

ANALYZING THE EFFECTS OF COLLABORATIVE EFFORTS TO PREVENT  
CHILD SEXUAL ABUSE IN MINNESOTA

BY

Daniel J. Schober

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of the University of Kansas in partial fulfillment of the requirements for the degree of  
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Stephen B. Fawcett, Ph.D., Chairperson

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Jerry A. Schultz, Ph.D., Committee Member

---

Yo Jackson, Ph.D., Committee Member

Date Defended: May 28, 2008

The Thesis Committee for Daniel J. Schober certifies  
that this is the approved version of the following thesis:

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Stephen B. Fawcett, Ph.D., Chairperson

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Dedication

In memory of John W. Schober

1943 - 2006

## ABSTRACT

Daniel J. Schober  
Department of Applied Behavioral Science  
University of Kansas

This study analyzes the effects of a community and state level effort to prevent CSA. Stop It Now! Minnesota, a CSA prevention initiative, received a grant from the U.S. Centers for Disease Control and Prevention to implement a multi-component intervention to prevent CSA. Stop It Now! Minnesota's intervention (the independent variable) trained adults to recognize and respond to the warning signs of CSA and provided support and services for potential perpetrators of CSA.

The analysis examined three outcomes. Stop It Now! Minnesota documented their efforts to create community/system change (new or modified community programs, policies, and practices). Rates and types of change were analyzed. Second, records of calls from Minnesota to a national Helpline were reviewed. Call volume and type served as a measure of population-level preventative behavior. Third, annual child maltreatment reports were reviewed to examine rates of CSA reports to the Minnesota Department of Human Services.

Results showed that Stop It Now! Minnesota facilitated numerous changes to the environment to prevent child sexual abuse. Preventative behavior in the form of Helpline calls increased, and reports of CSA in Minnesota decreased. These results suggest that Stop It Now! Minnesota's intervention was successful in preventing CSA. Implications for future research and practice are discussed.

## Table of Contents

Abstract	iv
Table of Contents	v
List of Table and Figures	vi
Introduction	1
Methods	7
Results	20
Discussion	34
References	45
List of Appendices	54
Appendix A	55
Appendix B	57

## List of Tables and Figures

Figure 1	Institute of Medicine Framework for Collaborative Public Health Action and related research questions	18
Table 1	Components and Elements of Stop It Now! Minnesota's Intervention	25
Table 2	Illustrative Community/system Changes Facilitated by Stop It Now! Minnesota	28
Figure 2	Cumulative record of community/system changes and associated critical factors	30
Figure 3	Distribution of Stop It Now! Minnesota's community/system changes by goal (N=355)	31
Figure 4	Distribution of Stop It Now! Minnesota's community/system changes by target (N=355)	32
Figure 5	Distribution of Stop It Now! Minnesota's community/system changes by change strategy (N=355)	33
Figure 6	Distribution of Stop It Now! Minnesota's community/system changes by duration (N=355)	34
Figure 7	Distribution of Stop It Now! Minnesota's community/system changes by sector (N=355)	35
Figure 8	Distribution of Stop It Now! Minnesota's community/system changes by ecological level (N=355)	36
Figure 9	Annual Helpline call volume from Minnesota and Virginia	37

Figure 10	Widespread behavior change in the form of cumulative calls (by type) from Minnesota to the Stop It Now! Helpline	38
Figure 11	Population-level outcomes in the form of total reported cases of child sexual abuse in the seven county Twin Cities area compared to those in the five county greater Milwaukee area	40
Figure 12	The association between community/system changes and reductions in total reported cases of CSA in Minnesota	41

The American Medical Association has called child sexual abuse (CSA) “a silent epidemic” (Massachusetts Citizens for Children, Inc., 2005). CSA is reported up to 80,000 times each year in the United States (American Academy of Child & Adolescent Psychiatry, 2004). Child maltreatment experts believe that CSA is significantly underreported. The U.S. Department of Health and Human Services Administration estimated 217,700 cases of CSA occurred in 1993 (Sedlak & Broadhurst, 1996). Underreporting is one of many challenges to addressing and preventing child sexual abuse.

Research on CSA has helped society better understand its effects. Child sexual abuse leads to significant harms for victims that range from sleep disturbances and eating problems to fear, anxiety, and depression (American Psychological Association, n.d.). Many of the health problems associated with child abuse can have an impact on victims into adulthood (Centers for Disease Control and Prevention, 2008). A notable body of research supports a victim-abuser cycle, in which the effects of CSA increase the likelihood of future perpetration (Borowsky, Hogan, & Ireland, 1997; Lambie, Seymour, Lee, & Adams, 2002; Ryan, Miyoshi, Metzner, Krugman, & Fryer, 1996).

Research has also underscored the pervasiveness of sexual offenders. Ryan et al. (1996) found that youth who have engaged in sexually-abusive behaviors are similar to the non-offending population. They analyzed a sample of 1,616 juvenile youth across 30 states that had a documented sexual offense and found that the race, income, religion, and environment (urban vs. rural) of these offending youth was



comparable to that of the broader population. While perpetrators of CSA do not have a particular profile, some factors that put individuals at risk for sexually abusing children have been identified. Risk factors for perpetration include poor mental health, including unhappiness and loneliness (Milner & Robertson, 1990), as well as engagement in risky behaviors. Borowsky et al. (1997) analyzed 71,594 surveys completed by male and female high school students in Minnesota to find that regular use of illicit drugs was related to sexual aggression (forcing someone into a sexual act).

Research on CSA prevention also suggests factors that protect individuals against perpetration. Lambie et al. (2002) found that victims of child sexual abuse who have not become perpetrators of CSA had higher levels of education than victims who had perpetrated CSA. Allen and Pothast (1994) also found education to be a protective factor among offenders compared to non-offenders. They further concluded that having a higher income was negatively associated with perpetration. Other protective factors included contact with friends and peers (Lambie et al, 2002; Borowsky et al., 1997), the presence of adults in the community, and academic achievement (Borowsky et al.).

The World Report on Violence and Health (2002) found the use of school-based programs to prevent child sexual abuse to be “one of the most widely applied preventative strategies” (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002, p. 75). For instance, Harvey, Forehand, Brown, and Holmes (1988) assessed the Good Touch – Bad Touch program among a group of 71 kindergarten children who learned CSA

prevention skills. The format involved story and film depicting typical children, as well as scenarios acted out by dolls. Three weeks after the program, children who participated could discern pictures of good touches from pictures of bad touches more accurately than children who did not participate in the program; at the seven week follow-up, there was an even bigger difference between participating and non-participating children. Dhooper and Schneider (1995) evaluated an intervention that involved the use of a puppet show that depicted situations of physical and sexual abuse, and taught preventative responses to the warning signs of CSA. After the puppet show, participants were given opportunities to ask questions. Participants were also told they could write letters to and receive responses from the puppets. Dhooper and Schneider found a statistically significant difference on 12-item CSA knowledge questionnaire when comparing students that had participated in the program to those who had not yet participated.

Other child sexual abuse prevention programs train children directly, using behavioral practice, feedback, and discussion. The Stay Safe Programme is one example; it trained 339 seven to ten year old children on prevention behaviors (including preventing inappropriate touching) through the facilitation of discussion, role play, and rehearsal (MacIntyre & Carr, 1999). The children who were trained on these safety skills performed significantly better on a brief questionnaire than a group of children who had not yet participated. The ESPACE CSA prevention program corroborated this finding (Hebert, Lavoie, Piche, & Poitras, 2001). Fifty-nine first and third grade children in Quebec City were initially selected to participate in the

program, which involved role play, modeling, rehearsal, and group discussion. These children showed significantly more knowledge than the control group on a knowledge questionnaire, and more prevention skills when presented filmed vignettes and asked behavior-based questions. Other investigations have reached similar findings. Conte, Rosen, Saperstein, and Shermack (1985), and Blumberg, Chadwick, Fogarty, Speth, and Chadwick (1991) used behavioral training and group discussion to train children to recognize and respond to CSA. They reported significant differences in the identification of inappropriate touches and knowledge of prevention concepts, respectively.

More comprehensive evaluations have been conducted to permit a broader assessment of school-based CSA prevention programs. Berrick and Barth (1992) conducted a meta-analysis of 13 separate child sexual abuse prevention program evaluations. The results showed statistically significant differences between experimental groups compared to control groups, as well as a general increase in knowledge for children from before participation in the program to after participation. Daro (1994) came to a similar conclusion in her review of 17 studies of CSA programs that employed random assignment of participants to experimental or control groups. Although specific knowledge increased for program participants, both meta-analyses cautioned that preventative behavior (and reduced rates of CSA) were not assured.

Child maltreatment experts have called for involvement of adults in efforts to prevent child sexual abuse. Borowsky et al. (1997) re-iterated that professional

members of the community, such as health care providers should be responsible for preventing CSA through recognizing risk factors and making it most probable that the protective factors are present. Finkelhor, Asdigian, and Dziuba-Leatherman (1994) found that involving parents in school-based CSA prevention boosted knowledge attainment, skill acquisition, and increased the probability of children reporting CSA. Wurtele (2002) also advocated for the inclusion of parents in CSA prevention to facilitate children's knowledge and skill gains and to ensure that adults take responsibility for reporting CSA. Reppucci, Land, and Haugaard (1998) call for community efforts to include all adults (not only parents) in preventing CSA, by reaching out to them (at work, church, and other places) to take responsibility for preventing CSA. Further, Berrick and Barth (1992) called for broad, community-level effort that institutionalize CSA prevention into the practices of the community and target leaders within the community to be involved with prevention.

