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Primary Prevention of Sexual Violence against Adolescents and the Community Readiness Model

Theresa A. DeWalt

Abstract: Sexual violence affects tens of thousands of people annually in the United States. Despite this, it is challenging to effectively implement sexual violence prevention strategies. One reason for this is because prevention efforts often do not fit the characteristics and level of readiness of the communities in which they are being implemented. This research proposal will use the qualitative community assessment tool, the Community Readiness Model (Jumper-Thurman, Edwards, Plested, & Oetting, 2001; Plested, Edwards, & Jumper-Thurman, 2003), to match a sexual violence prevention strategy to two specific communities in southeast Wisconsin. This assessment will result in recommended primary prevention strategies that will be tailored to fit the level of readiness of the communities, thus increasing the chance of their successful implementation.

Sexual violence affects tens of thousands of people annually in the United States. An average of 93,514 incidents of sexual violence were reported each year to law enforcement in the United States between the years 1995 and 2003 (Office of Justice Assistance, [OJA], 2005). Perhaps even more alarmingly, the number of reported sexual assaults represents only approximately one-third of the actual incidence of sexual violence occurring in our society, as it is one of the lowest reported crimes (Department of Military Affairs and Public Safety, 2000; National Crime Victimization Survey, 1999; U.S. Department of Justice, 2002). In addition, the majority of these victims were under the age of 18. In Wisconsin, 76.8% of all victims of sexual assault in 2004 were under the age of 18, with 70% of those under the age of 15 (OJA).

Victims of sexual violence often experience severe, long-lasting ramifications. The consequences of sexual violence can include post-traumatic stress disorder, depression, anxiety, interpersonal problems, pregnancy, sexually transmitted infections, suicidal ideation, self-harm behaviors, and eating disorders (Bensley, Van Eenwyl, Spieker, & Schoder, 1999; Davis, Combs-Lane, & Jackson, 2002; Gallo-Lopez, 2000; Resnick, 1993, Tjaden & Thoennes, 2000). The emotional, psychological, and

Correspondence concerning this article should be addressed to Theresa A. DeWalt, Department of Counseling and Educational Psychology, Marquette University, P.O. Box 1881, Milwaukee, WI, 53201-1881. Email: theresa.dewalt@marquette.edu.

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physical traumas that sexual violence victims experience can last for months, years, and for some, even a lifetime.

As a result of both the prevalence and extensive consequences of sexual violence in the U.S., governmental programs and rape crisis centers have been working to end its occurrence. Historically, these efforts have focused on changing the actions of potential victims to reduce the likelihood that they will become a victim. These "risk reduction" efforts often involve telling potential victims (particularly women) not to walk alone at night, to take self-defense classes, to carry pepper spray, and to watch their drinks in bars. However, in recent years, prevention efforts have focused more on changing the attitudes and behaviors that allow sexual violence to occur in the first place. These efforts, labeled "primary prevention," involve programming aimed at changing the social norms and beliefs in our culture that contribute to the occurrence of sexual violence.

RATIONALE FOR THE PROSPECTIVE STUDY

Despite increased attention on the primary prevention of sexual violence, it is still challenging to effectively implement sexual violence primary prevention strategies. One challenge arises because it is difficult to construct a prevention program that changes the social norms and cultural beliefs that both contribute to sexual violence and are reinforced on a daily basis through society's social structures and media influences. For example, many of today's songs, music videos, and movies perpetuate the image of women as sexual commodities. In particular, misogyny and the objectification of women are illustrated in the lyrics of many popular songs, including rapper Nelly's "Tip Drill" and Eminem's "The Eminem Show." The lyrics of these songs involve the sexual objectification of women and girls, and narrowly define a woman's value based on what she can provide sexually, thereby rendering her less than fully human (Katz, 2006; Koss, 1994). This perspective may contribute to one's ability to commit an act of violence against a woman (Centers for Disease Control and Prevention [CDC], 2004). Such songs' popularity in American culture illustrates our society's possible acceptance of, and desensitization to, the objectification of women, and in so doing, may increase the risk that those routinely exposed to this type of media, in combination with other risk factors, may become sexual perpetrators (CDC, 2004). It is challenging to develop prevention programs that can effectively counteract the social norms and attitudes that result from these types of pervasive media messages.

