major barrier to implementing prevention programming is turnover in the RCC.
Schools: parent/admin pushback	RCC reports that a major barrier to implementing prevention programming in schools is pushback on content from parents or school administrators.
Stigma of rape	RCC reports that a major barrier to implementing prevention programming is the stigma around the concept of rape, the word "rape," or the association with a RCC, which dissuades potential program attendees or participants.
Other community-level work?	
Community organizing	RCC reports they conduct community organizing work or build community capacity to prevent SV in their community or to address related issues.
Large scale events	RCC reports they conduct large scale events in their community, often oriented around raising awareness or sharing resources and often during Sexual Assault Awareness Month or Domestic Violence Awareness Month.
Policy work	RCC reports they conduct policy advocacy work as part of a larger community-level strategy.
Related issues	RCC reports they conduct work to address issues related to SV prevention (such as LGBTQ community organizing, affordable housing, etc.).
SART	RCC reports they are conducting other community level work through a Sexual Assault Response Team or other task force made up of representatives from various agencies and organizations.
Small scale events	RCC reports they implement small-scale events such as all-call trainings, speaker or movie screening events.
Working on it	RCC reports they do not currently offer any other community-level SV prevention-oriented work, but are working on getting some off the ground.

Appendix H: Thematic codebook

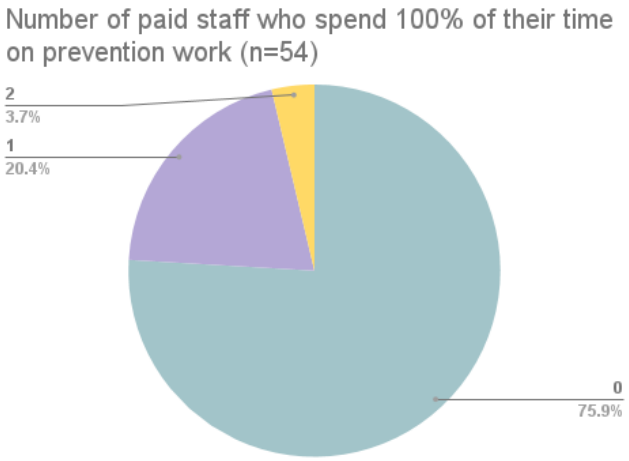
CODE NAME	Definition (apply this code when...)	Example quote
General		
Many hats	Interviewee says that RCC workers have to wear many hats -- mentioned either as a barrier (mostly) or helping the work	"Everyone at our agency wears ten million different hats"
Community/town culture	Interviewee references "small town culture," "rural community" and/or how community attitudes and culture affect their work	"I know there are small towns everywhere, but specifically there's a culture in the south with small towns"
Rural vs. urban	Interviewee brings up how doing this work differs in rural vs. urban setting	"Nobody in Raleigh cares about what happens west of them"
Prevention vs. response	Interviewee brings up response when asked about prevention and doesn't acknowledge the difference between the two	"No hospital in area, hard to do referrals" (when asked about barriers to prevention)
DV vs. SV	Interviewee brings up DV when asked about SV	"People are sometimes scared that you talk to young children about DV..."
Prevention starts young	Interviewee talks about the importance of doing prevention with young people	"I'd like to focus more on younger children"
Age appropriate	Interviewee mentions that the RCC includes different prevention content for different age groups and/or how prevention must be targeted according to age.	"There are restrictions on what you can include in curricula based on age"
DV prioritized	Interviewee states or alludes that the agency does more DV work as a whole	"There are a lot more resources for DV than SA...we go into schools and talk about DV"; "It's easier to talk about DV than SA"
Response takes priority	Interviewee mentions that prevention takes a back seat to response (because response is more urgent or pressing), so not a lot of time spent on prevention	"Clients are more urgent and we have to see all clients that come in"
Brainstorming how to do prevention	Interviewee says agency is just starting to brainstorm how to do prevention in their community	"We're still trying to figure out what direction to go in"
Perpetrators male/victims female	Interviewee alludes to women as victims "keep women safe" and males as perpetrators "talk to guys about good judgment"	"Talk to the guys and try to build them [perpetrators] up so they can come out and make a different choice"
Oppression question		