Child sexual abuse prevention efforts that involve adults have occurred, but less frequently than school-based CSA prevention efforts that put the responsibility of prevention on children. Binder and McNiel (1987) evaluated an effort that taught 60 parents, 12 teachers, and 88 children CSA prevention myths and facts. However, this evaluation did not train parents and teachers to prevent CSA, rather it focused on the outcome of parents having a better sense of what their children learned. Kleemeier, Webb, Hazzard, and Pohl (1988) assessed the effects of a CSA prevention program on the knowledge of teachers. This program involved six hours of training for 26 female elementary school teachers; training consisted of presenting CSA facts, and

behavioral skills training for identifying and reporting CSA. Kleemeier et al. found that teachers increased their knowledge of CSA and when they were presented vignettes depicting CSA, they could identify abuse and recommend appropriate action more accurately than those who were not trained.

Parent and teacher trainings represent a beginning to a more comprehensive, community-level effort for preventing child sexual abuse. However, few community-level CSA prevention efforts have been studied. Hoefnagels and Mudde (2000) reported on a national effort in the Netherlands to reduce child abuse (including CSA). This large-scale intervention involved a mass-media campaign (television, radio, and print media), training (about 500 teachers across 31 regions), and technical support (a phone line and additional human resources to investigate cases of child abuse). The results showed that fundraising for the campaign increased, media messages were sustained, and reports of physical and sexual abuse increased, while reports of emotional abuse (not targeted by the campaign) remained steady. Hoefnagels and Mudde state that despite the effort's success, the development of the campaign goals, strategic planning, and the formulation of the campaign's message were inadequate.

The present study examines the process and outcomes of a statewide effort to prevent child sexual abuse in Minnesota. The effort focused on CSA prevention in the seven county Twin Cities (Minneapolis and Saint Paul) and then expanded to communities throughout the state. It incorporated many previously recommended approaches in child sexual abuse prevention, including training adults to change

environmental conditions that contribute to CSA as well as in-depth planning and goal setting prior to the intervention.

This investigation will focus on a specific five-year period for an initiative known as Stop It Now! Minnesota. It will address four research questions:

1. Is Stop It Now! Minnesota's collaborative effort serving as a catalyst for community/system change to prevent CSA?
2. What factors or processes are associated with increases and decreases in rates of community/system changes for preventing CSA?
3. How are these community/system changes contributing to the efforts to prevent CSA?
4. Are community/system changes associated with indicators of success and population-level outcomes related to CSA prevention?

## Method

### *Context and Framework for the CSA Prevention Initiative*

In 2002, the U.S. Centers for Disease Control and Prevention's Center for Injury Prevention and Control developed an Injury Research Agenda (National Center for Injury Prevention and Control, 2002). This agenda focused on the translation of scientific research to programs and policies to prevent injuries and violence by promoting understanding of the antecedent conditions that lead to injury and violence. It also involved the widespread adoption of prevention and intervention activities. The Injury Research Agenda focused on preventing different types of violence including intimate partner violence, sexual violence, and child maltreatment. One of

the CDC's efforts to facilitate the translation of science to violence prevention programs and policies was through a grant initiative that funded several statewide, collaborative efforts to prevent child sexual abuse, including a grant to prevention practitioners in Minnesota. This award involved an initial three-year grant, with a focus on developing and implementing CSA prevention programming. Another focus of this period was to develop state and local-level collaborative partnerships to prevent CSA. Two years of funding for further implementation followed, from September of 2005 through September of 2007. In Minnesota, the CDC planning and implementation grants were awarded to Project Pathfinder (PPI). The grants provided funding to PPI's CSA prevention initiative, Stop It Now! Minnesota.

Stop It Now! Minnesota belongs to a network of local organizations, coordinated by Stop It Now!, a national organization (<http://www.stopitnow.org/>). Stop It Now! was founded in 1992; it has a distinct history and has developed innovative methods of preventing child sexual abuse. Their prevention model emerged from a partnership with the CDC in the early 1990's that involved a deep review of literature, identifying the risk and protective factors of CSA perpetration, as well as further evaluation and policy work (Stop It Now!, 2003). Stop It Now! pioneered an innovative approach to CSA prevention that promoted adult responsibility for recognizing and responding to CSA rather than child-victim responsibility for this. (Stop It Now!, n.d.). They evaluated their efforts and found that abusers will hold themselves accountable and come forward to help, thus, abusers are also targeted in their efforts to promote adults responsibility to prevent CSA (Stop

It Now!, 2002). Stop It Now!'s approach to preventing CSA has become a nationally recognized, public health perpetration prevention model.

Stop It Now! Minnesota's inception occurred at the conclusion of an annual sexual abuse treatment conference in Minnesota. A multi-sector group of statewide organizations formed the initial steering committee. The organizations that made up the steering committee included the Jacob Wetterling Foundation, the Minnesota Department of Health, the Minnesota Association for the Treatment of Sexual Abusers, and the Minnesota Department of Corrections. The steering committee gained feedback and consultation from the national Stop It Now! office, and formed an advisory board consisting of leaders from public, private, and non-profit organizations who became collaborators for Stop It Now! Minnesota's efforts to prevent CSA. Before receiving the CDC grant, Stop It Now! Minnesota received funds to secure a part-time staff member. This enabled Stop It Now! Minnesota to lay the groundwork for preventing CSA across the seven county Twin Cities area, which served as the initial focus during the first three years of the CDC grant.

Stop It Now! Minnesota focused on promoting adult and community responsibility for the prevention of CSA. Their efforts to address child sexual abuse sought change at multiple ecological levels: individual, relationship, community, and societal levels (Krug et al., 2002). The CDC developed goals for Stop It Now! Minnesota, which included: 1) developing and maintaining a statewide prevention collaborative, 2) developing and maintaining local (community) prevention collaboratives, 3) implementing state-level programming to prevent perpetration, 4)



implementing local-level (community) programming, and 5) participating in national-level prevention activities.

Stop It Now! Minnesota focused on primary prevention: prevention of child sexual abuse before it occurs. By contrast, most efforts to address CSA focus on secondary or tertiary prevention that aim to reduce harm from CSA after it occurs. Stop It Now! Minnesota's targets of change were adults, specifically professionals working with children and families. This initiative focused on enabling adults to recognize the warning signs of CSA perpetration and take action to prevent it from occurring. It also created services for adults having sexual feelings toward children. These services helped adult find resources and develop skills to appropriately deal with these sexual feelings.

Stop It Now! Minnesota's efforts to prevent child sexual abuse can be described in terms of the Institute of Medicine's (IOM) Framework for Collaborative Public Health Action (Institute of Medicine, 2003). The framework's five interrelated phases are: 1) Assessment & Collaborative Planning, 2) Targeted Action & Intervention, 3) Community & System Change, 4) Widespread Behavior Change & Risk/Protective Factors, and 5) Improvement in Population-level Outcomes.

Figure 1. Institute of Medicine Framework for Collaborative Public Health Action and related research questions.



During the first phase, *Assessment & Collaborative Planning*, the initiative conducted a random-dial telephone survey that measured current knowledge and concern for CSA. It also involved the development of a strategic plan as required by the CDC grant. The second phase, *Targeted Action & Intervention*, involved implementation of Stop It Now! Minnesota’s multi-component intervention. The intervention aimed to change the behavior of adults in multiple ways including provision of information about warning signs that put children at risk of sexual abuse, to the modification of CSA-related programs and policies. The third phase, *Community & System Change*, reflected Stop It Now! Minnesota’s efforts to change the environment in which CSA occurs by bringing about new or modified programs, policies, and practices related to preventing CSA.

The next phase of the IOM model, *Widespread Behavior Change & Risk/Protective Factors*, is hypothesized to follow *Community & System Change* with an increase of behaviors by adults to prevent child sexual abuse. One type of behavior change includes reporting situations in which children are at risk. The final phase of the model, *Improvement in Population-level Outcomes*, suggests that widespread changes in the community or system and related adult behaviors may lead to improvement in the desired outcome (i.e., a decrease in CSA across Minnesota).

#### *Collaborative Partners for the Participatory Evaluation*

The Work Group for Community Health and Development at the University of Kansas (KU Work Group) served as the scientific partner for this initiative. The KU Work Group provided support to ensure that Stop It Now! Minnesota was documenting their intervention. Stop It Now! Minnesota documented their efforts using the Online Documentation and Support System (ODSS), developed by the KU Work Group. Graphs, charts, and tables prepared from Stop It Now! Minnesota's documentation enabled a series of discussions to interpret and analyze these data in the tradition of community-based participatory research (CBPR). CBPR refers to, "a collaborative approach to research that equitably involves all partners in the research process and recognizes the unique strengths that each brings" (Minkler and Wallerstein, 2003, p. 4).

#### *Measurement*

Three measurement approaches were used to evaluate Stop It Now! Minnesota's efforts to prevent child sexual abuse: 1) documentation of

community/system change (an intermediate outcome), 2) analysis of Helpline calls (an indicator of widespread behavior change), and 3) a review of annual child welfare records that report alleged and determined cases of CSA (a population-level outcome).