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A second, and related challenge is the difficulty of implementing effective prevention strategies that specifically address the characteristics of a particular community. For example, an extremely effective prevention program in one city may fail in another community due to differences in knowledge, beliefs, and cultural norms. Some communities may reject public recognition of a local problem, other communities may show considerable interest in an identified problem but have little knowledge about what to do, and still other communities may have highly developed and sophisticated prevention programs (Oetting et al., 1995; Slater et al., 2005). Therefore, prevention strategies must be tailored to meet the social norms, knowledge base, and attitudes of the community members if the efforts are to be accepted and successful.

This research proposal will address these two challenges by assessing the knowledge, awareness, attitudes, and cultural norms of a community that speak to the community's level of readiness to accept primary prevention efforts aimed at reducing non-familial sexual violence against adolescents. The study will address the first challenge by recommending primary prevention strategies aimed at changing the social norms that contribute to sexual violence. The second challenge will be addressed through the completion of the Community Readiness Model, (CRM) an assessment aimed at understanding the unique culture, attitudes and knowledge of the communities which will receive the prevention programs.

This assessment will use the Community Readiness Model (Jumper-Thurman, Edwards, Plested, & Oetting, 2001; Plested, Edwards, & Jumper-Thurman, 2003), a community assessment tool used to match a prevention strategy to a specific community. The results of this assessment will be provided to the local rape crisis center serving the two communities that will be assessed. These recommended strategies will be tailored to fit the level of readiness of the communities served by the rape crisis center, and will therefore have an increased chance of success. Overall, the hope is that these prevention efforts will work to change the communities' acceptance of sexual violence.

Research Questions

This study will be completed in rural and urban Racine County, Wisconsin. Racine County was chosen due to its high rates of sexual violence (FBI Crime Statistics, 2005, http://www.areaconnect.com/crime/compare.htm?c1= Racine&s1=WI&c2=New+York&s2=NY, retrieved 1.15.07), the researcher's

professional association with the county as the director of the local rape crisis center, and the researcher's proximity to the community. The principal research questions of this study are as follows:

Question 1: What are the levels of community readiness in rural and urban Racine County regarding non-familial sexual violence primary prevention strategies within the adolescent population?

Question 2: What are the differences in level of readiness between rural and urban Racine County?

Question 3: How do the CRM Dimensions and Stages of Readiness inform the implementation of sexual violence primary prevention strategies for the adolescent population in rural and urban Racine County?

REVIEW OF THE LITERATURE

Sexual Violence

Definitions. Historically, sexual violence has been inconsistently defined. Specifically, researchers have disputed which of its various components (e.g., rape, fondling, contact and non-contact sexual abuse) should be included as part of the term (Basile & Saltzman, 2002). As a result of this lack of clarification, in 2002 the Centers for Disease Control and Prevention (CDC) developed the document *Sexual violence surveillance: Uniform definitions and recommended data elements.* The purpose of this document is to present a uniform definition of sexual violence and a consistent method to collect data on its occurrence. A consistent definition of sexual violence would help to measure and identify risk and protective factors for victimization and perpetration, which would inform prevention and intervention efforts (Basile & Saltzman). The CDC's resulting definition of "sexual violence" is as follows:

Nonconsensual completed or attempted contact between the penis and the vulva or the penis and the anus involving penetration, however slight; nonconsensual contact between the mouth and the penis, vulva, or anus; nonconsensual penetration of the anal or genital opening of another person by a hand, finger, or other object; nonconsensual intentional touching, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or buttocks; or nonconsensual non-contact acts of a sexual nature such as voyeurism and verbal or behavioral sexual harassment. All of the above acts also qualify as sexual violence if they are committed against someone who is unable to consent or refuse. (Basile & Saltzman, p. 9)

This definition of sexual violence is used for the purposes of this study.

Despite the use of the term sexual "violence," it is important to note that violence is not used during most sexual violations. In fact, physical violence, physical assaults, battery, and/or the use of weapons are not used during the majority of all sexual violations (OJA, 2005; U.S. Department of Justice [DOJ], 2002). Sexual violence, however, does often involve manipulation, coercion, power, and control. This challenges the stereotype that sexual violence is usually a physically "violent" act, and to underline the fact that most acts of sexual violence occur in more subtle, coercive ways (Tjaden & Thoennes, 2006).