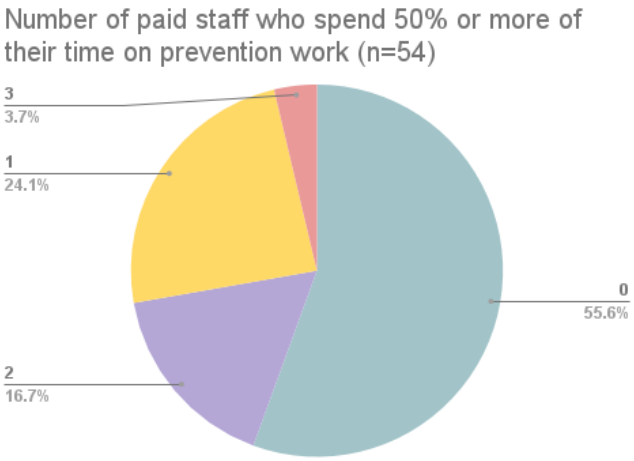
0: Anti-oppression work doesn't apply to us	Interviewee says something like "that doesn't apply to us" or otherwise indicates anti-oppression work is in a "different lane" than anti-violence work	"That's not my department, I don't do that" "There are bigger fish to fry… just getting out there with the broader issues is more our focus"
1. "We don't have that here"/"we have it covered"	Interviewee says something like "we don't have that here", "this isn't a problem here" (either in agency or community); OR, "we help everybody"/treat everyone the same"	"We don't have a lot of that here in our little town"; "we treat gay people the same way that I would treat a straight person"; "We wouldn't have a problem here saying anything or helping anyone no matter race, religion, sexual orientation. I know every employee here"
2. "We know we have it" but unsure what to do	Interviewee says something like "we try" or does not specifically name what they address and how they address it	"We try to handle those things as they come"; "We don't do anything specifically, but we definitely push equality"
3. Baby steps	Interviewee says something like "agency is talking about it" or making small changes to their curriculum	"We are in talks of whole agency doing a training on cultural competency.." or "We use inclusive language and that kind of thing"
4. Working on it	Interviewee says something like "want to include but don't want to step on community partners' toes"	"We have a strong religious community that is very homophobia and masculine-driven and anti-transgender"; "I don't want to make too much of a statement because it will be challenged"
5. Incorporating in programming	Interviewee says agency is actively incorporating a discussion of systems of oppression in thier prevention programming, either in schools or community	"We are explicit, talk explicitly about transphobia and homophobia, include language examples of verbal sexual harassment"
Asked for more information	Interviewee indicates that the agency needs more education and training	"I need more training on how to deal with that appropriately"; "We would require more training to target these populations for more effective programming"
Ideal world		
Same work, but more	Interviewee would continue doing the same work but on a larger scale	Would be in "all the schools, all the classrooms."
Expanded content	Interviewee talks about incorporating more/different content in their prevention programming, (which is often restricted due to community or societal attitudes or norms)	"I would want to have free reign on the sex ed side, it's hard to talk about rape is bad if you can't even get into mechanics of sex, because if not, you're just being vague about what rape is."
Prevention not necessary	Interviewee says that in an ideal world, prevention wouldn't be necessary (there wouldn't be SV/IPV)	"I wouldn't need prevention if I was in an ideal world"
Would address related issues	Interviewee mentions it would be a coordinated community response, other agencies would be doing the work; or that the agency would address issues like community poverty, schools, etc.	"Would have a staff member doing community macro policy work"

Risk reduction	Interviewee says the RCC would conduct risk reduction work in an ideal world, including "keeping people safe," or how victims can avoid violence.	“I want them [youth] to know what to do to make sure they aren’t a target… make sure you’re doing everything on your end to make sure you don’t get victimized.”
More partnerships	Interviewee mentions that more community organizations, agencies, and services (such as law enforcement, faith community, DSS, etc.) would be doing SV prevention work.	"It would be more than just our agency -- faith community, DSS, LE, justice, everyone would be on the same page."
Interviewer perceptions		
Were not used to being asked these questions	Interviewers perceive that interviewees are taking a long time to think before responding, potentially because they were not used to being asked to reflect or taking the time to reflect/respond to those types of questions	"I'm not used to answering these kinds of questions"
Working without jargon/frameworks	Doing prevention without realizing/calling it prevention	"Prevention isn't my role"
Not sure of what NCCASA does	Interviewers perceive that interviewee isn't sure of what NCCASA does, either because they explicitly state it, ask for things we can't do, or seem to think we control their funding	From our notes: “Surprised/interested in learning more about resources from NCCASA”
Strong community relationships	Interviewees mention having strong community partnerships or "no trouble with schools"	"Good relationships with schools and partners...took a long time" "The whole community is doing prevention work with us"
Strong understanding of community	They are an "insider" or have gained community buy-in as an individual or agency	From our notes: “Understood how general history of the community and how things generally work”
Realistic rather than idealistic	Seemed less comfortable talking about "ideal world" than the world they live in	"When you work in this field, you're not used to thinking like that"