*Documentation of Community/System Change.* Consistent with the IOM framework, Stop It Now! Minnesota was interested in understanding and improving its efforts to facilitate changes in communities and systems related to preventing child sexual abuse. Community/system change (CC) is defined as a new or modified program, policy, or practice in the community or system, facilitated by the initiative, and related to its goals and objectives. Examples of community/system change facilitated by Stop It Now! Minnesota included conducting a new training program on “How Understanding and Responding to Children’s Sexual Behaviors Can Help Prevent Child Sexual Abuse” (new program) and collaborating with the Archdiocese of Saint Paul to distribute CSA brochures, fact sheets, and safety plans for preventing CSA (new practice). For a documented event to be recorded as a CC it had to be: a) an instance of a new program, policy, or practice in the community or system, b) facilitated by individuals who are members of the initiative or acting on behalf of the initiative, c) related to the initiative’s chosen goals and specific objectives, and d) have already occurred (not merely be planned). Stop It Now! Minnesota documented CCs, using the Online Documentation and Support System. This measurement system has been developed, field-tested, and refined by the KU Work Group with diverse empirical investigations including efforts to prevent teen pregnancy (Paine-Andrews

et al., 2002), youth substance abuse (Fawcett et al., 1997), and chronic disease (Collie-Akers et al., 2007). Instructions for documenting and coding community/system change can be viewed in Appendix A.

Stop It Now! Minnesota staff documented community/system changes as they occurred. Stop It Now! Minnesota staff members were also trained to document instances of other events important to the initiative, such as media coverage received. They were trained to discern occurrences of CCs from non-occurrences, using codebooks with definitions, coding instructions, and opportunities to practice and receive feedback on coding. Monthly, a secondary coder reviewed each new entry, coded it, and provided written feedback for entries in which disagreements occurred. Initially, a CDC Program Officer served as the secondary coder, and later the first author assumed responsibility for quality assurance of data. The secondary coder's feedback on entries where there was a disagreement prompted the Stop It Now! Minnesota staff member to revise the description, add to it, or code it as a non-occurrence of a CC.

As Stop It Now! Minnesota documented each community/system change, they also indicated the intended contribution of each change on the broader environment. After describing a community/system change, Stop It Now! Minnesota staff classified it by particular: a) goal, b) target, c) behavior change strategy, d) duration, c) sector, and d) ecological level. For each of these items, a short list of possible choices was available. The documenter (the director of Stop It Now! Minnesota) selected the primary choice for each of these items depending on the intended contribution of the

change. The list of choices for each item in this analysis of contribution was developed by the CDC and the KU Work Group.

*Analysis of Helpline Calls.* Stop It Now! provided telephone support through their Helpline to callers from Minnesota who were concerned about their behavior or the behavior of others towards children. Professionals with experience addressing child sexual abuse answered Helpline calls and provided information to help callers take appropriate action. They also offered information on community-level resources, such as available treatment. These professionals recorded basic information about the call, such as the type of situation and how the caller heard of the Helpline. He or she coded the call as either green (i.e., requests for information where no sexual abuse is suspected), yellow (i.e., calls with warning signs of CSA), or red (i.e., calls in which abuse is believed to have happened). Stop It Now! agreed to share Helpline data with the author of this study; this data came from the years 2003 to 2007 (Stop It Now!, 2008). Data on annual call volume was used to evaluate a change in behavior across the state of Minnesota. Data on call type (i.e., green, yellow, or red) was used to evaluate the preventative nature of statewide behavior.

Stop It Now! also answers calls that come from other communities. They offer a Helpline in Georgia, Virginia, and Philadelphia. Stop It Now! shared Virginia's Helpline data from 2005 to 2007 with the author of this study (Stop It Now!, 2008). This data served as a comparison to Helpline data in Minnesota. Virginia was chosen as a comparison state because Georgia had also received funding from the CDC to implement a multi-component intervention to prevent CSA.

*Review of Annual Child Welfare Reports.* Annual child welfare reports from Minnesota were reviewed to evaluate Stop It Now! Minnesota's potential contribution to improvements in population-level outcomes (Minnesota Department of Human Services, 2002, 2003, 2004, 2005 March, 2005 July, 2006, 2007). The purpose of these annual reports was to describe the "state of children in Minnesota" (Minnesota Department of Human Services, 2002, p. 3), in terms of child maltreatment, children in out-of-home care, and adoptions. The Minnesota Department of Human Services prepared these reports for the state legislature as part of a directive in Minnesota statutes. The occurrence of child sexual abuse in the form of total reported cases (to the Minnesota Department of Human Services) was the indicator of interest for this empirical case study. Records for the years 2000 through 2006 were reviewed to examine the occurrence of CSA reporting across the five year CDC grant period.

Reported cases of child sexual abuse in Wisconsin served as a comparison to Stop It Now! Minnesota's effort. Wisconsin did not have CDC funding for a collaborative effort to prevent CSA, and did not launch a multi-component intervention to prevent CSA. Annual child welfare reports from 2000 through 2006 were reviewed; reported cases of child sexual abuse was the indicator of interest from these documents. Wisconsin's annual child welfare reports were prepared by the Bureau of Programs and Policies Division of Children and Family Services at the Department of Health and Family Services (Wisconsin Department of Health and Family Services, n.d.). These reports stated a purpose of, "allow[ing] decision makers, service providers and the public to understand and effectively respond to

trends in child maltreatment” (Wisconsin Department of Health and Family Services, n.d., p. 1).

Stop It Now! Minnesota launched the components of their intervention in the seven county Twin City area. The intervention was focused in the Twin Cities for the first three years of the initiative. Reported cases of child sexual abuse (the population-level outcome) were used from these seven counties only. The seven counties that make up the Twin Cities area are Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington counties; these counties have a collective population of 2,766,951 (U.S. Census Bureau, n.d.). The five county greater Milwaukee area in Wisconsin served as the comparison community. The greater Milwaukee area consists of Milwaukee, Ozaukee, Racine, Washington, and Waukesha counties. These 5 counties have a population of 1,706,077 (U.S. Census Bureau, n.d.). The director of Stop It Now! Minnesota recommended the use of the greater Milwaukee area as a comparison community due to its similarity in size and population to the Twin Cities, proximity, and similarity in population (Y. Cournoyer, personal communication, February 5, 2008).

#### *Components and Elements of the Stop It Now! Minnesota Intervention*

As displayed in Table 1, Stop It Now! Minnesota’s intervention consisted of multiple components and elements, primarily reflecting four behavior change strategies. The intervention’s components included: a) providing information and enhancing skills (e.g., skills building workshops to train adults to recognize and respond to inappropriate sexual behavior), b) enhancing services and support (e.g.,



incorporating child sexual abuse prevention skills into licenser training for child and foster care providers), c) modifying access, barriers, and opportunities (e.g., providing opportunities for those adults concerned about their sexual thoughts to gain online help and support), and d) modifying policies and broader conditions (e.g., providing testimony to policymakers on sex offender policies). This multi-component intervention (the independent variable) was intended to increase the occurrence of adults taking action to prevent child sexual abuse before it occurs. Increasing the occurrence of adults recognizing warning signs and taking action before a child is harmed was hypothesized to contribute to a reduction in total reported cases of CSA.

Table 1

*Components and Elements of Stop It Now! Minnesota’s Intervention*

Intervention components	Intervention elements
Providing information and enhancing skills	<ul style="list-style-type: none"> <li>• Presentations on adult and community responsibility for the prevention of CSA and Stop It Now! Minnesota resources</li> <li>• Dialogues and small group discussions among CSA victims, perpetrators, and the community to create awareness and an accurate understanding of the problem</li> <li>• Exhibits of Stop It Now! Minnesota program materials and resources at professional conferences targeting social workers, parenting organizations, and foster care providers</li> <li>• Workshops for child care providers, parents, and professionals who work with children to gain an accurate understanding of the sexual behavior of children and the skills necessary to respond to inappropriate sexual behavior</li> <li>• Use of non stigmatizing language in describing the behavior of CSA rather than labeling the “offender”</li> </ul>

<p>Enhancing services and support</p>	<ul style="list-style-type: none"> <li>• Partnerships with other agencies/organizations to prepare their clients to recognize and respond to situations in which there may be a risk of CSA</li> <li>• Collaborations with organizations working with children and families, to provide Stop It Now! Minnesota educational materials for distribution to their clients</li> <li>• Facilitation of regional meetings to bring together those from different organizations in the same community, working on preventing CSA</li> <li>• Licensor training for child care and foster care organizations on recognizing and responding to CSA</li> </ul>
<p>Modifying access, barriers, and opportunities</p>	<ul style="list-style-type: none"> <li>• Educating mental health treatment providers to incorporate the link between CSA and other mental health problems (e.g., abusing drugs and alcohol, depression) into screenings</li> <li>• An advertising campaign that reached adults at risk for perpetrating CSA with messages about finding help (e.g., billboards, radio, and internet popup advertisements)</li> <li>• Provision of online resources for those worried about sexually abusing children or those who suspect someone they know may be involved in CSA</li> </ul>
<p>Modifying policies and broader conditions</p>	<ul style="list-style-type: none"> <li>• Testimony to state-level commission on sex offender policy that resulted in recommendations for focusing on prevention</li> <li>• Providing information about the prevention of CSA to other statewide CSA prevention programs</li> </ul>

*Case Study Design*

This investigation used an empirical case study design with a non-equivalent comparison community. It focused on developing an empirical representation of how

the environmental intervention to prevent child sexual abuse unfolded over time. Emphasis is placed on systematic observation of the onset of intervention components and elements and any associated change in indicators of adult behavior change (e.g., Helpline calls) on the population-level, as well as potentially associated change in outcomes (e.g., total reported cases of CSA) on the population-level.