In addition, many people who work in the field of sexual violence use the word "survivor" to describe a person on whom sexual violence has been inflicted. This term is used to reflect that these individuals have endured and, in essence, "survived" a horrific life event. The word "victim" will be used in this document in an effort to be consistent with the language used in the prevention education field, reflecting that prevention programs work to prevent sexual "victimization." The use of the term "victim" in this document, however, is in no way meant to imply that those who have been sexually victimized are not "survivors."

SEXUAL VIOLENCE AGAINST ADOLESCENTS

Prevalence

This study focuses on sexual violence primary prevention strategies for adolescents because adolescence is a time of high risk for sexual victimization and perpetration (OJA, 2005). Lee, Guy, Perry, Sniffen, and Mixson (2007) state that "prevention work focused on adolescents is key to any comprehensive strategy to prevent sexual violence" (p. 15). Given this focus, information regarding the rates of sexual violence within this population is provided.

Approximately 1.8 million adolescents in the United States have been victims of sexual assault (Kilpatrick, et al., 1998). Statistics from the National Sexual Violence Resource Center indicate that the average age of sexual victimization for females is 15 years old (OJA, 2004). Adolescent females are particularly vulnerable to becoming victims of sexual violence, with teenagers between the age of 16 and 19 being 3½ times more likely than the general population to be victims of rape, attempted rape, or sexual assault (Bureau of Justice Statistics, National Crime Victimization Survey, U.S. Department of Justice, 1996). While the majority (82%) of all juvenile sexual assault and abuse victims are female (U.S. Department of

Justice, 2000), boys are also sexually abused and assaulted. The average age of sexual victimization for boys is 12 years old and one in seven males will be the victim of sexual violence during the course of his lifetime (Office of Juvenile Justice and Delinquency Prevention, 1999). Even more critical to sexual violence prevention efforts are the rates of underage sexual offenders. An average of 40% of all sexual offenders are under the age of 18 (OJA, 2005). These numbers clearly illustrate the need for juveniles to receive prevention and educational programming in an attempt to reduce their risk of becoming both perpetrators and victims of sexual assault.

Impact

Sexually victimized adolescents often experience unique negative consequences because of their state of physical, social, and emotional development. Given these maturational processes, adolescents' sense of self and place in the world has not yet been fully established. As a result, if they experience sexual victimization, the trauma of this experience has an increased likelihood of affecting their developmental process, including how they see themselves, and their perception of how safe the world is. Green et al. (2005) state:

While the literature has tended to focus on childhood as a time of particular risk, more attention might usefully be directed toward adolescence, in particular to those abused during this period. Adolescence is developmentally a time when individuals are separating from their parents, developing sexually and cognitively, learning to love and

socialize with their peers, and consolidating their identity ... having this process subverted by reactions to trauma may accelerate these processes, such as sexual experimentation. Assaults on physical integrity may blur distinctions between self and others and interfere with learning about boundary issues and continuity of self across time. (p. 373)

As a result of the particular vulnerabilities of this developmental stage, adolescents who are sexually assaulted are at a heightened risk for a number of other negative consequences. These include a reduced ability to reach intrapsychic and social developmental milestones, increased levels of mental health problems and risk of suicide, as well as increased risky sexual behavior (Alamo Mixson, 2007; Clements, Speck, Crane, & Faulker, 2004; Crowder & Myers, 1993; Downs, 1993; Kilpatrick et al., 2000; Rodrigquez-Srednicki, 2001).

SEXUAL VIOLENCE PREVENTION

Despite the pervasiveness of sexual violence, little is known about how to effectively prevent it. Up to this point in time, neither community-based practitioners nor academic researchers have developed prevention methods that have significantly reduced incidence rates, as demonstrated by the continued consistent rates of reported sexual victimization (Campbell & Wasco, 2005). As McCall (1993) stated, "sexual assault prevention programming remains a confused, scattered and sporadic enterprise with little scientific underpinning…" (p. 277). Prevention efforts are challenged by the many interrelated factors that contribute to sexual violence. Historically, for example, it has not been clear whether prevention efforts should be aimed at controlling crime, changing the behaviors of potential victims, or treating victims after an assault has happened. The prevention of sexual violence has thus been approached either as a matter of crime control or as a public health measure (McCall, 1993).

