New Mexico Coalition of Sexual Assault Programs
Sexual Assault Needs Assessment
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Purpose

The New Mexico Coalition of Sexual Assault Programs (NMCSAP) is the statewide organization representing the local sexual assault service providers and programs.[1] In this capacity, it fulfills a variety of roles that strengthen efforts to prevent and reduce sexual violence in NM. It acts as the repository for state data related to sexual and domestic violence perpetration and victimization. Reports generated from these data assist state and local agencies in advocacy, grant-writing, awareness-raising, and educational efforts. The NMCSAP provides state-level leadership in developing public policy to support sexual assault survivors. It provides ongoing best practices training and technical assistance to local sexual assault providers and programs, and to a variety of partner organizations and institutions that are vested in addressing the issue of sexual violence (e.g., criminal justice, medical and mental health providers, etc.). The NMCSAP, along with state agencies (e.g., Crime Victims Reparation Commission), oversees the implementation of state and federal sexual assault funds. It also works closely with organizations, such as the Coalition to Stop Violence Against Native Women, the NM Transgender Resource Center, and The ARC of NM, that serve populations with increased risk for sexual violence victimization. Member organizations of the NMCSAP include Sexual Assault Services Providers (SASPs) (e.g., rape crisis centers, dual domestic and sexual violence agencies, and mental health centers), Sexual Assault Nurse Examiner (SANE) programs, Children's Advocacy Centers (CACs), and community-based programs working with underserved populations.

Since 2022, the NM State Legislature has appropriated $4.2 million in recurring funds and $4.56 million in non-recurring funds to support sexual assault services (SAS), including sexual assault nurse examiner programs (SANE). This is a significant increase from prior state appropriations. This has uniquely positioned the NMCSAP to institutionalize operations that support its mission to, "...provide education, support, and advocacy to address all aspects of preventing and responding to sexual violence in NM from an anti-racist, anti-oppression foundation."[1] For example, a recently expanded workforce has allowed it the opportunity to support programs with training and technical assistance that had formerly only been available through subcontractors. The NMCSAP has also been able to focus on sexual assault service gaps, such as long wait lists and inadequate SAS in rural communities, as well as other systemic issues, such as data collection practices. The number of SASs in New Mexico has increased to 15, with 4 of those programs being added in the last year, one new SANE created in a rural community, and two developing SANEs underway.

Prior to 2022, the NMCSAP did not have the resources necessary to engage with SAS programs in a formal needs assessment process. As noted in several reports from national-level SAS technical assistance providers,[2,3] collaborative needs assessments can facilitate targeted, strengths-based, and client-centered technical assistance that promote the expansion and enhancement of client services and enables stronger SAS organizational practices. The NMCSAP SAS needs assessment provides a more complete understanding of current SAS in NM, allowing NMCSAP to better advocate for and support its SAS partners, and will inform future state and local sexual assault planning and service development.

Background

Sexual violence is an ongoing public health problem that affects people across ages, social stratifications, races and ethnicities, sexual orientations, and genders.[4] It encompasses a range of unwanted behaviors and actions, including rape, incest, sexual harassment, unsolicited sexual touching, nonconsensual image sharing, and other types of forced or coerced sexual experiences.[4] The impacts of sexual violence on mental well-being and physical health are well-documented, including immediate impacts (e.g., physical injuries, STDs, anxiety, etc.), and long-term and chronic conditions (e.g. depression, suicidality, cardiovascular disease, asthma, etc.).[5-8]

A previous review of sexual assault research shows that many sexual assault survivors do not receive services that are known to address both the short- and long-term effects of sexual assault. These include survivors living with mental, physical, and cognitive disabilities; people who are financially vulnerable; sexual and gender minorities; people with mental health issues; survivors with problematic substance use; and older sexual assault survivors.[9] This same research review identified a range of barriers contributing to populations that are underserved, including racism, discrimination, lack of insurance, limited or no access to transportation, and other obstacles.[9] Additionally, the social determinants of health (SDOH),[10] defined by Healthy People 2030 as economic stability; education access and quality; health care access and quality; neighborhood and built environment; and social and community context, are deeply intertwined with the risk of both sexual violence perpetration and victimization.[11-13]

The recent social isolation, economic strain, and psychological stressors related to the COVID-19 pandemic resulted in heightened vulnerability to interpersonal violence, including sexual violence,[14,15] as well as additional impediments to receiving SAS. SA organizations reported that the disruption of advocacy services resulted in less engagement in support systems by rape and SA survivors, as well as difficulty within organizations in assisting with tangible resources such as housing, transportation, and financial supports.[16,17]

There is also an economic burden to sexual violence. In an analysis conducted in 2016 by the Centers for Disease Control and Prevention (CDC),[18] the estimated lifetime cost of rape was $122,461 per victim, or nearly $3.1 trillion (in 2014 US dollars). Over half of these costs (52% or $1.6 trillion) were related to lost work productivity among victims and perpetrators, with 39% ($1.2 trillion) related to medical costs, 8% ($234 billion) related to criminal justice activities, and another 1% ($36 billion) in other associated costs, such as property loss.

New Mexicans are significantly impacted by sexual violence. According to the Federal Bureau of Investigation (FBI) state rankings (2019), NM ranks within the top 10 states in the nation for lifetime completed and attempted rape.[19] The FBI Crime Data Explorer [20] indicates that in 2022 in NM, the rape rate was 54.6 per 100,000 people, compared to 40 per 100,000 in the US. The most recent National Intimate Partner and Sexual Violence Survey was conducted in 2016/2017.[8] Based on data collected from adults in NM (18 years and older) that completed the survey, [21] almost one-quarter of women (23.8%) experienced completed or attempted rape sometime during their lifetime. While lifetime rape prevalence rates for NM men were not included in the report due to statistical instability, the lifetime completed or attempted made to penetrate prevalence rate for men in NM was 8.0%, compared to 10.7% in the US. In addition, according to the National Intimate Partner and Sexual Violence Survey (NISVS), 2.3% of female participants and 0.3% of male participants in the US reported rape victimization in the 12 months prior to completing the survey.[8] Based on these national 12-month prevalence rates and US Census Bureau 2022 population estimates for NM,[22] a projected 21,769 New Mexicans were rape survivors in 2022, including 19,315 females and 2,454 males.

Photo: UNM PRC

Methods

The NMCSAP contracted with the University of New Mexico Prevention Research Center (UNM PRC) to conduct a SAS needs assessment for the state with a focus on systems issues identified by SAS programs. Interview questions focused on strengths, challenges, future plans, and recommendations for improving the system.

Participants

Participants were recruited from a list of organizations and programs involved in SAS in New Mexico. The list was provided by the NMCSAP. The UNM PRC invited executive directors, SANE nurses, and other individuals knowledgeable about each organization and its services. In most cases, one interview was conducted per organization, although multiple individuals from the organization were able to participate. In one instance, two interviews were conducted with a single organization to accommodate conflicting schedules among organizational participants.

Data Collection and Analysis

The UNM PRC conducted semi-structured interviews with participants using an interview guide. Interviewers were experienced in qualitative research and were involved in the development of the guide. Interviews were conducted using videoconferencing and were audio-recorded. Interviews were expected to take approximately 1 hour with a single participant and up to 2 hours with multiple participants.

Audio-recordings were transcribed, verified, de-identified and uploaded into NVivo (v. R1) qualitative data analysis software. Data were analyzed using a codebook developed by the team and based on interview questions and common themes. Coding was conducted by three team members who worked to ensure consistency across coders.

Results

During June and July in 2023, the UNM PRC conducted 23 interviews with 35 individuals. This included 16 executive directors, 13 coordinators or other types of directors, 4 SANE nurses, and 2 individuals with other roles in the SAS system in NM. The number of participants in any one interview ranged from 1 – 4, with most interviews (70.8%) having one participant. Interviews averaged 60 minutes, with a range of 35 minutes to 124 minutes. On average, interview participants were involved in providing SA services for 12 years (range 6 months – 31 years). Individuals had been at their organizations on average for 8 years (range 6 months – 30 years) and in their positions on average for 5 years (range 3 days – 20 years). In several cases, interviewees reported holding a variety of positions within their organizations prior to obtaining their current role, including some who began as volunteers. Additionally, some individuals held dual positions at the time of their interview. Participants were from all regions of the state.

Table 1: Organizational Position of Needs Assessment Interview Participants (N=35)

Organizational Position	Number	Percentage
Executive Director	16	46%
Coordinator/Other director	13	37%
Sexual Assault Nurse Examiner (SANE)	4	11%
Other position	2	6%

Table 2: Number of Needs Assessment Interviews by Region (N=23)

NM Public Health Region	Number	Percentage
Northwest	10	43%
Northeast	5	22%
Southeast	5	22%
Southwest	3	13%


Photo: Leona Woelk

Themes

Researchers identified the following themes from the interviews: organizational strengths; organizational services; populations served, including harder-to-reach populations, service accessibility, and cultural responsiveness; organizational challenges; community-level initiatives and programs; the statewide sexual assault hotline; the impacts of COVID-19; loss of federal funding; and priorities for future development.

Organizational Strengths

Interview participants identified multiple strengths within their organizations. These are described below with example quotes.

Staff support and training

According to needs assessment participants, SA organizations prioritize the health and wellbeing of their staff and have implemented many strategies to support them while doing such difficult work. Many recognized the pervasiveness of vicarious trauma (secondary trauma experienced by those working with traumatized individuals) among sexual assault services practitioners. One interviewee talked about their own experience and how it honed their awareness of the impact of vicarious trauma on agency staff: *"And then I had a very good reminder a few months into working here when I took a sexual advocacy call, and it impacted me more than I could have possibly expected… I was numb for weeks. The vicarious trauma truly manifested…And so, I started immediately talking to the employees at the time, saying, 'This is so real. We cannot say we're okay when we are not okay.'"* Another stated, *"I mean, it's like a small thing, but just making sure our staff know that if there are things that are re-traumatizing or traumatizing or painful or triggering or anything like that, that the priority is to take care of [themselves] because we know that taking care of ourselves is the only way that we can sustainably take care of the community."* Another noted that acknowledgement of vicarious trauma was part of their interview process, sharing, *"So, I think that it's really great that the leadership team has a well-rounded kind of knowledge on the fact that [vicarious trauma] does affect you even when you think that it doesn't. And I feel like we are really great about educating on that up front. We start talking about it almost the minute people start interviewing. 'We need you to know that this is something that can happen.' And then we talk to them about ways of support."*

Common staff support practices included having *"an open door policy,"* doing regular staff check-ins, and debriefing after every case, especially if the case was particularly traumatic or difficult. One person stated, *"It's just good to have that support of your supervisors. That's how I get through it."* Many interviewees reported they also encourage staff to check in with each other and be open with each other if they are feeling burnt out or overwhelmed. In many cases, agency counselors or contract therapists make themselves available to their colleagues if they need more intensive support. In some communities, SA organizations also offer counseling to SA partners. One interviewee said their agency staff can receive counseling through a partner agency if needed.