## Results

This study examined five research questions of interest to Stop It Now! Minnesota and its scientific partners. The results are organized by research question. *Research Question 1. Is Stop It Now! Minnesota's collaborative effort serving as a catalyst for community/system change to prevent CSA?*

Stop It Now! Minnesota facilitated 355 community/system changes across the five-year grant period (September 2002 through September 2007), as of August 7, 2007. The inter-observer agreement between the documenter of community/system changes (Stop It Now! Minnesota) and the secondary coder (primarily the author of the study) was 84.95%. Inter-observer reliability was determined by considering all secondarily coded community/system changes and dividing the number of agreements by the sum of agreements plus disagreements and then multiplying this number by 100.

Figure 2 depicts the accumulation of documented community/system changes that the initiative facilitated across the state. With this cumulative graph, each new community/system change builds on previous CCs; for instance, when this month's five CCs are added to the prior total of 50 CCs, the new cumulative total is 55

community/system changes. A cumulative record enables a visual representation of periods of high rates of change (represented by steep upward parts of the line), as well as periods of low rates of change (represented by flat parts of the line). The initiative's CCs consisted of discrete instances of new or modified programs and practices. Table 2 displays examples of the types of events that the initiative documented and scored as CCs.

Table 2

*Illustrative Community/system Changes Facilitated by Stop It Now! Minnesota*

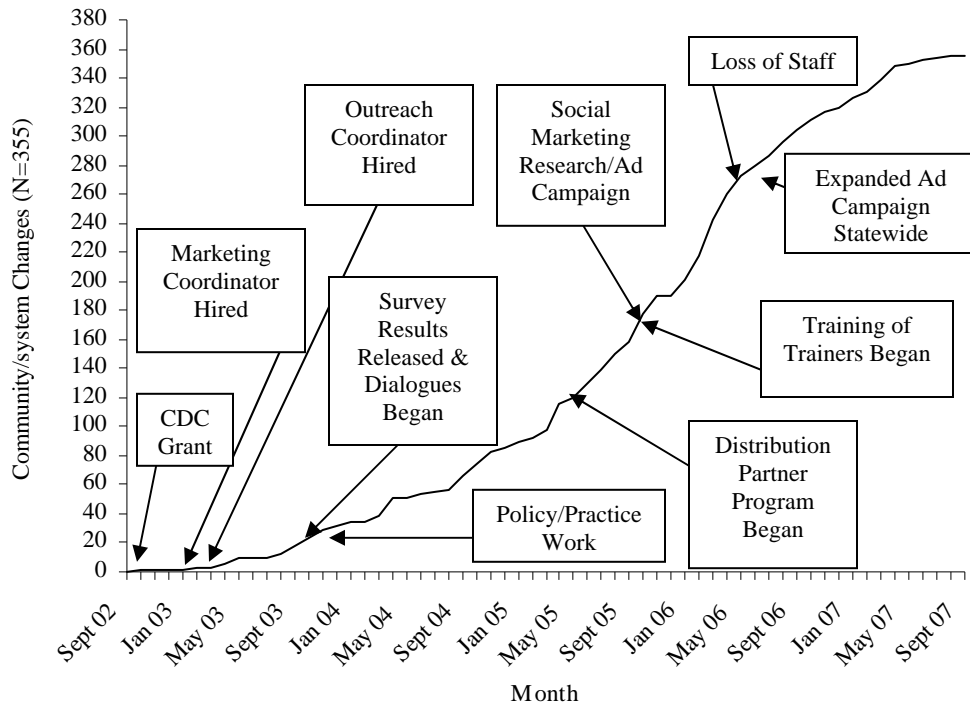
Type of community/system change	Illustrative community/system change (and sector in which change occurred)
New program	<ul style="list-style-type: none"> <li>Held the public launch of Stop It Now! Minnesota at the Minnesota Department of Health (Moving Beyond Fear: A Call to Action to Prevent the Perpetration of Child Sexual Abuse). Included a question and answer session and sample Helpline calls. Focused on introducing the work of promoting adult and community responsibility to prevent perpetration. (Multiple sectors)</li> </ul>
New practice	<ul style="list-style-type: none"> <li>The Archdiocese of Saint Paul Minnesota began distributing Stop It Now! Minnesota's <i>Prevent Child Sexual Abuse</i> brochure, Family Safety Plan, and <i>Talking with Children</i> fact sheet to parents who chose not to participate in the Archdiocese's Training. (Faith organizations)</li> </ul>

*Research Question 2. What factors or processes are associated with increases and decreases in rates of community/system change for preventing CSA?*

Across the five years of this CSA prevention initiative, periods of increases and decreases in the rate of community/system changes were evident. Through the process of participatory evaluation, the authors (community practitioners and

scientific evaluators) reviewed the community/system change data. Together, the team reviewed patterns in the data and identified critical factors that were associated with marked increases and/or decreases in the rates of community/system change. The results show an increase in the rate of community/system change following the receipt of the CDC grant, as well as the implementation of its main intervention components, including the statewide advertising campaign. Human resources contributed to an increase in rate of CCs as well; for instance, through training of community trainers, collaboration with other entities to distribute Stop It Now! Minnesota materials and hiring of new staff for Stop It Now! Minnesota (made possible by the CDC grant). Conversely, the loss or turnover of Stop It Now! Minnesota staff was associated with a decrease in the rate of CCs. Development activities, such as community dialogues, or policy work with child care organizations did not appear to yield immediate changes in the environment. See Appendix B for the protocol for community-based participatory research used in this study.

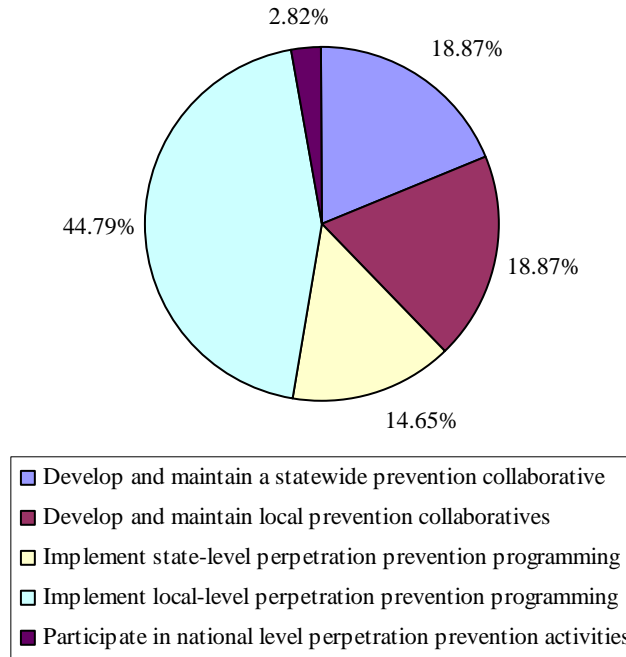
Figure 2. Cumulative record of community/system changes and associated critical factors.



Research Question 3. How are community/system changes contributing to the efforts to prevent CSA?

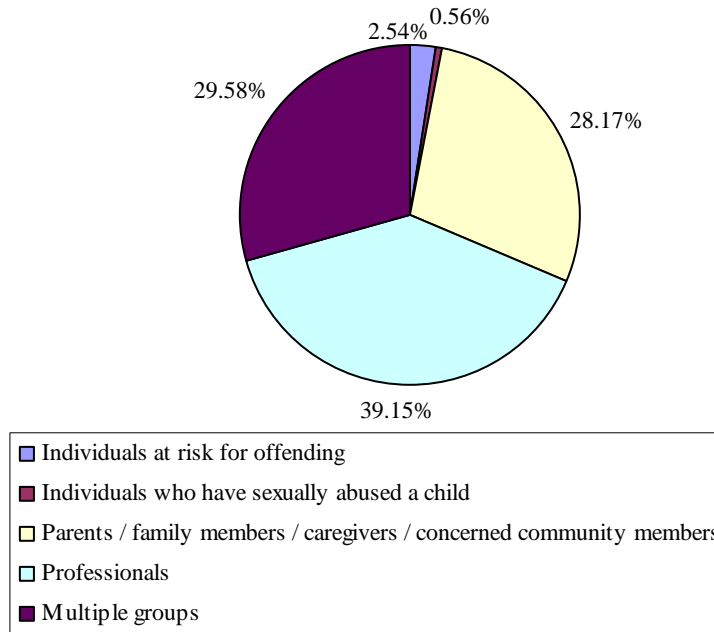
Stop It Now! Minnesota classified each community/system change by a) goal, b) target, c) behavior change strategy, d) duration, c) sector, and d) ecological level. Results for the classification by goal show an emphasis on the goal of implementing programming to prevent perpetration at the local level (44.79% of documented changes). Smaller proportions of community/system change were intended to develop and maintain a statewide prevention collaborative (18.87%), as well as local collaboratives (18.87%).

Figure 3. Distribution of Stop It Now! Minnesota's community/system changes by goal (N=355).



Stop It Now! Minnesota's CCs targeted multiple members of the community. The effort reached professionals (39.15%) as well as parents, family members, caregivers, and concerned community members (28.17%). Consistent with this primary prevention effort, fewer of the changes specifically targeted individuals at risk for offending (2.54%) and individuals who have sexually abused a child (0.56%). Almost a third of the changes targeted multiple groups (29.58%).