Some "sexual assault prevention" efforts have focused on changing the behaviors of potential victims. In fact, the majority of rape prevention programs have targeted women, and have used strategies such as self-defense classes, the inclusion of "blue lights" on college campuses, and victim advocacy programs (Hensley, 2003). Such a focus may reduce the likelihood that particular women become victims of sexual assault, but it does not address the common perpetrators of the act itself, as men commit the majority of sexual assaults (Katz, 2006, Koss et al., 1994, OJA, 2005, Tjaden & Thoennes, 2006).

In fact, millions of dollars have been spent annually in the United States on rape prevention programs that focus on changing the behavior of potential victims. When such programming is thoughtfully considered, however, it is clear that these steps do not actually *prevent* sexual violence. Changing the behaviors of potential victims will not reduce sexual violence; such efforts simply *reduce the risk* that a specific person will be victimized. Even if the person who receives the programming is not victimized, someone else may be: The rape may still occur, just to someone else. Such victim-centered programming is now labeled "risk reduction," and is losing favor with rape prevention organizations (CDC, 2004; Meyer, 2000).

Within the past five years, however, there has been increased interest in developing programs that do not simply change the actions of potential victims, but rather stop perpetrators from committing offenses in the first place. This type of programming, labeled "primary prevention," focuses on changing the attitudes and behaviors of the people who commit acts of

sexual violence, as well as the surrounding community members who may support and encourage those attitudes and behaviors (CDC, 2004).

Primary Prevention

Definition of Primary Prevention. Primary prevention is based on the tenet that for true change to occur in the incidence of any type of social problem, prevention efforts must address, pre-emptively, communities and society as a whole, rather than focusing only on individuals affected by the problem. The prevention of sexual violence requires changing existing conditions that either promote or fail to inhibit sexual violence to occur. In an effort to encompass the historical development of the field of primary prevention, Gullotta and Bloom (2003) proposed the following definition of primary prevention in the

Encyclopedia of Primary Prevention and Health Promotion. Primary prevention, as the promotion of health and the prevention of illness, involves actions that help participants ...1) prevent predictable and interrelated problems, 2) protect existing states of health and healthy functioning, and 3) promote psychosocial wellness for identified populations of people. These consist of a) whole populations in which everyone requires certain basic utilities of life; b) selected groups of people at risk or with potential to be at risk; and c) indicated subgroups at very high risk. Primary prevention may be facilitated by increasing individual, group, organizations, societal, cultural and physical environmental strengths and resources, while simultaneously reducing the limitations and pressures from those same factors. (p. 13)

This definition delineates primary prevention as efforts implemented on multiple levels within society, efforts that focus not only on the individuals who have already been affected by the problem, but also on those at risk for being affected and the population as a whole. This definition of primary prevention will be used in this study.

One of the central beliefs of primary prevention is that widespread diseases, disorders, and social dysfunctions cannot be reduced by efforts focused on those who have been already affected by the problem; rather, the problem must be addressed at its source. George Albee, a psychologist central to the development of the field of primary prevention, stated that "no mass disease (disorder) in human history has ever been eliminated or significantly controlled by attempts at treating the affected individual" (1996, p. 4). In order for true change to occur, efforts must focus on the root causes of the problem.

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Primary Prevention of Sexual Violence. Although primary prevention has been used to address many social concerns such as drug and alcohol use over the past few decades, until recently there has been minimal work on the primary prevention of sexual violence. However, that is changing. The Rape Prevention and Education (RPE) Grant Program of the Centers for Disease Control and Prevention (CDC) provides more than $42 million in funding to support rape prevention activities in all 50 states, 8 territories, and the District of Columbia (CDC, 2004). Until the 2006-2007 fiscal year, much of this money was used to provide "risk reduction" programming to potential victims. However, during the 2006-2007 fiscal year, the CDC mandated that all programs receiving Rape Prevention and Education Program funds begin to integrate primary prevention into their activities. This mandate requires that, rather than using risk reduction strategies, prevention efforts must focus on changing the attitudes, beliefs, and behaviors that contribute to a society that allows sexual violence to occur.

Despite this CDC mandate, there is still a great deal of confusion about how to apply primary prevention strategies to sexual violence. As previously discussed, it is challenging to develop a program that effectively changes the social norms that contribute to sexual violence when they are reinforced on a daily basis through years of socialization, media influences and familial learning. In addition, prevention efforts that are effective in one community are not necessarily effective in another community, given their different cultures and social norms. In order for any prevention effort to be successful, it must fit the social norms and belief systems of the community in which it is implemented. Out of this need to match prevention programs to specific communities arose the Community Readiness Model (CRM).