Supportive employee and wellness policies were also prevalent. Many SA organizations provided what were often described as *"generous"* paid time off, vacation, health, and mental health benefits. One interviewee mentioned that their agency pays 100% of their staff health premiums, with another reporting their agency picks up the co-pay for a certain number of mental health sessions.

Interviewees listed a multitude of other innovative ways they support SAS staff. Flexible schedules were mentioned by many interviewees, including remote or hybrid work options, 4-day work weeks, sometimes closing the entire agency for a day or a few weeks at a time, and having designated *"creative," "respite,"* or *"low-capacity"* days. Some built wellness time into their staff work schedules, or offered wellness stipends that could be used for gym memberships or other activities identified by staff as restorative. SA organizations also provided numerous bonding opportunities to support staff mental health and wellbeing. Examples included yoga sessions, retreats, staff and volunteer appreciation activities, staff and organizational celebrations, team activities, and book clubs. One interviewee stated, *"I have never felt so supported at an agency like I do here."*

Another interviewee shared the importance of having a traditional (Indigenous) blessing to her wellbeing, stating: *"I liked that I was able to go to [my work colleague] and say, 'Can we do blessings? Can we have someone come into the office and have a traditional practitioner come?' … we do really intense work, and sometimes victims may unintentionally unload here. And so, I think we recognize that sometimes we're not aware of the tension that's building within our work environment, not just physically but also spiritually…"*

Photo: Mahtab Soleimani

Staff training was another component of staff support. Some trainings promoted professional development, while others focused on self-care. Examples of trainings included advocacy, historical trauma, vicarious trauma, working with specific populations (e.g., people with disabilities, people who identify as transgender), trauma-informed practices, cultural responsiveness, reflective supervision, conflict management, as well as other types of trainings. Other common practices were paying for conferences and other professional development opportunities and membership in professional organizations.

Strong leadership

Overall, needs assessment participants reported that the administration and/or management teams of SA organizations in NM were very proactive and supportive. They demonstrated a commitment to SA survivors. One participant said, *"I'm not the one to say no. So, if the patient wants care, I'm the administrator who says, we'll figure it out. Do it and we'll figure out how to bill it or cover the costs."* Several interviewees spoke about the effectiveness of leadership despite their being tasked with multiple roles, such as financial manager, human resources (HR), Health Insurance Portability and Accountability Act (HIPAA) compliance officer, volunteer supervisor, etc. Several interviewees talked about the accessibility and transparency of their leadership team, with one interviewee describing how the board president has invited frontline staff to attend board meetings: *"Same thing, we're having another board retreat where they're working on a lot of different things here in the next few weeks. And the same thing, they want a staff member to attend, to really talk to them, and answer questions, and come up with ideas."*

Other examples of effective leadership included bringing in outside resources to assist with things like operational management and policy development, and successfully obtaining funds that have fostered financial stability. One participant shared, *"...whatever we have done has allowed us to have longevity as an agency... And part of that, too, is we are able to identify funding sources and are good at being able to get money so that we are able to have a budget that sustains the longevity and the programs that we do."* Other interviewees talked about administrative efforts to use legislative funds to ensure fair compensation for SANE nurses. Lastly, some participants shared how SAS administrators had actively engaged in professional development, attending trainings on reflective supervision and situational leadership.

Positive relationships

Many interviewees identified positive relationships as a core strength of their organization, including within their teams, with other organizations, and with the community overall. Relationships within agencies were strengthened through inclusive activities with staff and volunteers, such as weekly self-care activities and group therapeutic experiences. Many reported that feeling supported and being able to count on their colleagues fostered these positive relations. As one person noted, *"I think that's what's so good about a big agency like this, is you have support every way you turn."*

Positive relationships with other organizations benefited those seeking services, enabling comprehensive care through advocacy, case management, counseling, and court accompaniment. One participant said, *"And we've built enough relationships that [other organizations] will just get [survivors] in for an assessment. Just let them know somebody's supporting them, helping them, there for them. And they're usually really good about doing that, getting them slotted in the next day or whatever."*

Several SAS interviewees described positive relationships with their communities as a strength. They actively engaged with the local community and were responsive to community requests. One interviewee said, *"And so, we work really hard as a team to make sure that we are meeting our community where they are as far as [resources and statistics] and making sure that what we're teaching and what we're providing is up-to-date and is current."*

Collaboration across agencies

Numerous SA organizations highlighted their collaborative efforts with various organizations to enhance services for their clients. As one person stated, *"But because of our holistic approach and that sort of desire to always support people from all the different angles that they may need, it does mean that so much of our work is reliant on collaboration and working with, yeah, other groups, other organizations, both with refugee-serving organizations, immigrant-serving organizations, domestic-violence organizations…We're part of all of these different intersections."* According to interviewees, key collaborators included the NMCSAP, other SA organizations, law enforcement agencies, the University of New Mexico, and nursing schools. Additional collaborative partners mentioned by some interviewees were Native American or other population-specific service providers (e.g., lesbian, gay, bisexual, transgender, queer/questioning, intersex, and asexual/aromantic/agender (LGBTQIA+), people with disabilities, etc.), CACs, schools, domestic violence coalitions, hospitals, legal organizations, and district attorney's offices. In addition to service enhancement, other collaborative interactions focused on prevention, outreach, training, and education.

Participants discussed initiating and joining interdisciplinary teams, such as Multidisciplinary Teams (MDTs), where information and knowledge were shared. These collaborative efforts aimed to address systems issues, provided training and resources to community partners, and identified gaps in services. One participant provided an example, *"We recently were gathering a group for the Sexual Assault Kit Initiatives and seeing where we can bridge gaps in communication with law enforcement and victims, bridging gaps within the system in general."*

Effective recruitment and retention strategies

Most participating SAS agencies reported that successful recruitment and retention strategies have contributed to greater staff stability within their organizations. While various positions across organizations were highlighted for their high recruitment and retention rates, SANE positions tended to have the most stability. SAS interviewees described a robust array of benefits along with a supportive workplace culture as main factors in retention. Successful strategies included offering competitive wages and generous paid time off (PTO); paying for on-call shifts; implementing flexible and/or rotating schedules, including remote work options; offering wellness benefits; providing incentives; fostering community connections; and promoting self-care practices. One participant noted, *"There are a lot of policies that have been created within the last year… to keep folks and make sure that everybody feels safe, they feel supported, and they feel like they can do the work without any hesitancies or challenges."* This sometimes

required a shift in organizational and staff practices. Though somewhat challenging to implement because staff were used to going *"above and beyond"* to serve clients, one organization began to enforce a 40-hour work week more consistently to reduce staff burnout. Another organization reevaluated standards around education and experience to expand recruitment opportunities. This interviewee stated, *"We do have staff here that don't have the experience but might have education, or have the experience but don't have education, or don't have any experience at all, but they're interested in working in advocacy and interested in helping their communities. And so that's kind of what our staff is made up of. And it's really beautiful to see also just the growth and the collaboration from all the different backgrounds that we have. And so that's really cool."*

Advocacy and education

Many interviewees emphasized their organizational strengths in advocating for survivors. Advocacy is seen as a primary service that they offer to survivors. Participants cited various factors contributing to the effectiveness of their advocacy, such as offering 24/7 advocacy services, using trauma-informed care techniques, and disability-informed advocacy. Participants also highlighted their commitment to considering individual and cultural differences, as well as collaborating with other sexual violence organizations to enhance advocacy efforts. One person shared, *"Our advocacy department does not stop no matter what. So that's, I think, a strength of the organization."* Another interviewee mentioned the comprehensive advocacy training undergone by their team, stating, *"Everyone on our team [has] taken advocacy training."*

Additionally, several participants underscored their strengths in education, emphasizing their initiatives to educate both the community and team members about sexual assault, services, treatment, and recovery. One interviewee particularly emphasized education related to perpetrators, stating, *"And then…talking about the healing of our men and boys who are perpetrating the violence, right? But we know that it comes from somewhere. So, we talk about systems that are a part of the root causes like patriarchy, white supremacy, settler colonialism, and how those pieces fit in the system [leading] to where we're at now."*

Photo: Mahtab Soleimani

Frontline services

Some needs assessment participants discussed their initial client assessment as a crucial and successful component of their services. During this process, they inquired about client needs and used the information to determine the most effective forms of assistance. Some participants highlighted specific questions they deliberately avoided during this assessment, such as inquiries about income status, legal documents, insurance cards, and proof of citizenship, to ensure service and program accessibility. One interviewee said, *"Once they come into this unit, all services are provided, and then I figure out how to pay for it…We don't ask for insurance cards or proof of citizenship… And so…that's been part of our outreach message, 'You come to us and you don't have to prove anything except that you need care.'"* Based on outcomes of their initial assessments, SA organizations offered resources, referrals, and services tailored to the specifics of the clients' situations.

Inclusivity and diversity

Most interview participants emphasized their organization's commitment to inclusivity and diversity, both in terms of their staff and board members and the populations they serve. Many interviewees highlighted the diversity within their teams, encompassing various age groups, sexual orientations, races, cultures, education levels, languages, backgrounds, experiences, and genders. One participant elaborated, *"So one of the things that we look for when we're hiring staff is staff from different communities. And we try to represent every community in New Mexico specifically."* Several participants noted the higher representation of women compared to men in their agencies, noting that this may make it more difficult for men seeking services.