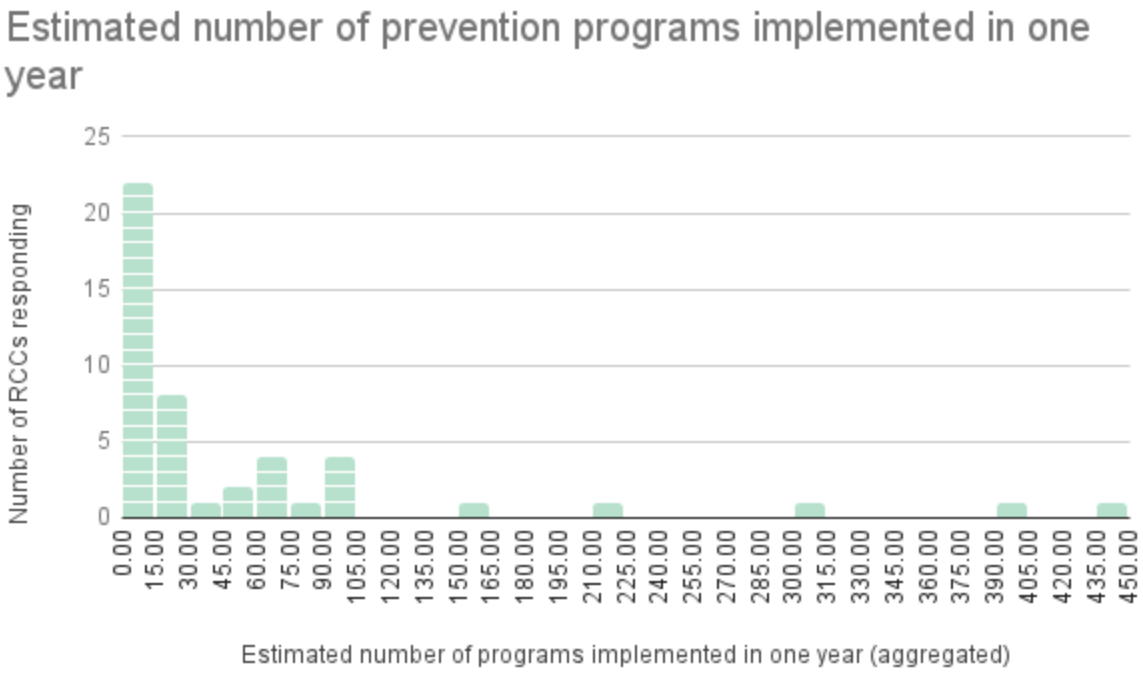
Appendix I: Descriptive assessment findings

The NCCASA intern used Google Spreadsheets to create graphs depicting descriptive assessment findings.

