2017 North Dakota Community Readiness Assessment: Primary Prevention of Violence against Women

Prepared for the North Dakota Department of Health Rape Prevention and Education Program and CAWS North Dakota.

NORTH DAKOTA DEPARTMENT of HEALTH

The Improve Group

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Introduction

In 2017, the North Dakota Department of Health, in partnership with CAWS North Dakota, contracted The Improve Group to assess community readiness for primary prevention of violence against women. The Community Readiness Model was used to assess readiness on both local and statewide levels. This model measures readiness in six dimensions: 1) community efforts; 2) community knowledge of the efforts; 3) leadership; 4) community climate; 5) community knowledge about the issue; and 6) resources. An assessment for the State of North Dakota was also conducted in 2010-11.

Readiness is the degree to which a community is prepared to take action on an issue, and is issue-specific, measurable, and can vary across dimensions and segments of a community. For a strategy to be implemented successfully, it is critical that a community is ready for it.

Community Readiness Model

The Community Readiness Model[1] is a method for assessing the level of readiness of a community to develop and implement prevention programming. Developed at the Tri-Ethnic Center for Prevention Research at Colorado State University, the basic premise of the Community Readiness Model is that matching an intervention to a community's level of readiness is absolutely essential for success. Efforts that are too ambitious are likely to fail because community members will not be ready or able to respond. To maximize chances for success, the Community Readiness Model offers tools to measure readiness and to develop stage-appropriate strategies. The Community Readiness Model has been used to assess readiness for a variety of issues, including drug and alcohol use, domestic and sexual violence, head injury, HIV/AIDS, suicide, animal control issues, and environmental issues. Communities have found it helpful because:

- It is an inexpensive and easy-to-use tool.
- It encourages the use of local experts and resources.
- It provides both a vocabulary for communicating about readiness and a metric for gauging progress.
- It helps create community-specific and culturally specific interventions.
- It can identify types of prevention/intervention efforts that are appropriate.

The Community Readiness Model can be used as both a research tool to assess levels of readiness across a group of communities and as a tool to guide prevention efforts at the

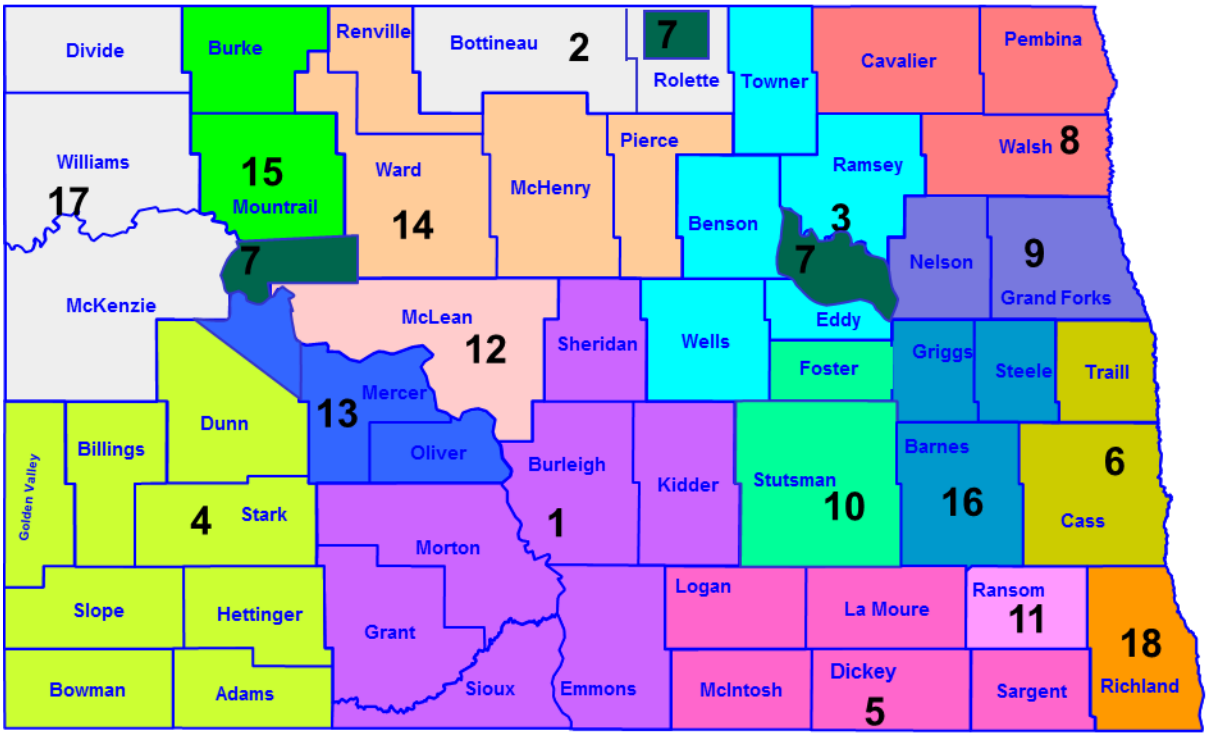
[1] Plested, B.A., Edwards, R.W., & Jumper-Thurman, P. (2006, April). Community Readiness: A handbook for successful change. Fort Collins, CO: Tri-Ethnic Center for Prevention Research.