Staff, volunteers, and board members reflective of community

Overall, most interviewees believed that their staff, volunteers, and board members reflected the makeup of their clients and communities. Several shared that inclusion and representation were often part of organizational discussions. Interviewees talked about diversity broadly, listing race and ethnicity, age, professional background, sex and gender identity, culture, community makeup, and lived experiences as considerations in the quest for a more diverse workplace. One person stated, *"And most have some very shared lived experiences with some of our participants, everything from being housing insecure to self-medicating and/or using substances, to sex work, to moving through various levels of educational attainment…we are community serving community."*

Several participants reported they have purposely worked for a number of years on being more representative. One stated, *"For the last 25 years, we've been working really hard on that."* Another said, *"But if you were to look at the staff that we have now versus the staff in the past, I would say we are a very diverse group and a very welcoming place."* Some areas of concern, according to a few participants, were not having sufficient representation from people with disabilities, LGBTQIA+ individuals, bilingual speakers, and those identifying as male. One person noted that their board is made up of

service providers, reflecting, *"It's pretty much our partner agencies. And I don't know if that's really how it should be, if we should venture out past that. When we got started, those were the people who supported what we were doing and so that's where we looked."*

Most interviewees believed that their staff, volunteers, and board members included SA survivors. In some cases, people definitively knew they were included. As one interviewee shared, *"I can say that because they have self-identified, about half of our board members right now are victims and survivors themselves because they have said, 'I want to give back, and I'm ready to give back. This is why I want to be part of the board of directors.'"* Another participant related, *"And I would say 80 to 95 percent of our staff are survivors of different types of violence, whether it's sexual violence, domestic violence, physical violence, stuff like that. So yes, we are survivor-led for sure."* While including survivors in the makeup of SA organizations was considered important, there were also concerns about protecting them from further harm. One participant explained, *"We started a volunteer class one time, and you have to be careful with survivors [volunteering]. They were triggered the very first night. One of them ended up coming to our counseling."* Another said this about integrating SA survivors into staff, *"I need to know that they're far enough on their healing journey that I'm not going to do something that's going to trigger them."*

Telehealth/Tele-counseling

Several interviewees described how incorporating telehealth and tele-counseling services had strengthened their organization. They utilized tele-video, telehealth platforms, and virtual tools such as Doxy and Zoom to conduct counseling sessions, advocacy, legal appointments, triage, and referrals. Interviewees emphasized various benefits associated with telehealth including service accessibility, particularly for individuals residing in rural areas or those without easy access to transportation, and opportunities for staff to work remotely as needed. One person noted, *"[Although it started because of COVID] we've kept [video options] because it seems easier to work with people."*

Other strengths

In addition to the primary strengths highlighted by participants, various individuals discussed a range of positive organizational attributes. These included having strong and trusted community relationships; having a client-oriented approach; employing a skilled team of therapists; ensuring accessibility in terms of the environment, location, and building; and attending to the needs of specific populations. Several participants also emphasized their robust outreach efforts and community education initiatives, which contributed to increased awareness of SA services in the community.

Organizational Services

SA organizations provide a wide variety of services to survivors. Descriptions of these services are provided below.

Advocacy

Interview participants talked at-length about their flexible, comprehensive, holistic, survivor-focused advocacy services. As one interviewee stated, *"…we meet the client where they're at, whether it's something that occurred 5 minutes ago, 5 hours ago, 5 years ago, 50 years ago. We meet them where they're at, and they're seeking our help or our guidance. So, we help them make decisions, give them their options, and give them that power and control back to really empower them to make those decisions of where would they like to go from here?"*

The majority of interviewees stated that their organizations provided some type of advocacy services. In most organizations, advocacy was provided by specific staff and volunteers that had completed a 40-hour advocacy training. Advocates were highly valued for their ability to connect with survivors, their knowledge of community resources, their capacity to triage clients and identify needs, and their ability to navigate sometimes complex criminal justice, medical, and social service systems. One person described their organization's advocates as *"courageous,"* while another stated, *"…our advocates go above and beyond…"*

Broadly speaking, advocates provided crisis response (e.g., triage and referral); legal advocacy (e.g., court accompaniment, assistance with restraining orders, legal referrals, etc.); medical advocacy (e.g., SANE exam and other types of medical exam accompaniment and referral, etc.); and social service advocacy (e.g., assistance with housing, financial, and basic needs, counseling referrals, etc.). In some organizations, advocates responded to all survivors, while other organizations had advocates that were designated to assist specific populations (e.g., children, people living in rural areas, students on campus, survivors with disabilities, etc.). Advocacy was typically provided in-person or over the phone. Additionally, one interviewee reported that they post an updated list of resources on the agency's website so survivors and community members can directly access needed provisions if they want to.

Medical and forensic services

Almost half of the participating organizations offered adult SANE exams. One interviewee described the importance of SANE services beyond the physical exam itself: *"And so our strength is our nurses who do the frontline services and response. I feel passionately that the nursing response to anybody who has experienced violence has value in the medical assessment and affirmation that their body is okay. And then also, in the linking of resources and referrals. And then finally, in the medical treatment and forensic documentation of the assault."* Several SA organizations conducted forensic interviews and SANE exams for children to assess for child sexual abuse, with one organization dedicated to diagnostic clarification and injury identification in children. A few also provided pediatric exams, distinguishing between acute exams (for SAs occurring within a 72-hour period for children or a five-day window for adults) and delayed disclosure exams (wherein the abuse might have happened months or years ago). One interviewee described the importance of the deferred exams, *"Not only do we provide acute SANE exams, but also regarding sexual assault, deferred sexual assault exams where they meet with our doctor. Our children meet with our doctor if there's any concerns for STIs or anything going on with their body, that they just want some reassurance or for the doctor to take a look at them and make sure that their body is healthy and that they're okay."* Several interviewees talked about their hopes to expand SANE and forensic services, especially in rural areas where access is limited.

Counseling

All needs assessment participants agreed that counselling was a vital component of care for SA survivors, particularly with therapists trained in trauma-informed practices. One interviewee stated, *"And we recommend counseling for everybody no matter-- because chances are, there probably is previous trauma. I mean, and we really try to get the people the counseling."* Those that did not have counselling services at their own facility stated that they provided referrals to therapists located in their community. Several agencies reported that they also referred to an outside agency for therapy services if requested by a client.

Agencies had differing structures for therapy services. Some had counselors on staff while others used contract therapists. Several mentioned using both, and one used a volunteer therapist until their agency was able to hire one. Agencies typically offered individual and family counseling, with some also providing group sessions. In several cases, non-traditional modalities were offered, including healing circles, yoga, or cooking or drumming. As one person explained, *"Right now, we're trying to think of what is best for our community by exploring what activity might work best."* Most reported that the number of therapy sessions was unlimited, and therapists worked with clients to establish a treatment plan that guided the course of therapy.

Many noted that the COVID pandemic influenced their counseling services, requiring that counseling be offered remotely through video or phone visits. While there was initial anxiety about the impact of remote therapy on clients, some noted that this added

flexibility had a positive impact. One person explained, *"And we started doing a lot of therapy remotely, which unintended result of that was that our no-show rate went down to almost zero. And so that will be continued...for those people who find it easier to not have to travel or find childcare or whatever those barriers are, we will continue to keep that telehealth model also."* Several interviewees mentioned that their agencies continued to offer both remote and in-person options, while others have returned to in-person sessions only.

Researchers asked needs assessment participants about counseling waitlists and received a variety of responses, including, *"So, it fluctuates every month."* In general, SA organizations saw waitlists as detrimental to client wellbeing and worked diligently to address them. Some said they currently had no waitlist but did have one until recently. Others said they always had a waitlist, even if it was minimal. Waitlists ranged from a few weeks to several months, though one person reported that, during the pandemic, some people waited over a year to be seen. Several participants said that even though they had waitlists, theirs were shorter than those of other counseling services in the community. Waitlists were often reported to be an outcome of staff vacancies and/or an increase in the number of survivors seeking services.

Given the ongoing issue of waitlists, several agencies expressed concern about how to address clients in the immediate aftermath of a sexual assault. As one person stated, *"But we just have nothing really for immediate care. Somebody that's presenting as like, 'I just need to talk to somebody. I need help right now. I need some support.' We don't really have any of that."* One interviewee reported that they've addressed this issue by scheduling crisis stabilization sessions at intake when needed, while others would ideally like to hire a specific person to serve clients in emergent crises.

Referrals

In addition to the in-house services offered by SAS agencies, they also provided referral services to other organizations aimed at addressing survivor needs. In some cases, the referrals were for SANE services, delayed pediatric exams, or other types of medical care (e.g., in cases of domestic violence). One person discussed the interplay between making referrals and providing direct support, stating, *"So, a lot of our work with SA folks really is referring folks out, but also sticking with them to ensure that the other individuals that they're working with are competent and compassionate as they are working with individuals."*

Several interviewees reported referring survivors for counseling services and other types of mental health or substance disorder treatment. One explained, *"And so for some of the folks that live in those farther away areas, we do have to refer for therapy because it's not great doing therapy with kids online. And it's hard for them to come all the way to [city], which is where our therapists are. So, we do some referral for kids for therapy. And for things like-- people may need all kinds of things like substance abuse treatment and things like that that we don't do."*

Other types of referrals included diagnostic testing services (e.g., neuropsychological, autism), immigration assistance, legal advocacy, court accompaniment, case management, basic needs (e.g., emergency housing, food, utility assistance), and transportation. As one person stated, *"It's really just a matter of that assessment and if what we offer is appropriate. And if not, we make those referrals to others."*

Housing

A few SAS agencies provided housing and offered emergency shelter. Some had transitional housing programs for both sexual assault and domestic violence survivors, with advocates assisting in finding housing and providing home visits. However, one interviewee highlighted the challenge of insufficient shelter capacity as well as the inability to secure hotel rooms as an alternative, saying, *"It would be nice to add more shelter space because at one point pre-pandemic, I mean, there was four single women to a room. And so, it would be nice to just add more rooms to our shelter and be able to serve more people because we have more space."*

Peer support

A couple of SA organizations offered peer support groups to foster mutual support and understanding among survivors within a safe space. In some cases, these groups were centered around immigrants and refugees with common languages. Participants were also able to become peer group facilitators, if desired. One interviewee described the value of this type of connection: *"Oftentimes, our women who are really feeling ready to be engaged and to kind of keep this cyclical process of healing going within the community will either end up helping us as peer support group facilitators or advocates within the community or even people like our community cooks."*

Transportation

A few of the participating organizations had the capacity to provide transportation for their clients to receive SA services or sometimes to go to related appointments. As one interviewee stated, *"We also can provide transportation as needed for survivors that may not have them. Transportation available for services with us and back to where they came from, that being home or somewhere else where they came from."* In one case, the interviewee reported that though they can provide transportation in general, in circumstances where a sexual or domestic assault had just taken place, the organization requested law enforcement to transport to decrease the likelihood of further violence directed toward the client or staff. Some organizations reported that, while they did not provide transportation directly, they could utilize a cab company or provide assistance for transport by bus.