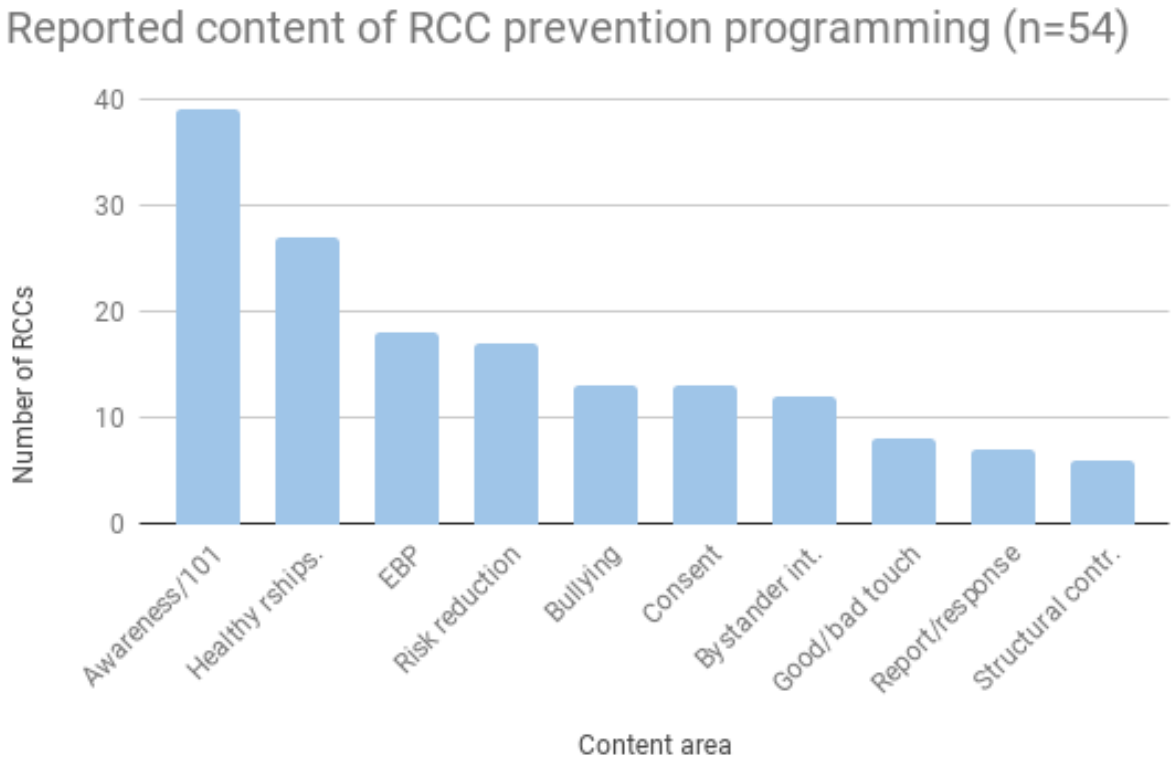




Of the 54 North Carolina RCCs interviewed, fewer than a quarter of them had one or more staff members who spent 100% of their time on prevention work. In that same number of RCCs, almost half (43%) had at least one staff member who spent 50% or more of their time on prevention work. Still, the majority of RCCs interviewed had zero staff members who spent 50% or more of their time on prevention work.

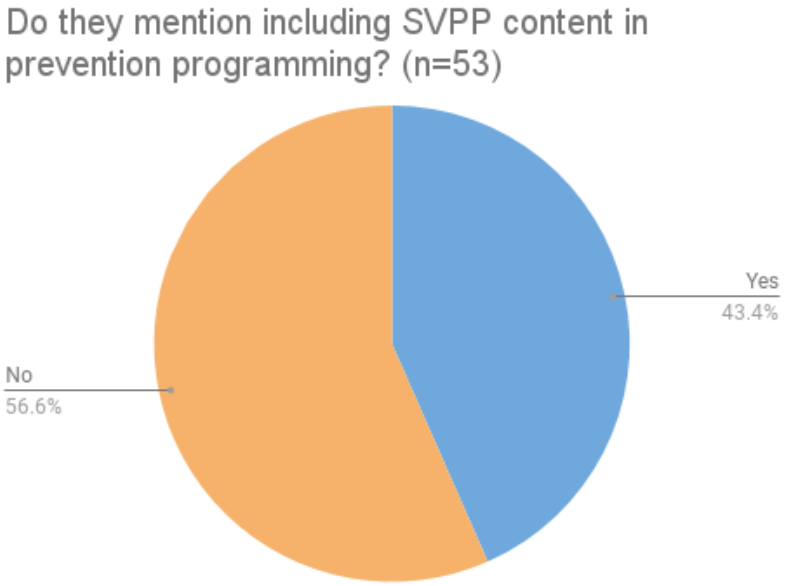


The majority of the 54 RCCs responding were delivering between zero and 15 prevention programs per year, followed by those implementing 15-30 prevention programs per year. Three RCCs reported implementing 300, 400, and 448 prevention programs per year.



A significant number of RCCs interviewed reported including SV awareness content in their prevention programming: 39 of 54 (72.2%). Eighteen (33.3%) reported using an evidence-based program such as Safe Dates or Shifting Boundaries, or an altered version of that program. More than a third (31.5%) reported focusing on risk reduction strategies such as self-defense or safety planning when asked about their prevention programming.