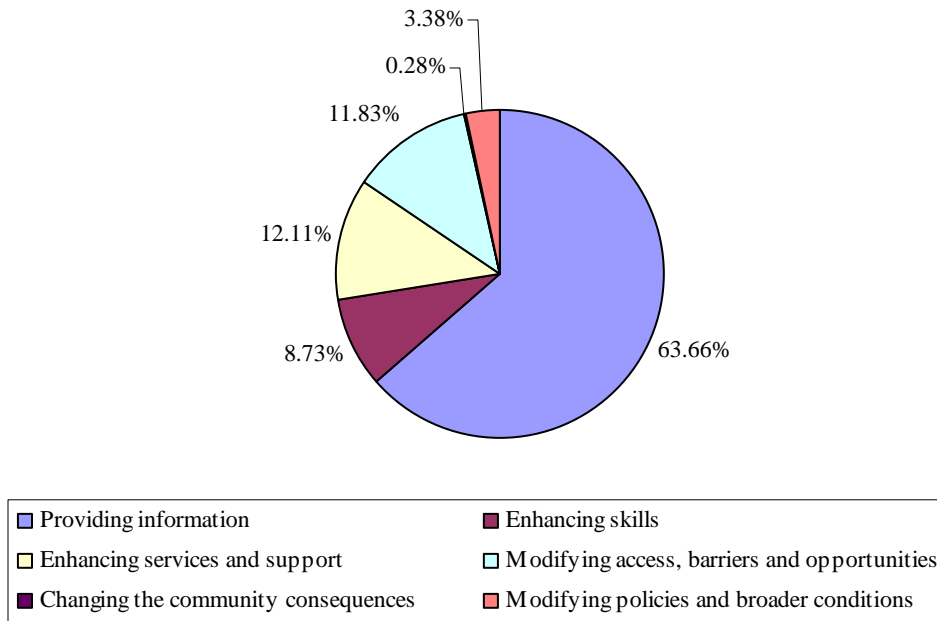
Figure 4. Distribution of Stop It Now! Minnesota's community/system changes by target (N=355).



The majority of changes focused on changing the behavior of adult community members by using the behavior change strategy of providing accurate information on what adults can do to prevent child sexual abuse (63.66%). Stop It Now! Minnesota also sought to change behavior on the systems level by enhancing services and support (12.11%) to those who can recognize the warning signs and prevent CSA as well as those in need of treatment. Some CCs involved modifying barriers, access, and opportunities (11.83%) related to CSA prevention. Fewer changes involved the change strategies of skills enhancement (8.73%), modification of policies and broader conditions (3.38%), and changing the community consequences of preventing CSA (0.28%).

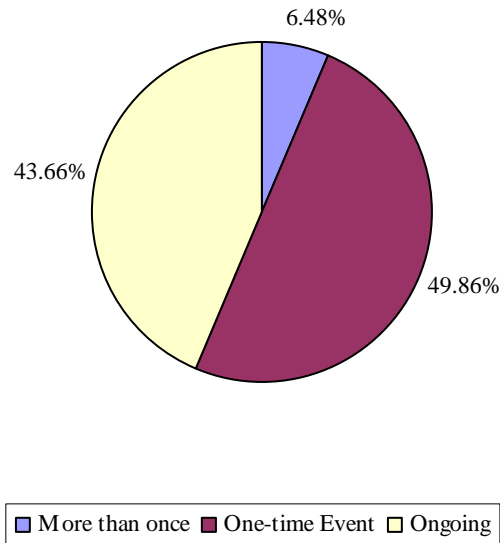


Figure 5. Distribution of Stop It Now! Minnesota's community/system changes by change strategy (N=355).



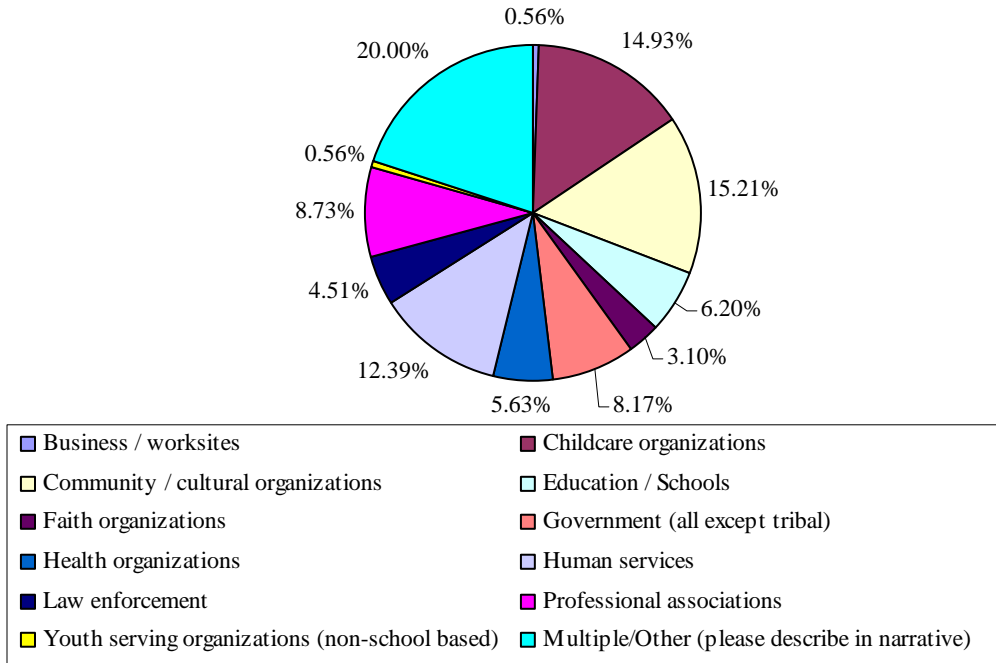
Many of the community/system changes occurred on an ongoing basis (43.66%), others were one-time events (49.86%), and few of the changes (6.48%) occurred more than once (but not on an ongoing basis).

Figure 6. Distribution of Stop It Now! Minnesota's community/system changes by duration (N=355).



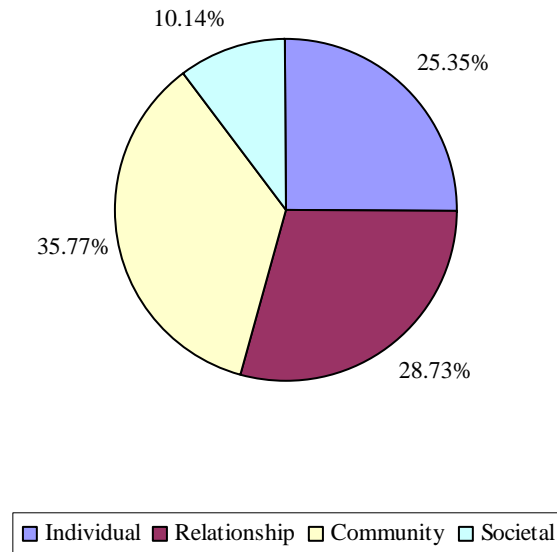
Community/system changes documented by Stop It Now! Minnesota occurred across 11 distinct sectors that were named at the beginning of the initiative. These sectors included childcare settings, schools, and faith organizations. Many of the changes occurred in either multiple sectors or in a sector that was not in the 11 main sectors (20.00%). Documented community/system changes occurred primarily in community / cultural organizations (15.21%), childcare organizations (14.93%), and the human services sector (12.39%). Less than ten percent of the changes occurred in any of the other nine sectors.

Figure 7. Distribution of Stop It Now! Minnesota’s community/system changes by sector (N=355).



Changes in the environment occurred on a variety of ecological levels. The majority of changes occurred on the community level (35.77%), with fewer changes occurring on the individual level (25.35%) and relationship level (28.73%). Few changes (10.14%) occurred on the broader societal level.

Figure 8. Distribution of Stop It Now! Minnesota's community/system changes by ecological level (N=355).

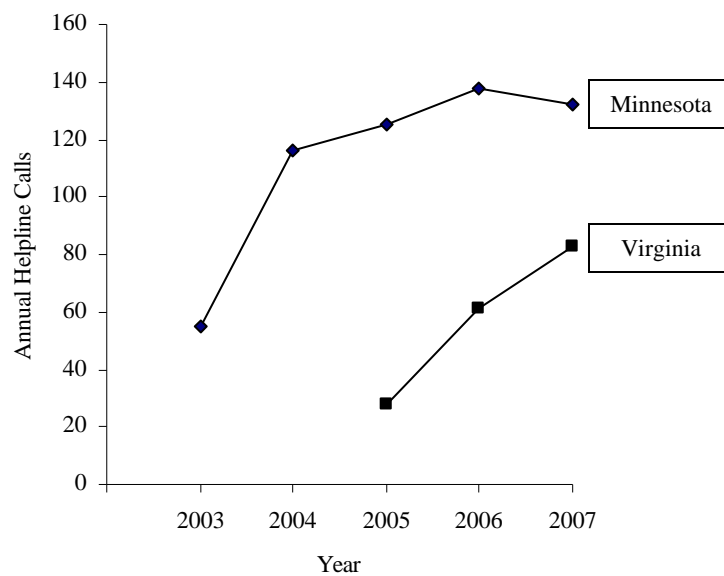


*Research Question 4. Are community/system changes associated with indicators of success and population-level outcomes related to CSA prevention?*

Community/system change is an intermediary outcome for Stop It Now! Minnesota. The aim of changing communities and systems (the protective environment) is to promote a widespread change in behavior related to preventing child sexual abuse (e.g., adults recognizing and responding to suspicious situations before CSA occurs). One indicator of success at the population level is calls to the Helpline before CSA occurs. The components of the intervention (e.g., workshops, billboards, brochures), prompt adults to call the Helpline if they suspect CSA may be occurring. Stop It Now! tracked the number of calls from Minnesota, throughout the grant period. As shown in Figure 3, the annual calls to the Helpline increased from 55

calls in 2003 (before implementation of the intervention) to 138 calls in 2006. In 2007, call volume decreased to 132, but remained higher than in the three years previous to 2006. Stop It Now! also answers calls from the state of Virginia. Stop It Now! began tracking Virginia's call volume in 2005, but only captured call volume for October through December (28 calls). Stop It Now! tracked Virginia's first full year of incoming calls in 2006. In 2006, 61 individuals called from Virginia and 83 called in 2007.