Basic Needs

Several interviewees discussed their agencies' efforts in supporting clients' basic needs, in addition to addressing the sexual assault. They highlighted their work to provide housing, food, and clothing through various means, such as operating food pantries, clothes pantries, thrift stores, shelters, and collaborating with local hotels. One interviewee stated, *"There's never enough to be able to help everyone with every single need that they potentially have. And with a lot of our folks being unhoused, it creates what feels like a cycle of dependence that it's my intention to break."*

Hotlines

Interview participants also described staffing 24-hour hotlines and text lines, and in one instance, a warmline for children that was opened for statewide access during the COVID-19 pandemic. One interviewee also spoke about a hotline that can be accessed by offenders as well.

Education

Several providers supported their clients and/or communities with technical assistance and educational classes, such as financial education, literacy workshops, and cultural education. One interviewee also discussed providing cultural competence education to other sexual assault service agencies, noting that agencies also need to diversify their workforce to better meet client needs, stating, *"...if [sexual assault service] agencies actually do want to better serve our populations, they need to hire professionals [that reflect those communities] to really do the work within those agencies to make sure that they are providing those services in an authentic way."*

Other

Additional services mentioned by participants included psychosocial rehabilitation; crisis stabilization; civic engagement activities (e.g., integrating clients into advocacy and policy work); case management; human trafficking screening; and counseling for people with gambling addictions.

Populations Served

Overall, interview participants emphasized that their organization was committed to serving any person that requested help. This included any persons regardless of race and ethnicity; sexual orientation and gender identity; background (e.g., military, undocumented) or socioeconomic status; and, those with cognitive, physical, or mental health disabilities. Most participants also stated that their organizations serve all ages, although some focus on specific age groups or refer specific ages (e.g., children) to other agencies for appropriate care. Across participating agencies, interviewees reported that the majority of SA clients identified as female and had limited financial resources. Some agencies tailored services to specific populations, such as Native American/Indigenous, Hispanic/Latino, or immigrant individuals.

Harder-to-reach populations

When asked about populations that were harder to reach and serve, several interviewees described the difficulty of engaging undocumented immigrants. One interviewee shared, *"Undocumented immigrants…are also part of a population that is very difficult for us to convince to come see us, but we advertise that we're not going to-- we're not going to ask about immigration status, or anything like that."*

Multiple interviewees reported veterans were another group that rarely sought SA services. One needs assessment interviewee explained, *"They don't want to be identified as veterans because they're so concerned and afraid about the military finding out that they're victims, right? There's a huge stigma regarding that population."*

Several participants discussed challenges with reaching the LGBTQIA+ community. In their experience, social stigma and concerns about safety hindered many from seeking services. One person stated, *"Another potential major barrier is that trans[gender] folks are terrified. We live in a political climate that is not kind to trans people. It doesn't always feel safe to be out. And how that translates to us is that people are terrified even to reach out to us, right?"*

Interviewees also touched on the difficulty in reaching individuals with cognitive and physical disabilities, including people who are deaf and/or blind. One interviewee shared,

"We're not doing a great job of reaching out to people who are blind or who are deaf and hard-of-hearing."

Additionally, a few interviewees shared the difficulties in reaching children, especially during the pandemic. One interviewee stated, *"One of the challenges I felt uneasy about during the whole pandemic was the fact that the children were not in school. So, they didn't have someone else outside of their family unit to confide in."*

Service accessibility

Given the range of clients seen by SAS organizations, many reported careful consideration given to service development, adaptation, and implementation to increase service accessibility. Most organizations offered language services to accommodate non-English speakers, including some with dedicated staff, advocates, nurses, or therapists fluent in Spanish or other languages and dialects. Interpretation services, translation resources, and language lines further aided in serving individuals whose primary language was not English. Several organizations reported specifically advertising their services in Spanish. As one interviewee stated, *"If you already have this traumatic thing and you're facing barriers, don't make language an extra barrier."* Another interviewee talked about incorporating culturally appropriate graphics into outreach materials to better reach Native American communities.

Other discussions centered on being able to effectively serve survivors who were deaf or hard-of-hearing, or blind or visually impaired. Most organizations offered American Sign Language interpreters, as well as tablets, phones, and closed-captioning to aid in communication with deaf or hard-of-hearing clients. One participant described how their shelter had been adapted, saying, *"...we have a notification system for somebody who is deaf or hard-of-hearing that has a light that flashes for somebody knocking on the door. It has a pad that goes under the pillow that shakes the bed."* Other adaptations included providing specialized phones and signage in braille for those with visual impairments.

Those with other physical, cognitive, or mental health disabilities also required extra consideration. Several interviewees described facility adaptations made to accommodate those with physical or mobility limitations. They ensured compliance with the Americans with Disabilities Act (ADA) by incorporating wheelchair ramps, elevators, accessible doors, and wheelchair-friendly bathrooms and showers. Several interviewees mentioned allowing caretakers to accompany survivors with disabilities while in shelter services. Other needs assessment participants said their agency employed trained interviewers proficient in communication techniques geared toward those with cognitive or communication disabilities. Other topics related to accessibility of services for people with disabilities were the importance of promoting and protecting the rights of individuals with disabilities, raising awareness of legal protections, and educating law enforcement on how to work with members of the disability community more effectively.

Additionally, SA needs assessment participants recognized that feeling welcomed and respected was also a factor in service accessibility, particularly as it related to clients that identify as LGBTQIA+. Several interviewees discussed the importance of training their agency staff to better understand the unique considerations of LGBTQIA+ survivors. Some were also intentional about hiring LGBTQIA+ individuals, emphasizing the provision of services without discrimination based on gender identity or sexual orientation, and engaging in community events specific to the LGBTQIA+ community, such as gay pride parades. Several interviewees noted that it was especially important to ensure that those providing sexual assault exams to transgender individuals be competently trained, and respectful and sensitive in their approach.


Photo: Mahtab Soleimani

Cultural responsiveness

Interview participants acknowledged the importance of being culturally responsive to the populations they serve. Providing language services representative of cultures in NM and fostering respectful relationships were seen as foundational aspects of cultural responsiveness. Many SAS agencies employed staff members with diverse cultural backgrounds and experiences that mirrored the communities they served. One interviewee articulated, *"And I think, also, the fact that we all are from the communities we serve and are really deeply connected and tied to the communities we serve, and we represent the populations that we serve, so immigrants, refugees, survivors ourselves…we are very reflective of our community. And I think that that's extremely powerful."*

Participants also described policies promoting accessibility and equity, including providing services without consideration for immigration status, sexual orientation, gender, gender identity, or socioeconomic status. A majority of interviewees discussed the importance of staff training to enhance cultural sensitivity and knowledge about groups who have experienced historical trauma, been marginalized, or have experienced other forms of discrimination. One participant shared, *"…what we do provide, especially related to sexual violence, is we build [advocate and provider] capacity in the realm of cultural and holistic knowledge that they can incorporate in their advocacy…are they incorporating medicine, traditional herbs, things like that, when they're grounding a survivor who might be in crisis? Are they connecting them to a medicine person to support with healing?"*

Organizational Challenges

Needs assessment participants identified a number of challenges to effectively operating their organizations and comprehensively responding to SA survivors. These included: lack of funding; recruitment and retention barriers; administrative burden; lack of community support services; social and cultural stigma; lack of transportation; and working in silos. The following section describes these challenges in more detail.

Lack of funding

All interview participants identified lack of funding as their most significant challenge. As one person summarized, *"Everything's going to come back to funding. Always funding. I wish there were a better, more poetic answer, but there is none."*

Many participants reported that a lack of funding to support hiring and training staff and an inability to offer fair compensation affected recruitment and retention. Offering competitive wages and reimbursement for training time was of particular concern for SANE positions. As one person said, *"I would love to be able to hire more nurses and find a different way to pay nurses… I think that in order for us to be able to have the staffing to provide services, being able to pay nurses to be trained is important."* Other positions, like advocates and therapists, were also reported to be underfunded. One person said, *"[Accessibility] could be increased if indeed nobody had to wait for long-term treatment. And we have not found a solution for that because the only solution would be to have some consolidated multi-year funding that would allow us to add full-time employees to our clinical team."* Another stated, *"It's very important to show up for people, travel to them…So, funding, of course. I'm sure everybody says funding. But the funding that's tied to positions to provide advocacy work so that we have a better idea of what is needed, because that's just the starting point."* There were also associated costs, such as advertising and administrative time, that added to the challenge of filling open positions or expanding the workforce.

Inadequate funding also impacted service access, with some interviewees reporting they were not able to provide coverage or could only provide limited coverage in rural areas. One person stated, *"…But services are limited out of those [rural] offices. And, again, it always comes back to funding, right, and staffing…"* Another person stated, *"Specifically, for sexual violence, I don't have a lot of funding…It's extremely limited. And so, it would be nice to have a little extra to do events, community awareness, and prevention…that's one of the things that I really want to get involved in. But I…don't know where that funding would come from to start up those programs because some of those programs, you have to buy the curriculums, you have to go through the trainings, and you have to have the materials and all the things."*

Funding structures were also highlighted as a barrier. Several interview participants talked about restrictions around certain funding streams that impeded the ability to provide things like on-call compensation or pay for administrative positions. A few interviewees also talked about needing unrestricted funds to support capacity-building,

team development, and technical assistance. Additionally, several participants discussed the restrictions on funds, preventing their use for prevention, and the vulnerability of prevention funds. One interviewee stated, *"The problem is when money gets tight, everybody wants to cut prevention. And I feel like that's always an issue."*

One interview participant spoke of the frustration of grant writing itself as well as the constant need to compete for SA money. Multiple participants also talked about ongoing increases in cases and community needs, while funding did not increase or did not increase adequately. One person described it this way: *"I mean, I did a calculation of our increase in client numbers from fiscal year '19 to fiscal year '22, and we've had over a 400% increase in clients over those three years. However, of course, as you can imagine, our funding has not increased at that same rate."*

Photo: Leona Woelk

Recruitment and retention

Most interviewees described recruitment and retention issues as barriers to providing services at their organizations. The positions of SANEs, advocates, forensic interviewers, and counselors/therapists were often portrayed as difficult to fill because they all required specialized, time-intensive training. One interviewee explained, *"Well, we've tried for many years to hire a licensed therapist. And we've not been able to find one that would fit our needs. I mean, I've literally been looking for 10 years."* Another said, *"And I think the challenge that we have in keeping people is that we're not looking for someone to be super well-versed in sexual assault advocacy. We're looking for someone to be very well-versed in sexual assault advocacy and disability."* Additionally, there is no guarantee that staff that have completed these specialized trainings will stay at the organization, which can be draining on both staff and resources. As one person described it, *"It can get a little discouraging sometimes when you spent this time mentoring and helping somebody kind of get to a place where they're ready to kind of fly on their own, and then they decide that they're not up for it. Then…it can get a little discouraging."* Additional personnel vacancies mentioned by interviewees included case managers, clinical directors, advocacy coordinators, and communications/marketing personnel. A few participants also talked about volunteer positions being hard to maintain as they require extra staff supervision.