THE COMMUNITY READINESS MODEL

The Community Readiness Model (CRM) is a method of community assessment developed by the Tri-Ethnic Center at Colorado State University. The CRM works to ensure that prevention programs match the unique characteristics, social norms, and belief systems of a particular community. The CRM provides a system of evaluation that assesses a community's level of readiness to adopt a particular type of prevention initiative. An assessment of community readiness is critical to the success of any primary prevention strategy because for the prevention efforts to be successful, they must match the culture and social norms of the

community, as well as take into account its assets and limitations. A clear picture of the community's strengths and limitations will provide the opportunity for the prevention efforts to be built on the policies, programs, and interventions that are congruent with the goals of the prevention efforts (Jumper-Thurman, Edwards, Plested, & Oetting, 2001).

Dimensions of the CRM

The heart of the Community Readiness Model (CRM) is the six dimensions that describe a community's readiness to address a specific problem. The six dimensions are community efforts, community knowledge of efforts, leadership, community climate, knowledge about issue, and resources.

The first of these dimensions "community efforts," pertains to the current efforts in the community to address the problem. The second dimension, "community knowledge of efforts," relates to community members' level of awareness of what efforts are in place to address the problem. The third focuses on the "leadership" in the community. This dimension identifies the particular leaders in the community relevant to the problem, and also assesses the degree to which political and other community leaders are concerned about and involved in working on the problem. The fourth dimension is "community climate," or the community's attitude toward the problem and the obstacles that may exist in addressing the problem within the community. The fifth, "knowledge of the issue," focuses on how knowledgeable community members are about the problem, what local data are available regarding the extent of the problem, and how people in the community gain information about the problem. The last dimension, "resources," describes what assets the community offers to support efforts to address the problem. Resources include services available to people affected by the problem, financial avenues to support community efforts, volunteer involvement in supporting these efforts, and the business community's attitude about supporting these efforts.

Stages of Readiness

The six dimensions of the CRM are assessed through interviews with individuals from the community who have knowledge about the issue. The resulting data are then assessed and placed along a continuum of readiness. The CRM defines nine stages of readiness, ranging from "no

awareness" of the problem to "professionalization/high level of ownership" of the problem.

The first stage of community readiness is "No Awareness." At this stage, the community generally does not recognize that there is a problem. The second stage of readiness is "Denial" in which there is little to no recognition of the problem within the community. "Vague Awareness" is the third stage of readiness. This stage is marked by a sense that there may be a problem in the community and that something should be done about it, but there is little motivation actually to do anything. The fourth stage of readiness is "Preplanning." Within this stage, the community recognizes that there is a problem locally, and the community members share a belief that something should be done about it. "Preparation" is the fifth stage of readiness. At this stage, the community is planning how to address the problem. In addition, information is available regarding how the problem affects the community locally, as well as various possible prevention activities, actions, or policies to address the issue. The sixth stage of readiness is "Initiation." At this stage there is enough local information about the problem to justify significant prevention efforts. These prevention activities are underway, but they are still viewed as new efforts. "Stabilization" is the seventh stage of readiness, and here a few programs or activities are being run and, overall, the programs experience support from community leaders. The individuals who address the problem are well trained, and the efforts are well established. At the eighth stage of readiness, that of "Confirmation/Expansion," there are standardized efforts in place and the community leaders support expanding and improving the efforts. The original efforts have been evaluated and revised, and new efforts are being explored and planned. During the ninth and final stage of readiness, "Professionalization" or "High level of community ownership," there is detailed knowledge regarding the prevalence, risk factors, and causes of the problem. Efforts to address the problem are strategic, and some programs aim to address specific risk factors and/or high-risk groups. The staff who work on the problem are highly trained, and the community leaders and members are involved in, and supportive of, the efforts. Thorough and effective evaluation occurs at this stage, and the results of the evaluations are used to modify and expand the programs.

Key Respondents

In the CRM, the researcher interviews "key respondents" to gain information about a community's readiness to address a problem. Key

respondents are used to gather information in two main areas. The first is to characterize the state of knowledge and attitudes of a particular community, and the second is to assess the community's existing structural capacity to implement a particular type of prevention strategy. The CRM recommends selecting representatives from various professional systems within the community to serve as key respondents. These respondents include representatives from the school system, law enforcement, the legal system, mental health/social service systems, the medical system and the community at large.