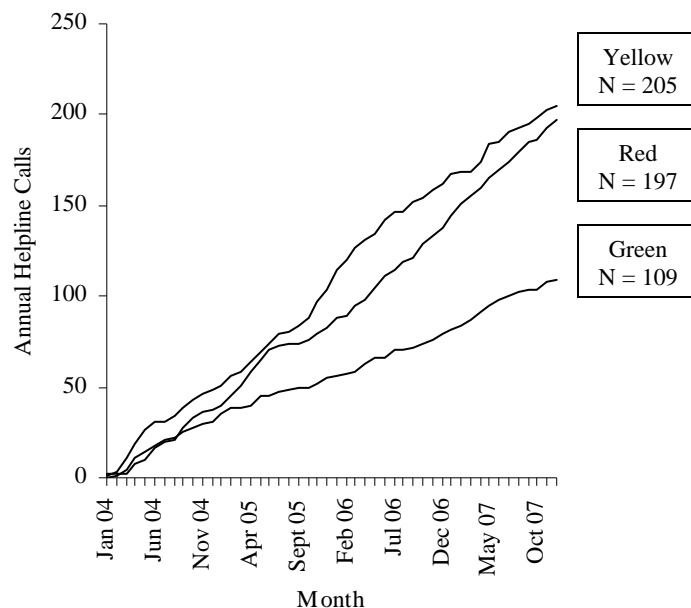
*Figure 9.* Annual Helpline call volume from Minnesota and Virginia.



In 2004, the Helpline began classifying the incoming Minnesota calls by type (i.e., red, yellow, and green). From 2004 to 2007 (during implementation of the intervention), the Helpline answered 109 green calls (e.g., information requests), 197 red calls (calls in which abuse is believed to have already happened), and 205 yellow calls (calls involving situations with warning signs of child sexual abuse); see Figure

4. The cumulative rate of calls (i.e., calls per month) increased fastest for yellow, second fastest for red and third fastest for green calls. This marked increase in reporting the warning signs of CSA (yellow calls) through the Helpline was associated with the unfolding of the comprehensive intervention (community/system changes) facilitated by Stop It Now! Minnesota.

*Figure 10.* Widespread behavior change in the form of cumulative calls (by type) from Minnesota to the Stop It Now! Helpline.

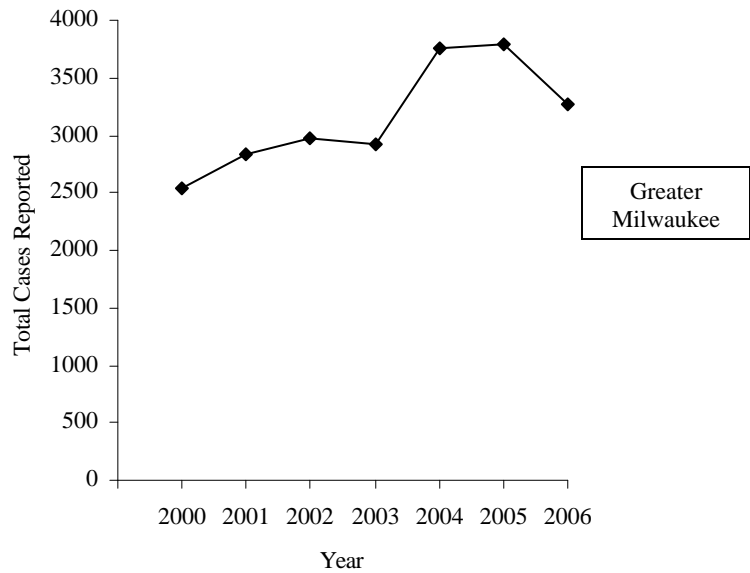
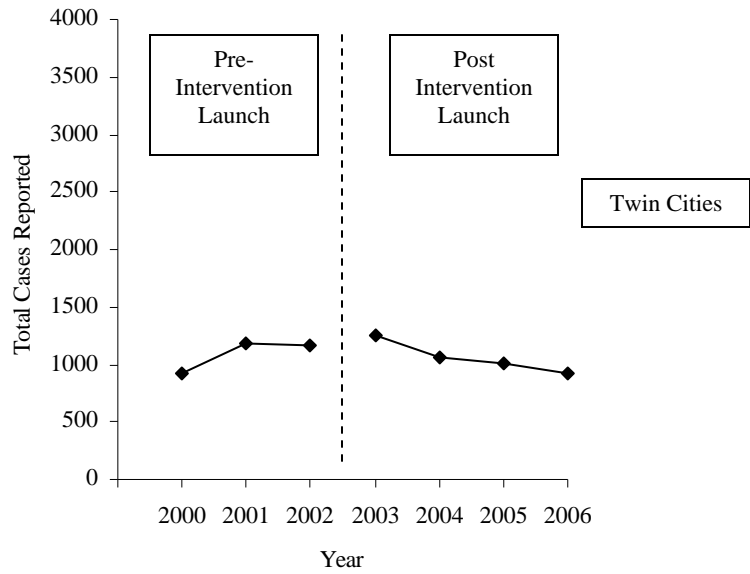


The IOM framework posits a widespread change in behavior (increased calls to the statewide Helpline) should contribute to a change in population-level outcomes. The outcome of interest in this study is the total reported cases of child sexual abuse. The population of interest is the seven county Twin Cities, the sole focus for the first three years of the initiative. The average number of total reported cases of CSA

across a seven year period (2000 to 2006) was 1,075.14 cases per year. During the 3 years prior to the launch of Stop It Now! Minnesota's intervention (2000 to 2002), the average number of reported cases per year was 1,094.33. In the four full years that followed the launch of the intervention (2003 to 2006), the average number of reported cases per year was 1,060.75; reported cases of CSA from pre to post implementation decreased by 3.06%. The most recent year (2006) had the lowest number of reports (922) for the 7 year period.

The greater Milwaukee area observed an increase in child sexual abuse reports from 2000 to 2006. The average number of reported cases of CSA in the greater Milwaukee area across the seven year period was 3,157.71 cases per year. In the three years before Stop It Now! Minnesota's launched its intervention (2000 to 2002), reported cases per year in the greater Milwaukee area averaged 2,784.67. In the years that followed the launch of Stop It Now! Minnesota's intervention (2003 to 2006), the average number of annual reports increased to 3,437.5 cases per year. This results in a 23.44% increase in the number of reported cases from pre to post launch of Stop It Now! Minnesota's intervention. From year to year, CSA reports increased four of six times from 2000 to 2006.

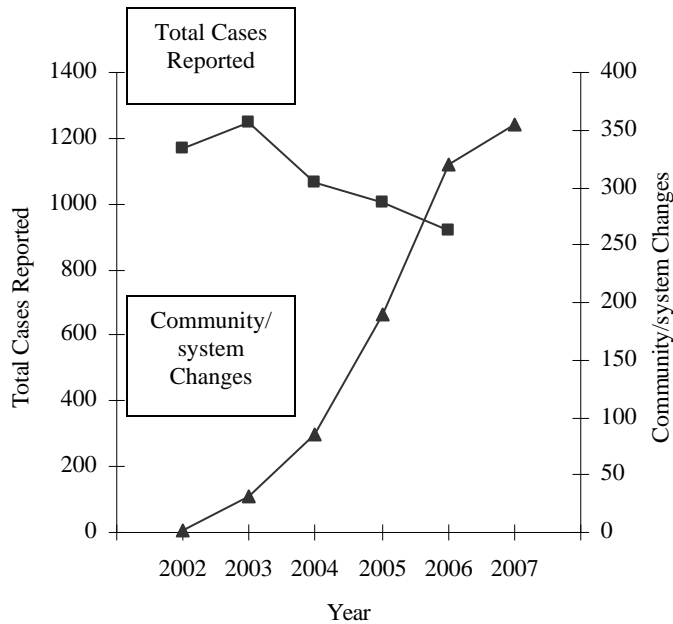
Figure 11. Population-level outcomes in the form of total reported cases of child sexual abuse in the seven county Twin Cities area compared to those in the five county greater Milwaukee area.





Improvement in this population-level outcome was also examined in light of the community/system change. Stop It Now! Minnesota facilitated change in the community/system in the form of new and modified programs and practices. This accumulation of change is temporally associated with a reduction in reported cases of CSA. After 2005, Stop It Now! Minnesota’s efforts appear to tip reported cases of CSA.

*Figure 12.* The association between community/system changes and reductions in total reported cases of CSA in Minnesota.



### Discussion

This study systematically examined the effects of a multi-component, collaborative effort to prevent child sexual abuse in Minnesota. The results suggest that this effort was effective as a catalyst for changing communities and systems related to prevention of CSA in Minnesota. Three hundred and fifty-five

community/system changes were facilitated during the five years of the initiative, on average, over six new or modified programs or practices per month. The study also examined the factors that were associated with increases or decreases in rates of community/system change. One factor that appeared to influence the rate of community/system change was human resources. The addition of a part time marketing coordinator and a full time outreach and education coordinator in January and March of 2003, respectively, was followed by a marked increase in community/system changes that began in September of 2003. By contrast, the reduction of staff in May of 2006 was associated with a decreased rate of community/system change that occurred about six months later.