Several interviewees talked about recruitment being affected by whether applicants were a good fit for the organization. One stated, *"So, it's hard to find people that have the same values [as our organization] that want to work for the victims, that won't judge the victims."* Several interviewees from rural areas noted that hiring was difficult *"because the pool [of applicants] is small."* A number of rural organizations have attempted to address this by hiring from urban areas in NM or from outside of the state, but this had its own challenges. One said, *"And we actually, in the last couple of years, have hired several people who tried to come here...and could not find housing. And had to not take the jobs because they couldn't find housing."* Another said, *"They could be across the country, and they're interested in taking one of the positions. But then there's the relocation that becomes the issue. And not everybody wants to live in [rural NM]. So, I mean, we could even get applicants from Albuquerque, but making the move from Albuquerque to [rural NM] is a completely different culture shift and environment and everything."*

Organizations working with specific populations faced additional recruitment and retention challenges. One person explained that *"...because of our priority in making sure our clients are feeling comfortable with their case manager and the language and the cultural expertise that our case managers have, then every case manager has to be an expert in all of the possible areas of work that we do rather than being an expert in a specific department of services."* Applicant pools for these organizations may also be quite small, as described by one interviewee: *"Our communities are interlaced. Our families are interlaced. And so oftentimes, we struggle with just the pool of applicants that we may have. And also, because we really want to prioritize hiring people from within our community, it can get really hard for us to find folks who are able to work with us in this capacity because of how small the communities are."*

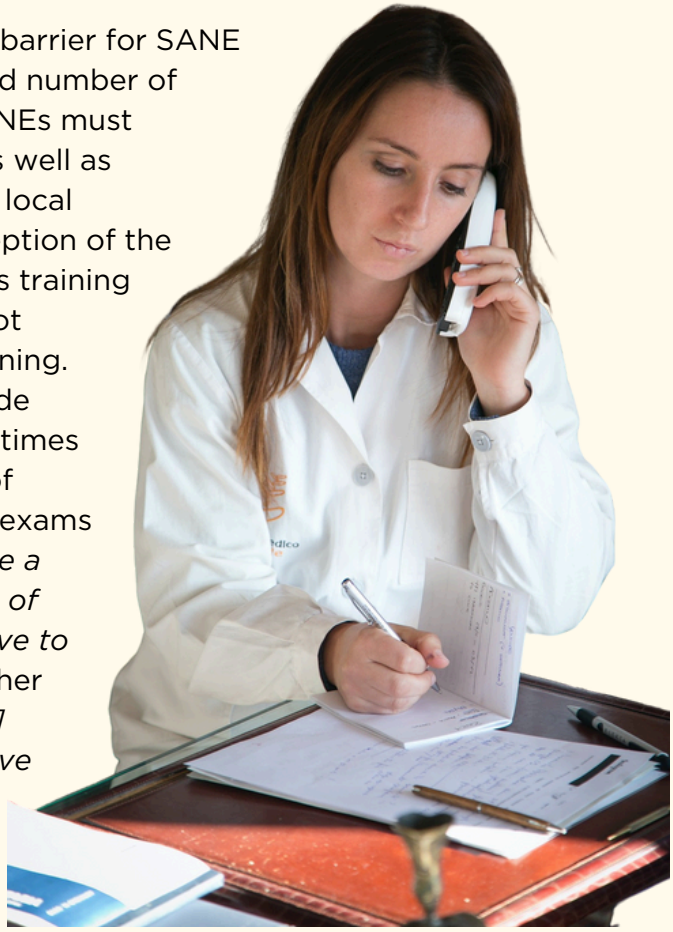
Many reported that the nature of the work itself contributed to low retention rates. This included working with clients living in *"very heavy"* circumstances, such as financial hardship, lack of personal safety, untreated mental health conditions, and other types of adversity; needing to manage high caseloads; and having to take on-call shifts. Across organizations, many positions required on-call participation, including CEOs, Executive Directors, managers and supervisors, various types of advocates, forensic interviewers, SANEs, psychotherapists, volunteers, and physicians. Challenges associated with on-call responsibilities included extensive training, schedule coordination and coverage, and the need for increased funding to compensate employees for additional on-call hours, particularly after office hours.

Vicarious trauma also affected staff recruitment and retention across organizations. One person noted that SANE training itself may be traumatizing, *"I mean, they see the visible, sometimes bruising, marks, bleeding...the things that they see is really traumatic. The pictures that they have to take, the stories that they have to take in."* As others explained,

"But sometimes we go through the high turnover. In this field of work, as you can imagine, it could be very mentally, emotionally, physically exhausting because the need is so high," and *"...sometimes we're good at leaving it there, but sometimes it goes home with us."* This could affect board member selection as well, as one interviewee explained, *"But the recruitment for our board of directors is sometimes challenging because of the topic, right, sexual assault. They're like, 'Oh, I don't know if I can do that.'"*

Recruitment and retention of SANEs were of particular concern. Needs assessment participants reported that qualified candidates were often rare, especially in smaller communities. This led to service gaps in some areas of the state, with one person stating, *"So we have not been able to provide 24/7 SANE coverage in a really long time."* One factor related to the modest pool of potential candidates was a general lack of awareness among nurses of SANE as a career option. One participant noted, *"I think as far as the nursing side, they don't even talk to you about it in most nursing schools...I think that even just starting to put that idea into nursing school and just discussing it as a career option would assist in the nursing side some. We go out and speak to our college occasionally, but there's so many nursing schools across the state, and people have no idea that this is an area of nursing that they can get into."*

Rigorous training requirements were also a barrier for SANE recruitment and retention, as was the limited number of times a year SANE training was offered. SANEs must complete 40 hours of classroom training, as well as additional clinical skills training followed by local preceptorship. In many cases, with the exception of the 40-hour classroom training and clinical skills training provided through NMCSAP, SANE's were not compensated for the time they spent in training. Preceptorship in rural communities was made more difficult by low case numbers. It sometimes took many months to achieve the number of required cases necessary to perform SANE exams independently. One person stated, *"We have a hard time recruiting, and I think it's because of all of the training requirements that they have to do prior to even doing a SANE exam."* Another said, *"So our nurses have to shadow [SANE] nurses first for five exams, and then they have to be shadowed for five exams. So, you can imagine...[they're] kind of just like, 'I'm not getting paid for it' and they kind of, kind of go away after a while."*



Additionally, interviewees reported that in many cases SANE positions were part-time, with nurses needing to have full-time employment in addition to their SANE work. This often meant nurses needed to arrange time off from their main job or give up their weekends to complete the SANE trainings. It also meant that many SANE exams or on-call shifts took place after SANEs had finished one or sometimes multiple 12-hour shifts in other medical settings. Several interviewees talked about how exhausting and unsustainable SANE work could be under these circumstances. One person expressed, *"So all of these nurses, most of them have other full-time jobs. Some of them have part-time jobs. So that can be a hiring challenge. How is a nurse, who has another job, going to fit SANE examinations into her schedule?"* Another said, *"Because [SANE nursing is] a demanding job…I mean, they're just burned out."*

Another person felt that the distinctiveness of the circumstances under which SANEs practice affected retention. They explained, *"But this is a very independent practice. You're doing this exam at 2 o'clock in the morning, and most nurses are used to working as part of a team and consulting somebody in real time and working together. And so, some nurses…when the reality comes that they need to do [sexual assault exams] all by themselves, it's something that they didn't realize even during the training and the preceptorship how independent the role is."*

Administrative burden

Many interview participants described how complicated it was to manage the administrative processes related to SA services and programs. They often described the disconnect between knowing that *"we're doing wonderful work"* at the macro-level but being required to report at the micro-level.

Reporting. Participants described the time-consuming and resource-intensive nature of responding to multiple funders with disparate reporting requirements. Some organizations had designated staff for collecting and entering data for reporting, but in most cases data collection and entry was a shared endeavor. It required combing through multiple records to report on staff that work across a variety of funding streams. This also led to concerns that funders had a narrow view of the work being accomplished by the organization. One person lamented not being able to report all of *"the wonderful things that we're doing as opposed to just the five people that go under this grant."* Several participants acknowledged that the NMCSAP has been working to streamline the data collection process, but some reported that it has become more burdensome. As one person explained, *"…the new requirements of reporting for our SA services has been really hard on us. Just being able to collect the information monthly now and entering into that system…it's been hard. And before, we were reporting monthly but not as detailed information…And it just takes a lot more time and energy in collecting all that information from case managers, from legal to our lawyers and then our counselors. It's been a burden for us."*

Capacity. Many interview participants discussed challenges related to administrative capacity. Several interviewees described themselves as *"wearing many hats"* and being *"pretty spread thin."* Despite this, they talked about not having the ability to hire staff that could ease the burden, like HR managers, grant writers, or program managers. Hiring itself often exacerbated the capacity issue, as it required significant time to recruit, interview, and train new employees. As one person stated, *"But in order to hire more people, I need to have more time to hire, and I need to hire administrative support…So, I think that's been really hard."* Similarly, another participant said, *"…it's more of like the structural needs of supporting the organization's capacity-building and time to grow… that balance is definitely probably our biggest challenge in terms of hiring."* Lack of administrative capacity could be even more problematic in rural communities where they found it challenging to fill staff vacancies with qualified applicants.