Reliability and Validity of the CRM

The reliability and validity of the CRM have not yet been well established. The developers of the CRM explain that it is hard to establish the reliability and validity of a measure that assesses constructs that vary with each application. For example, the CRM assesses the extent of knowledge and degree of support within a particular community to address an issue at a given point in time. The developers state that it is challenging to apply standard techniques for establishing the validity and reliability of a model when the "community" and the "issue" being examined change from application to application. The developers also argue that each application of the CRM is unique, and as a result, it is not likely that the constructs that the CRM is measuring have been assessed by other measures, making it difficult to establish the model's validity (Plested, Edwards & Jumper-Thurman, 2006). Despite these challenges, some attempts have been made to establish the reliability and validity of the tool, both during its development and after its completion.

Inter-rater reliability. Some efforts have been taken to establish the inter-rater reliability of the CRM. The transcripts of the CRM interviews are scored independently by two scorers to obtain the level of community readiness within each dimension. One attempt to establish the inter-rater reliability of the tool involved comparing the degree to which the two scorers chose the same stage of readiness for each dimension across 120 interviews pertaining to communities' stages of readiness to accept prevention initiatives. The results of this assessment indicated that the scorers selected the same stage of readiness 92% of the time across the120 interviews (Plested, Edwards, & Jumper-Thurman, 2006). This high level of agreement speaks to the inter-rater reliability of the tool.

Acceptance of the CRM. In place of providing information on statistically supported levels of reliability and validity of the model, the developers of the model often point to the general acceptance of the model by professionals across the country. Plested, Edwards and Jumper-Thurman (2006) stated, "Although it is not a scientific demonstration of validity, the widespread acceptance and the breadth of application of the model lends credence to its validity" (p. 65). The developers likewise argue that despite the model's recency, it has been readily accepted and used as an essential element in prevention program implementation. The model has been used in a variety of projects, including AIDS prevention, domestic violence prevention, elimination of heart disease, and the reduction of sexually transmitted infections (Plested, et al.).

PRIMARY PREVENTION OF SEXUAL VIOLENCE AND THE CRM

The principles of primary prevention fit well with the Community Readiness Model. Primary prevention asserts that sexual violence does not occur as a result of individual characteristics alone. Rather, social norms, family culture, and community climate interact with individual characteristics and influence an individual's likelihood to commit acts of sexual violence. For any significant reduction in sexual violence to occur, the entire social system must be examined. The CRM provides a mechanism to examine the larger social system and tailor the primary prevention efforts to match their level of readiness.

PROPOSED PROJECT

For the purposes of this study, the researcher will complete CRM assessments to determine the level of readiness for the implementation of primary prevention strategies in two communities within Racine County, Wisconsin. The first assessment will be completed in the rural community in Racine County, and the second assessment will be completed in the urban community in Racine County. The assessments will focus on the level of sexual victimization and perpetration within the adolescent population, and the results of the study will provide information necessary to develop primary prevention strategies that match the social norms and climate of these two geographic communities in Racine County. Following completion of the study, the information gained will be provided to the area rape crisis center to inform their prevention efforts.

Instrument

The Community Readiness Assessment involves semi-structured interviews based on open-ended questions relative to each of six dimensions of readiness. Examples of questions used to assess the dimensions include, "Please describe the efforts in your community to address sexual violence within the adolescent population" and "How are the leaders in your community involved in efforts regarding the reduction of sexual violence within the adolescent population?" *Assessment #1—Rural Racine County:*

The City of Burlington

The first assessment will evaluate the readiness for prevention efforts in the western, rural portion of Racine County, situated in southeastern Wisconsin. Rural Racine County is composed of several small towns, with Burlington as the largest city. This project will involve completing approximately five interviews with key respondents who live or work in the rural portion of the county. Key respondents will include individuals from the medical and mental health professions, law enforcement, social service organizations, the school system, and members from the community at large (adolescent students from the area high school). *Assessment #2—Urban*

Racine County: The City of Racine

The second assessment will evaluate the readiness for prevention efforts in the eastern, urban portion of the county. The city of Racine is composed of approximately 80,503 people, and is the main city in Racine County, which has a total population of 195,146. Racine is the 5th largest city in Wisconsin, and has one of the state's highest rates of reported sexual offenses. Key respondents will be recruited from the following areas: the school system, community members at large (students from an area high school), the District Attorney's Office, the Human Services Department, law enforcement personnel, medical professionals, mental health practitioners, and social service agencies.