Other factors that were associated with the accelerations in the rate of community/system change were the launch of the program, the expansion of the program's components, and the launch of the statewide advertising campaign. Additional factors associated with lower rates of change included the initiative's facilitation of community dialogues and policy work with child care organizations. These activities were developmental in nature and potentially competed with other efforts to change the environment. It is important to note that these are associations of factors with rates of change. This case study design does not account for the delayed effects that some factors may have on the rates of change, nor does it eliminate confounding factors that were occurring in the broader social environment and may have affected rates of change.

Results from the classification of community/system changes suggest that this primary prevention effort differed from many other secondary and tertiary prevention efforts. Many efforts to address child sexual abuse have targeted children exposed to potentially harmful situations. By contrast, this effort targeted those adults who are in a position to recognize the signs of CSA and take action to prevent it. Targets of change included professionals, parents, family members, caregivers, and individuals having sexual feelings toward children. The initiative focused on providing adult members of the community with accurate information about CSA, such as warning signs of CSA, how to report situations where “things did not seem right,” or how to obtain help themselves. Stop It Now! Minnesota’s effort to prevent CSA involved collaborating with a broad and inclusive group of change agents within communities throughout the state.

In this comprehensive effort, community/system changes occurred in all eleven targeted sectors. Stop It Now! Minnesota’s efforts to prevent CSA embodied a grassroots effort as the majority of the changes happened via development and implementation of prevention efforts on the local level, community by community. By contrast, the minority of changes occurred at the statewide level. In this grassroots approach, the vast majority of community/system changes occurred on the individual, relationship, or community level, while few of community/system changes occurred on the societal level.

Stop It Now! Minnesota’s community/system changes were associated with increased calls to the Helpline (a widespread change in behavior). Minnesota call

volume was greater than Virginia call volume in both 2006 (138 verses 61) and 2007 (132 verses 83). It is unlikely that child demographics contributed to these differentials in call volume. The 2006 child population throughout the state of Virginia (1,806,847) was larger than in Minnesota (1,257,264) (U.S. Department of Health and Human Services, 2008). It is also unlikely that the occurrence of child sexual abuse in Virginia is significantly less than in Minnesota, as the U.S. Department of Health and Human Services cites that Virginia substantiated 950 victims in 2006, while Minnesota substantiated 920 victims in the same year.

Both Minnesota and Virginia launched social marketing campaigns to promote adult responsibility of recognizing and responding to child sexual abuse. Virginia spent more on their advertising the Helpline than Minnesota, but concentrated their social marketing campaign toward Richmond and Roanoke (as well as a few other communities) (J. Habana Hafner & S. Hudson, personal communication, April, 1 2008). Although Minnesota spent fewer dollars on their social marketing efforts, they focused on the entire state. So, it is not surprising that statewide, Minnesota residents called the Helpline more frequently. Minnesota's multi-component intervention was more extensive than Virginia's. Virginia conducted a few community dialogue sessions, but did not implement any of the other intervention components that Stop It Now! Minnesota did. Stop It Now! Minnesota provided the Helpline number with all printed materials, trainings, and nearly all other components, and this may have directly contributed to Helpline call volume.

The IOM Framework for Collaborative Public Health Action theorizes that a widespread change in behavior (increased reporting to the Helpline) should be followed by a change in population-level outcomes. A reduction in total cases of CSA reported in the Twin Cities was the population-level outcome of interest for this study. The seven county area saw a 3.06% decrease in the annual number of CSA cases reported from pre to post launch of the intervention. The greater Milwaukee area served as a comparison community; in the greater Milwaukee area there was a 23.44% increase in the number of annual reports of CSA for the identical time periods. Although the Twin Cities and greater Milwaukee locations may differ in many ways, key elements that could potentially affect reporting are comparable across the two areas. Statewide, the child population in Minnesota (1,257,264) is only slightly smaller than the child population in Wisconsin (1,312,530) (U.S. Department of Health and Human Services, 2008). Both states mandate reporting from six sectors (law enforcement, health/medical, mental health, social services, education, and childcare). Mandated reporters made the majority of reports in both states in 2005 and 2006 (Minnesota Department of Human Services, 2007; Wisconsin Department of Health and Family Services, n.d.); information on the proportion of mandated reports were not available in the Wisconsin child welfare reports before 2005. So, the opportunity for CSA to occur is similar in both states. The legal responsibility to report CSA is consistent across states, and in both states it is mandated professionals that report CSA the majority of the time.

Strengths of using total cases of child sexual abuse reported, from annual child welfare reports, should be pointed out. First, this data is collected by local agencies that had no stake in the results of this study. Second, the fact that the majority of reports were mandated by law reduces the likelihood of systematic underreporting. Finally, the use of total reported cases does not introduce differences in legal definitions or in the systems level responses, as confirmed cases would; this is why total cases reported was chosen as a population-level outcome over confirmed cases of CSA. Perhaps the most significant threat to internal validity is that both states rely on local agencies to submit data on reported cases for their annual child welfare reports.

This participatory research study had a number of additional methodological strengths. The study used a systematic measurement system for documenting the unfolding of a multi-component intervention in the form of community/system change. The measurement system for community/system change has been extensively field-tested across diverse contexts and issues; and specific operational definitions, a documentation protocol, and coding instructions helped data recorders discern occurrence of new or modified programs, policies, and practices (how the environment was changing) from non-occurrences. Incoming calls to the Helpline provided an indicator of behavior change for the collaborative effort at the state (population) level. Fryer, Kraizer, and Miyoshi (1987) found that written tests of knowledge and attitudes do not necessarily provide a valid measure of the actual preventative behavior. The present study examined changes in adult behavior

(Helpline calls and reports of CSA) associated with the intervention, and did not rely on proxy measures such as written tests.

A second strength of this study was its contextual validity. This comprehensive intervention occurred in multiple communities throughout the state and reached its targets through eleven sectors and all ecological levels highlighted by the World Health Organization's World Health Report on Violence (Krug et al., 2002). Third, the design of the measurement system, data recording, and interpretation of data was done using a participatory research approach, involving the Director of Stop It Now! Minnesota and outside scientific partners. Collaborative interpretation of data occurred multiple times and was made easier by online lists and graphs generated by the Online Documentation and Support System. The director of Stop It Now! Minnesota and the KU Work Group reviewed records of the change effort and reflected on the initial interpretation of the data for each research question.

A fourth strength was the participatory nature of the study, which joined research and practice. Stop It Now! Minnesota documented 355 community/system changes in the protective environment throughout Minnesota. It used systematic reflection on how these changes were contributing (e.g., distribution of changes by sector) to make adjustments in this primary prevention effort. This study also helped to reveal the level of institutionalization of the prevention effort since 178 of the 355 documented changes happened either more than once or on an ongoing basis.

Along with numerous strengths, this study also had a number of limitations. This empirical case study in one state/community permits only limited generalization

of findings to other states/communities. The CDC granted funds to Stop It Now! Minnesota because of its statewide capacity and readiness to launch a large scale intervention to prevent child sexual abuse. Other communities or states would vary in regards to their capacity and readiness, which may further limit the generalization of the findings of this study. As with all case studies, a direct cause and effect relationship cannot be established. Although responding to CSA on the statewide Helpline increased, we do not know what proportion of these individuals were exposed to components of the Stop It Now! Minnesota intervention. Confounding (and perhaps causal) factors cannot be ruled out; for example, stories in the media about CSA that were not related to Stop It Now! Minnesota's efforts could have contributed to increased calls to the Helpline or to decreased reports of CSA beyond the documented implementation of the intervention.

The outcome data used in this study also presents limitations. The CC measure relied on self-reported data. Although the KU Work Group established regular communication with Stop It Now! Minnesota to ensure accurate and complete documentation, Stop It Now! Minnesota's efforts may not be fully or accurately captured. Further, the impact of each discrete community/system change was not quantified; for instance, community/system changes involving providing information may have had less impact than others that enhanced access to services. Outcome data on the use of calls to the Helpline provides a moderately sensitive, but indirect indicator of the initiative's success in changing adult behavior on a widespread scale. Finally, data from 2007 were not available for assessing the impact on reported cases



of CSA in the Twin Cities and the greater Milwaukee area; reports from 2006 were the most recent available data.

Future research should attempt to use stronger experimental designs to test the effects of child sexual abuse prevention efforts. For instance, engaging a group of similar communities that have a common interest and readiness in CSA prevention would enable use of an interrupted-time series design across communities. The implementation of a CSA intervention could be staggered across states/communities, which would permit stronger conclusions about cause and effect relationships. Systematic replication of effects across different states/communities, perhaps using multiple case study designs, would help establish the generality of the findings. Additionally, an analysis of the components of the Stop It Now! Minnesota intervention would enable a clearer understanding of the effects of the intervention. For example, one component of the intervention involved licensor training provided for child care and foster care organizations on recognizing and responding to CSA. Assessing the knowledge and skills of these providers after participating in the training would provide a clearer understanding of the specific elements of Stop It Now! Minnesota's multi-component intervention.