Policies and procedures. Some participants discussed the lack of administrative capacity to develop policies and procedures or employee handbooks. They stated that they did not have the capacity to *"start from scratch,"* and even when, the NMCSAP provided templates and examples of documents, it still required staff time to adapt the materials to fit the specific organization. One person emphasized that it was not a matter of more training, saying *"I don't really need help in learning how to grant write. I do need help in just other people writing the grants or having an administrative assistant or things like that…"*

Grant processes. There were also challenges with financial sustainability and grant application processes. One person reported a concern that grants themselves were too *"cookie cutter,"* and did not allow the flexibility to support the unique needs of rural vs. urban providers. Another described the dilemma of responding to the financial constraints of grant applications: *"But because we're grant-funded and especially because we're funded by federal funding, state funding, like municipal funding, sometimes we can't hire unless we know that we're going to have that funding. But we don't know. We can't write that into the budget unless that person exists. So, these systems are just not built to support this and trying to find funding to cover somebody. And I don't like offering jobs that I don't feel like I can sustain at least a few years. So, I think, yeah, those kinds of things are really hard for us to kind of navigate, is what risk do we take by continuing to push ourselves to carry more than we can as an organization or as an individual staff, or to risk not getting that funding that we applied for and then having to figure out how we're going to fund this role. So, I think it's always risk management and what's possible within that."*

Lack of support services

Multiple interviewees discussed the lack of support services in their communities as a significant barrier to providing comprehensive sexual assault care. Mental health services were the most often mentioned gap. This included counseling services, inpatient care for those with chronic mental illnesses, child therapy, and psychiatric care that included

medication management. One person reported, *"I feel like we're doing the best of our ability, but we could always do more for sure. I wish we had more-- we're having a hard time right now finding placements. So, more inpatient placements and/or transportation for our clients. So, people who are, when you say chronically mentally ill that are needing inpatient and stabilization right here, right now, emergency services, we're having them stay at our hospital for days at a time and sometimes being released because there isn't placement for them, there's not transportation for them."* Another person indicated that they provide mental health services, but not after hours or in locations outside of their agency, lessening the accessibility of care. They stated, *"I'll give you an example. If a client might be better served at home doing therapy, and the only thing that we can do is phone, well, that is really a compromised sense of accessibility that they're going to have. But we are not prepared and equipped to serve outside of our building."* Another participant shared, *"I think that we need more mental health services. Honestly, there's just not enough. Our community is really struggling with that. I think being able to assist in any way, we try to do our best to be there for everything, but we can't because we don't have the staff to do it. I think that's a huge need."* Several interviewees said that the shortage of mental health providers also contributed to wait lists for therapy services.

Other interviewees discussed lack of medical services as an issue, including acute and delayed pediatric exams and SANE services. This resulted in referrals to other centers or medical providers, which sometimes meant travelling some distance. One person shared, *"... we do have to refer those out to a different nurse practitioner... So that is not super convenient for our delayed pediatric cases."*

Lack of transportation

Most interviewees reported that transportation was a substantial barrier for SA survivors, especially in rural areas of the state. Many agencies were not able to provide transportation themselves, and public transportation was often nonexistent, spotty, or difficult to access. One interviewee reported, *"We have a lot of families-- a lot of the populations we serve are impoverished or having car issues or have never had transportation. And it's not realistic to think that somebody can walk to our center in what we're having-- it's like 108 degrees, and they're going to walk five miles over here to meet with us for a couple of hours. It just seems super unrealistic. So being able to provide that transportation is always a little bit of a challenge."*

Sometimes an additional issue, even when clients had transportation, was long travel distances to services. One person stated, *"We do whatever we can to get them there, but a lot of times, there are clients that they don't want to travel 45 minutes to get a SANE exam."* Another said, *"We had a family come from [a rural area]...traveling two hours, receiving exams, traveling back another two hours. That's a full day of missing work, right, or missing school, whatever the situation may be."*

Several participants talked about collaborating with law enforcement to transport clients or trying to help clients use public transportation, but these options were also sometimes problematic. One person stated, *"However, there are people that don't feel safe on buses, or don't like buses, or don't know how to use public transportation. So that's potentially a barrier for folks."* Another shared, *"There are trust issues, of course, between our population and officers. And so, it hasn't always been easy for them to access services because they don't want to come with a police officer sometimes."*

Stigma

Several interview participants discussed the social stigma surrounding SA as a barrier. They reported that it hindered SA survivors from coming to their organizations to receive treatment and support, and, as one interviewee stated, *"... [SA is] more of a taboo issue than even domestic violence."* In addition to the shaming and victim blaming experienced by the general population, a few interviewees mentioned veterans, people with disabilities, and LGBTQIA+ individuals as facing additional stigma when seeking services. One interviewee stated, *"I mean, we're in a really conservative community and the LGBTQ community probably doesn't feel very represented or protected here."*

Several interviewees discussed cultural stigma as an additional challenge, particularly among Native American, Asian, immigrant, and refugee populations. Organizations serving these communities approached this taboo topic carefully. One person said, *"But as our outreach specialist would tell you, in certain cultures, it is not seen as appropriate to talk about sexual violence and that kind of stuff."* Another person explained, *"That's one of the biggest barriers is because talking about sexual violence is taboo or a lot of the teachings that have been taught in the past from our elders is that talking about sexual violence will bring sexual violence into your village or into your community or into your home. And so, one of the things that's hard is talking about that it's already here. And so, if it's already here, then how do we address it? And how do we prevent it in the future? And so that's one of the conversations that we're navigating with our elders and with our communities. And so, we do that through education. We do that through trainings."*

Working in silos

A few interviewees described organizations or systems working in silos as a barrier to serving SA survivors. Participants discussed how law enforcement, hospitals, SA agencies, other social services agencies, and schools often worked independently, and didn't coordinate around SA or addressing survivor needs. Participants that identified silos as a barrier felt it also prevented them from receiving SA referrals. One person said, *"It's a community issue with-- law enforcement just doesn't want to call anybody. They don't want anybody around to stick their nose in their business if you will. They are very closed."* Another reported, *"There'll just be some schools that we know that there's sexual assaults happening because we're seeing those victims, and the schools just won't let you in."*

Community-level Initiatives and Programs

Community education and outreach

All agencies involved in the SA needs assessment provided some type of community outreach and education. Interview participants described various avenues for outreach, including participation in annual and community events, such as PRIDE events; Domestic Violence Awareness month; SA Awareness month; local health fairs; community or cultural gatherings; radio and television interviews; social media (e.g., Facebook); and agency-specific marketing campaigns. Typical outreach materials included flyers; posters; radio and newspaper advertisements; decals; and packets of materials that could be distributed to potential clients by local partners, such as law enforcement. Several interviewees reported that clients also learned about their services through *"word of mouth."*

Photo: Mahtab Soleimani

Most interviewees also discussed community engagement as an outreach strategy. In some cases, this involved participation in local collaborative partnerships, such as the county health council, where they could interact with other community providers. In other cases, education was focused on specific groups such as schools, campuses, criminal justice personnel, parents, people living within specific geographic or other locations (e.g., in low-income housing). Some awareness and education efforts were aimed at the general public. One-time educational and awareness sessions were varied and included topics such as agency services and location, the dynamics of sexual assault, transgender 101, LGBTQIA+ 101, consent and body autonomy, healthy relationships, sexual assault and people with disabilities, root causes of sexual violence, trauma and brain development, SANE services, and other related topics.

Despite the variety of outreach and education methods employed, not all strategies were successful. As one person said, *"So really trying to educate [the community] on what the dynamics of sexual abuse and sexual assault include. So, we did that for a couple of years. We were semi-successful. We had some people come out [to events] and some [events] where we didn't have very many people come out."* Similarly, others reported, *"I do find that we don't reach everyone, so we're always thinking about what we can do to better get our organization out there"* and *"We still struggled with people knowing that we were here and understanding what we do"* and *"I do believe that there is some more area of growth and opportunity for us in outreach efforts because we are a nonprofit that's been around [for over 20 years], yet the community still isn't sure that we exist."*

Many interviewees mentioned the thoughtfulness, creativity, and individualization needed to improve education and outreach efforts, because *"... sexual violence can be a scary topic."* One person explained, *"We may not come in right away talking about sexual violence or what it is. It may be a very subtle and slow process to get to a place where that trust is built to talk about those things."* Several interviewees also discussed the need to provide education within an appropriate cultural context. One person summarized their approach this way: *"But there are also some things that we have to be specific to each community and some teachings and things that we're not allowed to teach to other communities. And so that's, again, going back and making sure that each event that we-- each training and each event that we are conducting is specific and is intentional for what we're trying to do."*

Prevention initiatives

Most interviewees reported that their agency participated in prevention activities. However, it appeared that there was some confusion among providers about the difference between one-time educational and awareness-raising sessions and comprehensive SA prevention, including primary prevention (strategies that take place before SA has occurred to prevent initial perpetration or victimization). Examples of this included responses like, *"The prevention is about awareness,"* and *"So yes, it's one time a year for the schools,"* when participants were asked to describe prevention initiatives.

Interview participants provided several reasons for not participating in SA prevention. This included not having funding for prevention. It also included not having capacity for prevention, as one person described, only when *"...our advocacy department gets to full capacity, then our outreach and prevention specialist doesn't have to be in advocacy and can devote more units of their time out in the community doing that outreach and education of not only who we are, but prevention."* Others described how disrupted community relationships due to COVID-19 have impacted prevention access. One person said, *"It's truly rebuilding our relationships with other organizations, like just saying, 'Hey, we're still here. We're still operational.'"* Others reported schools were not always open to allowing the number of sessions required for sufficient prevention dosage. As one interviewee explained, *"But actually doing a prevention program, multiple-week evidence-based? No, we can't get [approval] for that. We're lucky to have the one-hour slot..."* Still others described cultural or community taboos that required, *"...a very culturally nuanced way that may not be directly saying this is prevention for sexual assault".* One participant stated, *"So, for me, it's starting those conversations and just having those conversations about prevention and what that looks like for our Tribal communities."*

Photo: UNM PRC

For the organizations that were providing SA prevention programming, the most common location was in school environments, including Head Start centers, elementary, middle and high schools, and college campuses. Often this included prevention sessions in multiple grades and within several school systems. Other venues included community organizations, youth centers, detention centers, Bureau of Indian Education (BIE) residential dorms, and juvenile programs. Several interviewees described working at the policy level of prevention in schools, colleges, or with the local Prison Rape Elimination Act (PREA) program. One interviewee identified their agency's transitional living program as a prevention strategy, saying, *"I would say that the number one [prevention strategy] is our upcoming transitional living program…with that high number…of individuals who are currently unhoused…Getting folks off the street and into a safer housed environment would certainly cut down on the level of risk and the…number of folks experiencing sexual assault."*

Several interviewees noted that support from the NMCSAP was helpful in building and expanding prevention programming, with one stating, *"And it's going really well, getting into real prevention."*

Statewide Sexual Assault Hotline

Participants generally supported the idea of a statewide SA hotline in New Mexico, but many were immediately concerned about when or how they would be asked to participate in the hotline, mainly due to staffing and funding limitations. This concern was captured by one participant who stated, *"I don't think that our organization would have the capacity. We just are so short-staffed at the moment."*

Interviewees recommended use of advanced technology and standardized training for staffing the hotline, and were concerned about cultural needs of the diverse populations in New Mexico.