23 of 53 RCCs (43.4%) mentioned including content that could prevent SV from happening in the first place, such as teaching consent, bystander intervention skills, or addressing structural

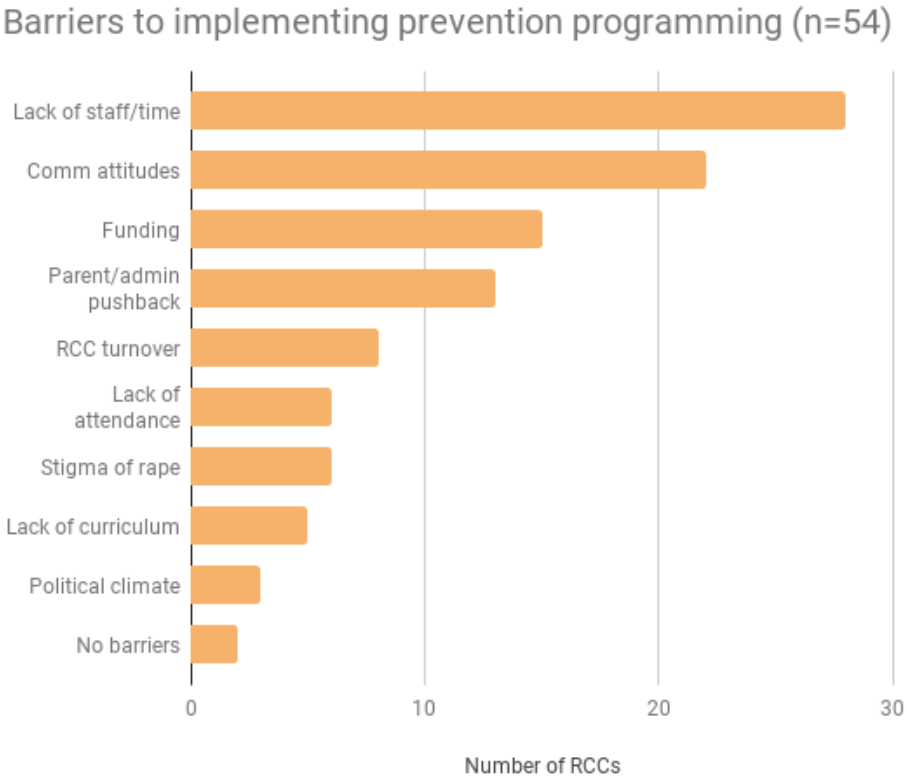


factors that support SV, when asked about their prevention programming. 30 RCCs (56.7%) did not mention including SV primary prevention content when asked about their prevention programming.

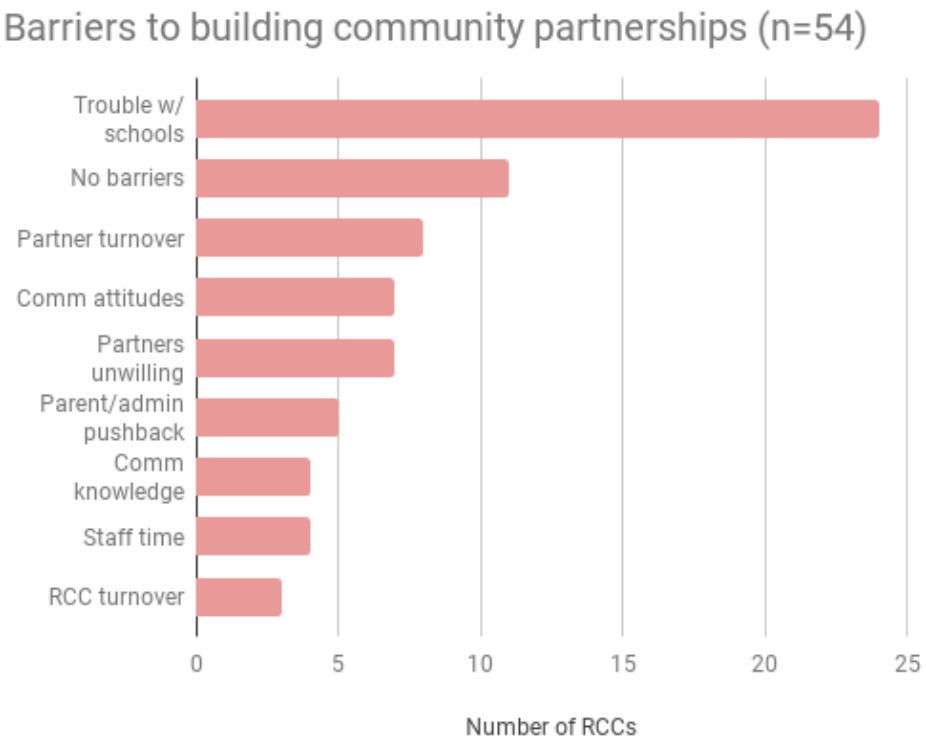
Two different questions aimed to elicit information from RCCs about barriers they faced:

1) What have the barriers been to building relationships with community partners?
2) What are some other major barriers that your agency faces in implementing prevention programming?