The findings of Stop It Now! Minnesota's efforts have implications for public health policy and practice. The formation of Stop it Now! Minnesota began after an annual sexual abuse treatment conference when CSA prevention and treatment agencies had the opportunity to interact. Treatment providers, prevention organizations, and practitioners need to assure regular occasions to directly

communicate with each other. Funding and resources for preventing child sexual abuse must continue to be available for collaborative efforts. Funding and resources should be available for emerging initiatives, but also for sustaining initiatives that have succeeded in preventing CSA. Hoefnagels and Mudde (2000) asserted the importance of planning and goal setting, which Stop It Now! Minnesota incorporated into its approach. Incentives might be established for comprehensive CSA prevention initiatives that make significant progress in changing environments and improving population-level outcomes. Stop It Now! Minnesota created numerous collaborative relationships with other agencies, service providers, and community leaders to prevent CSA, which suggests the importance of supporting local, grassroots efforts in addition to broader national efforts. Finally, more reliable systems and practices for monitoring CSA must be developed. The U.S. Centers for Disease Control and Prevention is working towards more uniformity in monitoring child maltreatment, specifically in defining maltreatment and documenting it (Leeb, Paulozzi, Melanson, Simon, & Arias, 2008). Leeb et al. pointed out challenges associated with ineffective child maltreatment surveillance, including limited ability to “identify those groups at highest risk” and “monitor changes in the incidence and prevalence of child maltreatment over time” (Leeb, et al., 2008, p. 3).

Stop It Now! Minnesota set out to develop, implement, and maintain a collaborative effort to prevent child sexual abuse on the community and state level. Over the five-year grant period of planning and implementation, it was able to bring about a multitude of distinct changes in communities in Minnesota related to its

mission. These changes enabled members of the community to recognize the warning signs of child sexual abuse and to intervene *before* abuse occurred, as suggested by the increased calls to the statewide Helpline. It is plausible that the intervention - and associated increased recognition and reporting of CSA in Minnesota - contributed to decreased reports of child sexual abuse. Although this is a promising start, continued efforts to promote adult responsibility may yield greater improvements in the incidence of child sexual abuse and prevent its destructive effects on children, families, and communities.

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## List of Appendices

- Appendix A      Documentation and Coding Instructions for Community/system  
Changes (CCs)
- Appendix B      Protocol for Community-Based Participatory Research Used in this  
Study

## Appendix A

### Documentation and Coding Instructions for Community/system Changes (CCs)

**General Definition:** **New or modified programs, policies or practices in the community or system facilitated by the initiative and related to its goals and objectives.** Changes that have not yet occurred, which are unrelated to the group's goals, or those which the initiative had no role in facilitating are not considered community changes for the initiative. [Note: We use the term “Community/System” and “Community” Changes interchangeably since they represent the same type of event at different levels (e.g., neighborhood or city or broader system).

**Coding Instructions:** **Specific instructions for using the definition to code events follow:**

- CC1 Community changes must meet all of the following criteria:
  - CC1.1 have occurred (e.g., when a policy is first adopted; when a new program is first implemented - not just been planned), and
  - CC1.2 are related to the initiative's chosen goals and objectives, and
  - CC1.3 are new or modified programs, policies, or practices in different parts of the community or system (e.g., government, business, schools, health organizations), and
  - CC1.4 are facilitated by individuals who are members of the initiative or are acting on behalf of the initiative.
- CC2 When considering whether an event is new or modified: to be judged as “new,” a program, policy or practice must not have occurred before in the effort (e.g., with these groups of people, with these organizations or partners, in these settings, delivered in these ways). To be judged as “modified,” a program, policy or practice must be expanded or altered (e.g., a training program was expanded to include new modules, a policy was altered to affect new groups of people, a program was delivered in new organizations or places).
- CC3 When considering whether to score multiple events as one instance or as multiple instances of a community change: To be judged as multiple instances, changes must be implemented in multiple settings (e.g., different schools or businesses) or levels (e.g., local, state levels) AND require separate approvals (e.g., a school principle approved a life skills program to be taught in her school; a second principle later agreed to do so in his school). If the event either occurred in only one setting or occurred as a result of one approval, it is coded as **one** instance of community change (e.g., the school board agreed to implement a district-wide life

skills program that was implemented in multiple schools).

- CC4 When multiple entries of the same event are being entered/documentated: The recorders involved should discuss how to record the event as a single entry (e.g., the same program implemented in the same place by multiple groups). If there is disagreement, a data coordinator should resolve differences to best represent how the environment is changing in a way that does not count the same event multiple times.
- CC5 The *first* instance of implementation of a new program or practice in the community is coded as a community change, since it constitutes a change in a program or practice in the community.
- CC6 A first time occurrence or enactment of a policy is recognized as a CC at the point of approval to implement the policy.
- CC7 The *first* committed agreement of collaboration between two or more organizations or individuals facilitated by individual(s) who are acting on behalf of the initiative. For a collaboration to occur, independent groups must commit to sharing at least one of the following: 1) resources, 2) responsibilities, 3) risks, and/or 4) rewards.
- CC8 Not all first-time events are community changes; *the event must meet all parts of the definition of a community change*. For example, if staff members attended a seminar for the first time it is generally not a community change.
- CC9 Specifically excluded as community changes are Planning Products (e.g., new bylaws, completed action plan) and Resources Generated (e.g., a grant or donation to the initiative) that occur internal to the initiative.

## Appendix B

### Protocol for Community-Based Participatory Research Used in this Study

#### Reflection Questions for Sensemaking and Adjustments— Participatory Evaluation of Collaborative Efforts to Prevent Child Sexual Abuse

Work Group for Community Health and Development, University of Kansas  
<http://communityhealth.ku.edu/>

##### **Reflection Question # 1: What Are We Accomplishing?**

(Evaluation Question #1 Is the effort serving as a catalyst for change in preventing CSA?)

[Materials needed: Listing of accomplishments; Figure 1, Cumulative number of community/system changes]

##### Specific Reflection Questions:

- What community/system changes (i.e., new or modified programs, policies and practices facilitated by the initiative) are we bringing about? [Review listing]
- What's missing? Has the initiative documented all the changes it has brought about? [Review listing, adding to list as needed]
- (Evaluation Question #1) What overall pattern of change do the results show (e.g., high/ low rate; stable/ increasing/ decreasing)? In recent months, what does the pattern look like? [See Figure 1 Cumulative rate of change]
- (Evaluation Question #1) What does the pattern suggest about the state of the effort as a catalyst for change in preventing CSA? [See Figure 1 Cumulative rate of change]

##### **Reflection Question # 2: What Are We Seeing?**

(Evaluation Question #2 What factors or processes are associated with the rate of change?)

[Materials needed: Figure 1, Cumulative number of community/system changes]

##### Specific Reflection Questions:

- When (what months) do we see marked increases in the rate of change? When were there marked decreases? [See Figure 1 Cumulative rate of change]
- What was happening when (or immediately before) there were marked increases/ decreases in the rate of change (e.g., completed action plan; new leadership, staff or partners)?
- What does this suggest about the potential importance of particular factors or processes to your effort?



### **Reflection Question # 3: What Does It Mean?**

(Evaluation Question #3 How are community/system changes contributing to efforts to prevent CSA?)

(Evaluation Question #4 Are community/system changes associated with improvements in population-level outcomes related to CSA?)

[Materials needed: Figures 2a-2f, Breakdowns of community/system changes by category; Figure 3, possible associations of community/system changes with more distant population-level outcomes]

Specific Reflection Questions for EACH category of analysis (i.e., by goal addressed, sector in which the change occurred, target of the change, behavior change strategy used, duration, and objective):

- (Evaluation Question #3) What do the results show about the distribution of changes by XX (e.g., primary goals addressed; primary sectors in which changes occurred)?
- What does this suggest regarding the initiative's contribution to preventing CSA?
- What adjustments (if any) should be made in what the initiative is doing?
- (Evaluation Question #4) Is the unfolding of community/system changes (an intermediate outcome) associated with improvements in population-level indicators of success?
- What adjustments (if any) should be made in what the initiative is doing?

### **Reflection Question # 4: What Challenges Are We Facing?**

[Materials needed: CSA Workstation, see “troubleshooting guides” under “Solve a Problem”]

Specific Reflection Questions:

- What problems and challenges is the initiative facing?
- What types of supports/ resources would help us effectively address these challenges?

### **Reflection Question # 5: What Could Help?**

[Materials needed: CSA Workstation, see “toolkits” under “Plan the Work”]

Specific Reflection Questions:

- What types of ongoing/ upcoming work will we be engaged in?
- How can we best review/ chose among different types of support available?

### **Reflection Question # 6: Who Could Help?**

[Materials needed: CSA Workstation, see “Ask an Advisor” feature]

Specific Reflection Questions:

- What types of expertise/ skills would be helpful in guiding our work?
- Who could serve as a potential advisor?
- How could we make connections to needed sources of help (e.g., links to advisors)?

**Reflection Question # 7: What's the Plan?**

[Materials needed: CSA Workstation, see “toolkit” for “Developing strategic and action plans” under “Plan the Work”]

**Specific Reflection Questions:**

- What community/system changes are we attempting to bring about during the next few months?
- Who, is going to do what, by when to bring this about?
- What opportunities for change are emerging?
- What threats do we see that suggest the need for change?
- What else should be done (and added to the action plan)?

**Reflection Question # 8: What Are We Learning?**

[Materials needed: CSA Workstation, see “Lessons Learned” under “Success Stories”]

**Specific Reflection Questions:**

- What have we learned that can help us improve our work?
- When considering what we are learning, what adjustments should be made?

**Reflection Question # 9: What Are We Proud Of?**

[Materials needed: Listing of accomplishments; CSA Workstation, see “Success Stories”]

**Specific Reflection Questions:**

- What accomplishments (e.g., new programs, policies, and practices) are we particularly proud of?
- What audiences or groups would benefit from hearing about these accomplishments?
- How should we best reach audiences (e.g., letter to key stakeholders, feature story, newsletter article, manuscript for professional publication)?