Impacts of COVID-19

COVID-19 made a substantial impact on access to and delivery of SA services. Some agencies reported a decline in SA reports, coupled with an increase in counseling referrals and delayed pediatric referrals. Interviewees were aware that incidents may have occurred during the lockdown but went unreported or underreported. Conversely, several interviewees noted an increase in child abuse reports and a surge in demand for services addressing survivors' basic needs. One agency reported a significant (148%) increase in clients during the pandemic. As one participant shared, *"And in COVID, we experienced a lot of clients that weren't immediately sexually assaulted. It was something years back. So, they were coming for the therapy piece."*

The pandemic prompted a rapid and widespread adoption of virtual services, necessitating adjustments in counseling, training, and support delivery for both agency staff and clients. The negative impacts on these agencies were complicated, affecting accessibility, staff well-being, financial stability, and the ability to provide in-person services. Transitioning to online services posed challenges for both staff and clients, with many agencies reporting difficulties in retaining staff and facing high turnover rates during the initial pandemic period. Additionally, agencies had to limit the number of clients seen and housed at shelters due to capacity limits; a lack of available shelter space; and financial strain exacerbated by the need for personal protective equipment (PPE), adapting to a virtual work environment, and decreased donor dollars.

As a result of the pandemic, virtual counseling became common across agencies, although the extent of adoption varied among organizations. One interviewee stated, *"But they are still offering virtual counseling as well, which has helped because we do service such a large area. And I think that more people are willing to sign up for counseling sometimes when they're not having to come in."* Most agencies also exhibited varying degrees of flexibility in work policies, with most embracing hybrid and remote work schedules to ensure staff safety and accommodate individual needs. Addressing basic needs alongside trauma support also became more common. One participant described this increase, *"So, we're also trying to deal with basic need items like housing, food, clothing, those types of things, everyday need, on top of what is the initial trauma that brought [the survivor] to our doors."* Although some agencies seamlessly integrated these services, others were still navigating the logistics of providing for additional basic needs.

Loss of Federal Funding

Participants were asked about how reductions to the federal Victims of Crime Act (VOCA) funding would affect their organizations. Responses varied. A few indicated that their VOCA funding was not considerable so they felt their organization could absorb the reduction without a sizable change to staffing or services. Several reported that their funding was diversified and therefore somewhat flexible. As one person described it,

"There is some ability to kind of piece things together and move things a bit to cover some staff time if there is a gap in a specific funding source. So, we are lucky in that way, that we're not down to the penny, like dependent on that for specific roles."

Other interviewees were quite concerned about federal funding cuts, as VOCA made up a large portion of their annual budget. In most cases when people expressed apprehension, they were worried about not being able to expand their workforce, often in the areas of advocacy or counselling. Others mentioned the potential loss of staff positions, such as forensic interviewer, legal advocate, nurse practitioner, or administrative staff. One stated, *"[anticipated] VOCA cuts will cut the team in half. And … [we'll be] losing survivors who need that forensic exam because we don't have the advocates to support a 24-hour service, an on-call status like that."* Others expressed concerns that funding cuts would result in losing staff because of an inability to offer competitive salaries, or through staff burnout because of staff shortages. One interviewee said it would affect the ability to pay rent, *"So VOCA cuts will be very significant for me."* Another talked about impacts beyond SAS agencies, saying, *"I think the biggest thing that will happen is that it will impact our community partners, which means that we'll have less connections to do those warm handoffs. As other agencies lose staff and as other agencies lose capacity, the first thing to go is working with those other agencies and maintaining those relationships. So that's what I fear will happen anytime there's major cuts budgetarily to any sort of programming."*

Many participants stated that they would attempt to fill in the gap in funding by applying for federal grants or other state funds, foundational grants, corporate sponsorships, other types of grants, or through local fundraising efforts. One interviewee felt that perhaps the NMCSAP could play a role in this area by creating positions at the Coalition that could assist organizations in identifying funding sources and help with actual grant writing and grant editing, so organizations were more competitive. A number of interviewees expressed appreciation for the ongoing work the NMCSAP has done to secure SA funding through the NM legislature. There was also appreciation for the NMCSAP's efforts to inform them of impending cuts. One person stated, *"I think that it's easy to kind of get into a panic when you hear that there are going to be cuts in federal funding. So, I think that there has been good preparation from the Coalition that this isn't something that's taking us all by surprise. They've been very good at keeping us informed and educated on what was going on."* Several interviewees also expressed optimism that the NMCSAP would be able to secure needed funds during the 2024 legislative session to help defray the impact of VOCA funding cuts.

Underlying this discussion was the awareness that SA would continue to affect people and their communities, as one individual stated, *"I think one thing to say is that whether or not funding is cut or whatever, the need of the community remains. And our advocates, our service providers, we all get together and find ways to meet our families' needs and the clients' needs that come here. And so, I think sometimes when we hear funding cuts, it can feel a little scary just because you're like, 'Okay. Well, how do we navigate the funding cuts,' right? But it doesn't keep families from coming to our door… So, the need remains, funding or no funding."*

Priorities for Future Development

Needs assessment participants discussed anticipated short-term changes (within 6-12 months) in service provision, staffing or clients, as well as priorities for future growth. Several interviewees did not anticipate any short-term changes, although one person clarified, *"I think we did make a pivot within this last year. And so, I don't think we're doing any more changing, hopefully, within the next year."*

A number of organizations anticipated hiring additional staff, often SANEs or advocates. Several interviewees talked about using new staff to help address gaps in underserved areas. Some interview participants mentioned potentially opening satellite offices. Others talked about expanding outreach, education, and prevention through hiring, updating outreach materials, and developing culturally responsive, population-specific curriculum. One person talked about focusing on rebuilding community relationships to re-establish provider education. Several others shared their intention to have preliminary discussions regarding prevention with potential collaborators and community leaders, including conducting focus groups for direct input from community members on curriculum development. One said, *"Well, for me, specifically, I would love to prioritize prevention and get back into community and go to schools and talk with kids and families."*

Other more immediate goals included opening a transitional housing unit; providing more intensive advocacy to human trafficking survivors; opening a human trafficking program with transitional housing; restructuring to account for program expansion; switching a virtual peer support group to in-person; developing an agency website; having better communication with medical staff; and continuing to investigate ways to mitigate the effects of vicarious trauma.

When speaking of more long-term goals, several interviewees talked about expanding or restructuring programs. One participant discussed expanding to hire a SANE nurse, saying, *"I'm hoping to be able to provide more sexual assault services, but it won't be over the next 6 to 12 months. I think getting SANE nursing and everything here will take longer than that."* Another participant discussed expanding services to include pediatric exams. Another hoped that domestic and sexual violence services could be housed in the same facility, with nurse practitioners being able to provide both physical and sexual assault exams rather than being specialized to one service. Another interviewee envisioned expanding the role of SA nurses in underserved communities, given the many barriers to healthcare access experienced by rural populations. They explained, *"And you realize that healthcare is not accessible to most people... So my goal for the future would be to do everything we can with the nursing professionals to improve healthcare overall. So, we're not just doing sexual assault. It's another level of healthcare that's not being accessed by most populations."*

Additionally, one interviewee's goal was to ensure that each nurse in their organization was certified in their field of practice by the international Association of Forensic Nurses. Another interviewee shared that their agency's long-term goal was to become a national organization, with the shorter term goal of developing staffing and capacity to eventually make that transition.

Finally, several interviewees said that identifying and securing funding was their greatest priority. As one person explained the concern around VOCA cuts and staffing, *"When I say that, meaning, can we find alternative funding to supplement -- I try my very hardest to keep the staff that I have and just not bring back roles that are vacant, and that's kind of what happened with our counseling department. Why it doesn't exist is because we didn't have the staff in those [positions when we experienced prior funding cuts] and so we just never hired them back so that we could retain current staff."*

Recommendations for Additional Ways NMCSAP Could Support SA Organizations

Overall, SA organizations expressed appreciation for the myriad ways the NMCSAP has supported organizations and expanded its workforce and technical assistance capacity in recent years. A number of participants also shared ideas for additional supports and technical assistance the NMCSAP could provide. These largely fell within three categories: infrastructure, technical assistance, and funding.

Recommendations from SA organizations

Infrastructure

Participants discussed the hiring of personnel that could assist with specific tasks statewide. The most frequently mentioned recommendation was for the NMCSAP to establish a shared HR department that could be accessed by all SA organizations. A variation on this recommendation was hiring HR staff (potentially contractors) that could be shared by several organizations locally. Interviewees felt this would reduce administrative burden, freeing time and resources at the local level for addressing services. Several participants also recommended hiring a trauma-trained clinical director to support counseling services across SA organizations. Some interviewees proposed having this person be available to provide emergency counseling assistance to help stabilize survivors in the immediate aftermath of an assault while waiting for ongoing therapy to become available. Others suggested that this person could assist with waitlists, particularly in underserved areas. Several interviewees suggested that the NMCSAP hire one or more grant writers that could help locate potential funding sources and work with agencies to apply for federal, state, local, foundation, and other funding. They proposed that this person (or people) could assist organizations with writing or editing grant proposals to increase competitiveness. Some participants requested assistance with SANE recruitment, having a staff person spending dedicated time in different communities to help with recruitment strategies, processes, and concerns.

In addition to staffing, interview participants had several other recommendations for improving the SA system statewide. One interviewee proposed stronger collaboration with the state domestic violence coalition. Another suggested the NMCSAP start an employee assistance program that would be open to all SA organizations to ensure that providers experiencing burnout or vicarious trauma had access to more immediate help. A third participant recommended accessing or leveraging funds through the NMCSAP to purchase group insurance for SA organizations. This was viewed as a way to offer more comprehensive benefits to employees, especially those working in smaller, less resourced agencies.