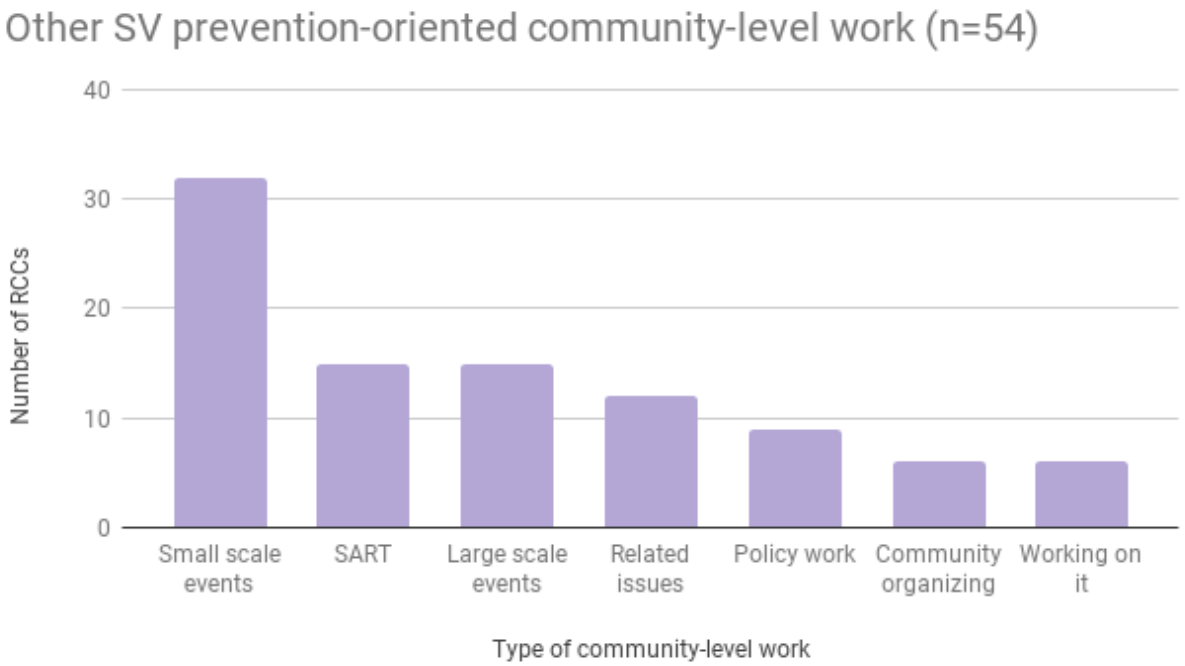
Below are graphs depicting RCCs' coded answers to both of these questions.



The most commonly identified barrier to implementing prevention programming was a lack of staff time to implement prevention programming specifically: 51.9% of RCCs interviewed identified this barrier. This barrier is closely tied to another commonly identified barrier: lack of funding for prevention programming (27.8%). A significant percentage (40.7%) reported that community attitudes—for example, about SV, gender, or sex—were a barrier.



The barrier to building relationships with community partners identified by the most RCCs (44.4%) was trouble getting into schools because of school board or state requirements. More RCCs reported facing no barriers to building partnerships (20.4%) than to implementing prevention programming in general (3.7%).



RCCs were also asked about SV prevention-oriented community-level work they were conducting, outside of any individual-focused, classroom-based SV prevention programs they were implementing. When asked this question, 59.3% of RCCs reported offering small-scale events in their community, such as speaker panels or movie screening events. 27.8% of RCCs brought up large-scale fundraising or awareness-raising events, often planned during Sexual Assault Awareness Month or Domestic Violence Awareness Month. This work was often oriented around raising awareness, raising funds, or sharing resources for survivors of violence and less often around the primary prevention of SV. 27.8% reported coordinating a Sexual Assault Response Team or other task force.