Participants

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The participants for this study (called key respondents) will include between ten and twelve community professionals and/or community members. These key respondents are not necessarily "experts" on the topic; rather, they simply hold a position that would allow them to be informed on the issues. School personnel from one rural high school and one urban high school will be queried to aide in the selection of two adolescent participants (one adolescent from rural Racine County and one from urban Racine County). These two adolescents will represent members of the "community at large." Informed consent and parent permission will be acquired prior to the participation of adolescents in the study.

Interviews

Two graduate students (not the researcher) trained in the CRM interview process will complete all key respondent interviews via the telephone. The semi-structured interview is comprised of the twenty-eight questions that make up the "Community Readiness Assessment Interview Questions." These questions have been adapted to discuss non-familial sexual violence within the adolescent population. The CRM interviews will be completed via the phone and audio-recorded (with key respondent permission) to ensure an accurate and complete depiction of the interview.

Transcription

The interviews will be audiotaped and transcribed verbatim (except for minimal encouragers) by either the researcher of this study or a volunteer graduate student. All identifying information for participants will be removed, and each participant will be assigned a code number to maintain confidentiality.

Procedures for Analyzing Data

After the interviews are completed and transcribed, the scoring process will begin. The researcher and one other person trained in using the CRM, will independently review and score the interviews according to the six dimensions of the CRM.

The first step of the assessment process involves each scorer individually reading the transcript of each interview in its entirety. The second step involves the use of anchored rating scales to assist the scorers

in determining the stage of readiness for each dimension. The scorers independently read the anchored rating scale for the dimension being scored, and assign a stage of readiness for that particular dimension based on the interview data. The third step of the assessment process involves each scorer entering her or his independent scores for each of the dimensions in the "individual scores" table on the "Community Readiness Assessment Scoring Sheet." The fourth step involves the two scorers discussing their individual scores. At this stage, the goal is for the two scorers to reach consensus about the stage of readiness for each dimension of each interview. If there is disagreement between the scorers, they will review the documentation that led to their decision and discuss the data that support the stage they have chosen. After consensus has been reached, the combined score is entered in the "combined scores" table on the Community Readiness Assessment Sheet. The fifth step involves adding each dimension score for each interview to yield a total score for each dimension. That score is then divided by the number of interviews to yield the "calculated score." In the sixth step, the sum of all of the calculated scores is determined, and that sum is divided by the number of dimensions. This score is the overall stage of readiness for the community, and corresponds to the numbered stages of readiness. The last step in the assessment process is to document the scorers' qualitative impressions of the interviews and qualifying statements that may relate to the level or readiness for the community. These impressions are used to provide qualitative support for the community's stage of readiness.

Implementation

The results of this assessment will allow the researcher to better understand the current level of awareness, knowledge, beliefs and social norms regarding non-familial sexual violence within the adolescent population in these particular communities. This understanding will inform the researcher about the community's stage of readiness to receive primary prevention interventions. The CRM suggests strategies for the effective implementation of primary prevention strategies according to the community's stage of readiness. These suggested strategies will be compared with the sexual violence prevention literature so as to recommend appropriate primary prevention of sexual violence programs and awareness techniques that are most likely to be successful in the two communities in Racine County. The researcher will then provide the rape crisis center recommendations about appropriate sexual violence primary prevention programming for the adolescent population. The rape crisis

center has agreed to implement the recommended strategies in both rural and urban Racine County. The format, structure and nature of these prevention strategies will be dependent on what is recommended by the results of the CRM assessment. Examples of interventions for communities at lower levels of readiness may include one-on-one visits to key community members, making presentations on the issue to various groups and submitting articles to the newspaper and local newsletters in an effort to raise awareness of the issue. Communities at higher stages of readiness may benefit from trainings for community professionals on the issue, implementing evaluation of existing programs, and holding recognition events for community supporters of the prevention efforts.

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Theresa A. DeWalt
Theresa DeWalt received her BA degree in Psychology and Political Science from Beloit College. She is currently a fifth year student in the Counseling Psychology PhD program at Marquette University. In addition, she is the director of the rape crisis center in Racine County, Wisconsin. Her research interests include the development and implementation of sexual violence primary prevention programming that match the cultural, political and social norms of the community in which they are to be implemented.