Technical support

Interview participants also requested technical assistance and access to information and training that would facilitate their operations. Multiple interviewees recommended that the NMCSAP routinely provide an updated Coalition staff contact list, including names, positions, contact information, and area of expertise, along with staff photos. It was suggested that this information be distributed at meetings and electronically whenever staff changes occurred. Several participants also requested that the NMCSAP develop a repository of HR information that would be easily accessible to SA organizations. Items to include in the repository were sample policies and procedures, sample contracts with the most up-to-date legal language, and examples of job descriptions. One interviewee suggested that the NMCSAP coordinate routine meetings between finance directors at SA organizations. The interviewee felt that an opportunity for finance directors to share tips and resources and discuss struggles with funders would build relationships, identify systems issues, and result in smoother operations. Another interviewee requested that the NMCSAP conduct a new salary survey to ensure salaries for various positions remained competitive. One participant recommended providing vicarious trauma training focused more on organizational-level responses or strategies, delivered in-person at individual agencies, potentially including local community partners. Lastly, one individual suggested that the NMCSAP collaborate to offer legal consultation opportunities for clients and their families around the state. This was an identified need for many clients with a variety of issues for which they needed legal advice but for which they had no ability to pay.

Funding

Several interviewees spoke of the need for unrestricted funds that could be made available to SA organizations. Examples of how the funds could be used included for organizational capacity-building and to assist clients with basic needs. A few participants also highlighted the need to advocate for funds to specifically address gaps in mental health services in underserved areas.

Summary

The SA needs assessment was aimed at assisting the NMCSAP in learning from SA agencies how their organizations were functioning, particularly after COVID-19; what services they provided and the challenges they faced in providing those services; what effects the federal VOCA funding cuts would have on agencies and services; future plans and priorities for growth; and recommendations for ways the NMCSAP could support the organizations and strengthen the SA system in NM.

SA needs assessment participants identified multiple organizational attributes and service areas, which they felt were robust. These included staff support and training, particularly to address the effects of vicarious trauma; effective leadership; positive organizational and community relationships and collaboration; successful recruitment and retention strategies; crisis stabilization and other frontline services; trauma-informed advocacy; SA education; commitment to inclusivity and diversity, including staff, volunteers, and board members reflective of the communities they serve; telehealth and telecounseling services that increased service accessibility; and other strengths, such as being community-based.

The variety of services provided differed among organizations based on type of agency, funding levels, client-, community- and agency-identified need, and organizational capacity. All organizations provided some degree of advocacy and referral services through advocate or case management positions. Many provided medical and forensic services, counseling, and/or assistance with basic needs. Several organizations offered housing or shelter services, peer support groups, and/or transportation. Other services included hotlines, awareness, and prevention education.

Most organizations were committed to serving any person that requested assistance, while some were dedicated to serving specific populations, such as Native Americans or people living with disabilities. Participants also described populations that were difficult to reach, including immigrants, veterans, members of the LGBTQIA+ community, people with disabilities, other marginalized populations, and children. Interviewees provided many examples of how they had attempted to make their services more accessible. This included providing bi-lingual or multi-lingual staff along with translation and other language services. Many described environmental adaptations, advocacy efforts, and staff training aimed at increasing accessibility for people with physical, cognitive, and emotional disabilities. Still others talked about increasing accessibility through providing welcoming and safe spaces and culturally responsive services, including hiring staff members representative of clients and communities for which they provided services.

Interviewees described multiple challenges faced by their organizations. The most significant was a lack of funding, which affected organizational capacity, services, and service accessibility. Another sizable barrier was recruitment and retention. This included, among other concerns, a lack of qualified applicants, rigorous training requirements, vicarious trauma, the complex nature of the work itself, and unsustainable workloads and/or work schedules. The administrative burden of operating SA organizations was also challenging. Complex reporting requirements, lack of stable funding, and inadequate administrative capacity, particularly related to HR duties, made operations more difficult. Other challenges that affected service provision included lack of community-based support services and transportation, social and cultural stigma associated with SA, and related agencies and systems working in silos.

All needs assessment participants reported their organizations were involved in some type of community education and outreach activities. These efforts were vital to ensuring communities and partners were aware of SA services and were educated on root causes and long- and short-term effects of SA on individuals, families, and communities. Many interviewees also described community-based prevention activities, mostly through prevention curriculum implemented in schools or colleges. There was interplay between outreach and prevention, with several interviewees discussing how outreach activities and community engagement were important precursors to establishing the relationships and trust necessary for implementing SA prevention programming. Further organizational and community education will be required to differentiate outreach and education from prevention.

In general, interviewees were supportive of a statewide SA hotline. There were questions about expectations of local program staff's participation in the hotline and concern over their already full workloads.

COVID-19 had significant impacts on SA organizations. It caused an immediate disruption in services as organizations worked to reconfigure operations to comply with COVID-19 restrictions while still being responsive to SA survivors and community needs. Agencies saw decreases in some areas, such as SA reports, and increases in other areas, such as counseling referrals or requests for help with basic needs. Many SA organizations lost employees during the initial period of COVID-19, and also reported decreased financial donations. Virtual services were instituted, most often for counseling but also for advocacy and other services as well, along with flexible work-from-home policies. While many of the SA organizations were concerned about the effect of virtual services on clients, most reported continuing some virtual practices as they increased accessibility for some clients and allowed for more accommodating work schedules. Though lessening somewhat over time, the effects of COVID-19 on operating practices and client needs have continued.

SA organizations had differing responses to the reduction in VOCA funding. Some interviewees believed their organization would be minimally affected based on the small percentage of VOCA funds they received or because they have diversified funding that allows them some operational flexibility. Others were very concerned about the funding cuts, reporting they would impede program expansion, potentially cause staff layoffs, and cause disruption to client services and community partnerships. Many were or had already attempted to secure other funds to ease the effects of the reduction. Others remained somewhat optimistic about the NMCSAP's ability to obtain state dollars for SA services. Several were appreciative of the transparency of the NMCSAP regarding the federal cuts, and the focused attention the Coalition has placed on minimizing the impact of the reduction on organizations and communities.

Needs assessment participants shared a variety of short- and long-term priorities related to SA services and program operations. Short-term plans included things like hiring staff, opening satellite offices, expanding education, outreach and prevention services, and rebuilding community relationships post-COVID. Other short-term goals were to open transitional housing units, develop a website, and focus on organizational restructuring to account for increases in programs and staff. A few organizations reported that they did not anticipate any changes in the immediate future. Long-term goals included things like expanding or reconfiguring services, exploring ways to expand the role of nurses in medically underserved areas, increasing the number of nurses with national certifications, and to eventually become a national organization. Furthermore, several interviewees said their long-term goals would center on securing alternative funding.

SA organizations had several recommendations for NMCSAP related to SA infrastructure, technical assistance, and funding. Infrastructure recommendations included establishing a shared HR department to improve administrative capacity at the local level; hiring a clinical director to provide additional support to counseling services and address gaps in coverage; hiring grant writers to support SA organizations in identifying and securing financial resources; bringing on someone to assist with SANE recruitment; increasing collaboration with the state DV coalition; establishing an employee assistance program available to SA agencies; and purchasing group insurance for SA organizations to improve employee benefits, especially for smaller organizations.

Recommendations related to technical assistance comprised routinely providing updated NMCSAP employee information to facilitate awareness of individual programmatic roles and responsibilities; developing a repository of HR-related documents; coordinating regular meetings with agency finance directors to foster relationships and identify systems issues; conducting a salary survey; providing in-person organizational-level vicarious trauma training; and making legal consultations available to clients and communities in local settings.

Further recommendations were to secure or make available unrestricted funds to strengthen local programs; and secure or designate funds specifically to address gaps in mental health coverage.

Limitations

This research has several limitations. The purpose of the research was to learn more about the needs of SA organizations within the context of their services, organizational strengths, and ability to function with reduced financial resources. Qualitative research methods are appropriate for this type of study, but generalizability is limited due to the purposive sampling. Another potential limitation is response bias, given that not all SA organizations who were invited to participate in the study responded. The effects of the potential response bias are unknown.

Conclusion

Sexual assault is a pervasive problem in NM, with both immediate and long-term consequences for survivors, their families, and communities. The NMCSAP is the statewide entity that provides a multitude of training, technical assistance, grant management, and system supports to reduce and moderate the effects of sexual violence across the state. NMCSAP partner organizations include SASPs, SANE programs, CACs, and community-based organizations that directly serve SA survivors, collaborate with other related systems and agencies, and engage with local communities to increase public safety and address community needs. This SA needs assessment provides information about what is working well within the system and what impedes service provision and program expansion, as well as organizational capacity limitations. With recently expanded internal capability and guided by needs assessment recommendations, the NMCSAP, in collaboration with its partner organizations, is positioned to take strategic actions to improve NM's SA service system and identify areas for future growth.

NM Sexual Assault Needs Assessment Recommendations

Based on a literature review and an analysis of these data, the UNM PRC developed the following recommendations to increase statewide infrastructure and connectivity among sexual assault organizations. Progress on the recommendations subsequent to the completion of the needs assessment in 2023 is noted below in the status column as: In Progress – implementation of the recommendation is already underway; Future – implementation of the recommendation has not yet begun but is included in future plans; or Not Feasible – the recommendation is not a feasible action of the NMCSAP.

Recommendation	Status
Create a statewide SA hotline operated by NMCSAP with its own staffing structure that does not rely on coverage by local program staff	In Progress
Inform SA organizations about and promote use of existing human resources templates, materials, and consultants, and query organizations regarding additional specific needs to facilitate hiring processes	In Progress
Coordinate quarterly meetings for agency finance directors	In Progress
Develop a brief presentation on SANE services and employment opportunities that can be used by NMCSAP and SA organizations to inform local nursing education programs about SANE as a career path	Future
Develop training materials and talking points illustrating prevention as a component of comprehensive SA services that can be used by NMCSAP and local program staff to educate organizational staff and board members locally	Future
Create a communications plan explaining/promoting the statewide hotline for multiple audiences including SA organizations, community partners, policymakers, and the public	Future
Investigate additional options for providing culturally specific training to SA organizations to avoid overburdening community-based, population-specific organizations	Future
Consider employing or contracting with specialized personnel (e.g., grant writers, crisis counselors) that could support SA agencies statewide	Future
Strengthen collaborations with mental health organizations, the NM Coalition Against Domestic Violence, and legal aid organizations to support and advocate for each other and enhance services for SA survivors statewide	Future
Consider developing a strategic plan to outline implementation and evaluation plans to measure progress toward increasing infrastructure and connectivity	Future
Investigate the potential for purchasing group health insurance for SA agencies statewide to provide cheaper rates	Not Feasible

Photo: Mahtab Soleimani

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