Relatively fewer RCCs reported conducting work that could prevent SV from happening in the first place; for example, by working to change community attitudes and norms that create an environment supportive of SV. 22.2% of RCCs reported conducting community-level work to address issues related to SV, such as affordable housing, attitudes toward LGBTQ+ individuals, or harmful gender norms. 11.1% specifically brought up community organizing work, often in partnership with other organizations or coalitions, to build community capacity to prevent SV.

Appendix J: Summary of qualitative themes

To identify salient qualitative themes, two NCCASA interns independently read through call notes for the first ten calls and completed a list of salient overall themes. The interns discussed to come to a consensus of a list of 28 themes: 11 applying to the call in general, 11 applying to specific questions, and 6 to capture interviewers' perceptions.

Then, both interns coded one third of the dataset (18 calls) independently, then met to discuss codes for that portion of the dataset and roughly estimate interrater reliability. Of the 18 calls, interns agreed on all codes for 13 (72.2%). There was particularly high interrater reliability for the question focused on how prevention programs incorporated systems of oppression: interns were in agreement on 17 of 18 calls, or 94.4%. Interns discussed inconsistencies in their chosen themes and definitions for inclusion or exclusion were refined to address those inconsistencies. Two general codes were added. See Appendix H for thematic codebook.

The following table contains our 11 general call codes, 6 interviewer perception codes, and the frequency and percentage that they were found in our dataset.

Theme	# of RCCs	% of RCCs
General		
Many hats	12	22.2
Community/town culture	35	64.8
Rural vs. urban	18	33.3
Prevention vs. response	24	44.4
DV vs. SV	8	14.8
Prevention starts young	14	25.9
Age appropriate	31	57.4
DV prioritized	8	14.8
Response takes priority	8	14.8
Brainstorming how to do prevention	9	16.7
Perpetrators male/victims female	5	9.3
Interviewer perceptions		
Were not used to being asked these questions	7	13.0
Working without jargon/frameworks	10	18.5
Not sure of what NCCASA does	3	5.6
Strong community relationships	17	31.5
Strong understanding of community	27	50.0
Realistic rather than idealistic	6	11.1

NCCASA interns also asked participants, "If you lived in an ideal world without the barriers we discussed, what would your prevention programming look like?" The majority (70.4%) reported

they would be conducting the same general kind of work, but on a larger scale. 38.9% of RCCs said they would expand the content they offered, and 13% said they would better address issues related to SV, such as sexism, racism, homophobia, transphobia, and other systems of oppression.

We were also interested in examining interviewees' answers to a question focusing on anti-oppression work ("Sexual violence and survivors' experiences are impacted by homophobia, transphobia, racism, and other forms of marginalization/oppression. How does your prevention programming incorporate or address this?"). To do so, we coded them into the following categories:

Code	Definition	Number of RCCs	% of RCCs
0. Not interested	Interviewee does not recognize anti-oppression work as necessary to anti-violence work.	5	9.3%
1. Not recognized as a problem	Systems of oppression, such as homophobia, transphobia, or racism, are not recognized as problems in the community or within the RCC.	10	18.5%
2. Awareness, but no action	Interviewee indicates that RCC is aware that systems of oppression should be addressed, but does not know where to start.	15	27.8%
3. Preplanning	The RCC recognizes that something must be done about systems of oppression and has taken some steps to do so, but efforts are not clear or focused.	12	22.2%
4. Working on it, but experiencing barriers	The RCC recognizes something must be done and has ideas about how to do it, but experiences the community or other stakeholders' reactions as barriers to the work.	9	16.7%
5. Active incorporation in programming	The RCC is actively incorporating a discussion of systems of oppression into prevention programming, either in schools or in the community.	2	3.7%

These results indicate where efforts may be focused in order to increase the number of RCCs that are incorporating other anti-oppression work into their SV prevention work. 27.8% of RCCs

reported they knew they should be addressing systems of oppression, but didn't know where to start. Work with this group may involve sharing strategies or model curricula. On the other hand, for the 18.5% of RCCs that did not recognize systemic oppression as a problem in their communities, the coalition may choose instead to share relevant research and expertise on how systemic oppression contributes to SV. Across the levels, coalitions may build partnerships between RCCs at different levels of "readiness" to incorporate anti-oppression work and facilitate conversations about ways some RCCs have effectively incorporated this work.