individual community level. For this assessment, readiness was measured at community- and statewide levels. The model is a seven-step process that begins with defining the community and the problem, moves into assessment and scoring, and then suggests strategies that can be used to bring communities closer to readiness. The assessment can also be used to help communities detect change over time. The seven steps of a Community Readiness Assessment are outlined next.

Step 1: Identify issue. For this assessment, the issue is "primary prevention of violence against women" and is described as efforts that promote healthy relationships.

Step 2: Define "community" with respect to the issue. For this assessment, the geographical community is the State of North Dakota. Data was supplied by 16 of the 20 communities that have sexual assault/domestic violence programs that are members of CAWS North Dakota, the statewide coalition addressing sexual and domestic violence. First Nations Women's Alliance provided data on behalf of the tribal programs.

Figure 1: North Dakota communities

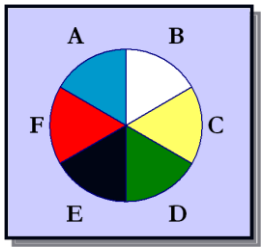


*Fargo (6) and Grand Forks (9) received RPE funding 2011-2017. ** Williston (17) and Bottineau (2) did not participate in 2017.

1) Bismarck
2) Bottineau**
3) Devils Lake
4) Dickinson
5) Ellendale
6) Fargo*
7) Tribal areas
8) Grafton
9) Grand Forks*
10) Jamestown
11) Lisbon
12) Washburn
13) Beulah
14) Minot
15) Stanley
16) Valley City
17) Williston**
18) Wahpeton

Step 3: Interviews. To determine a community's level of readiness to address the issue, interviews were conducted with key informants. Interviewers included members of the State Capacity Building Team (SCBT), comprised of Rape Prevention and Education (RPE) grantees, the RPE Director, the Improve Group's Empowerment Evaluation team, and CAWS North Dakota staff. CAWS North Dakota member programs were asked to assemble at least six other individuals from various sectors including education, law enforcement, health care, and other community-based organizations in their community who are "in the know" about prevention programming. Group interviews were conducted by phone. A template with interview questions (Appendix A) was provided to interviewers. Interviewers asked key informants about six areas related to their prevention work:

A. What are the existing prevention efforts?
B. What is the community's knowledge of existing efforts?
C. How is leadership involved with prevention?
D. What is the community's climate regarding prevention?
E. What is the community's knowledge of the issue?
F. What are resources like for prevention?



The level of readiness, from 1 to 9, was then assigned to each of the above dimensions as a readiness "score." Descriptions of scores are as follows:

1. **No Awareness:** The community or the leaders do not generally recognize the issue as a problem.
2. **Denial**: There is little or no recognition that this might be a local problem, but there is usually some recognition by at least some members of the community that the behavior itself is or can be a problem.
3. **Vague Awareness**: There is a general feeling among some in the community that there is a local problem and that something ought to be done about it, but there is no immediate motivation to do anything.
4. **Preplanning**: There is clear recognition on the part of at least some that there is a local problem and that something should be done about it.
5. **Preparation:** Planning is going on and focuses on practical details.
6. **Initiation**: Enough information is available to justify efforts (activities, actions, or policies).
7. **Stabilization**: One or two programs are running, supported by administrators or community decision-makers. Programs, activities, or policies are viewed as stable.
8. **Confirmation/Expansion**: There are standard efforts (activities or policies) in place and authorities or community decision-makers support expanding or improving efforts. Community members appear comfortable in utilizing efforts.

9. **Professionalization**: Detailed and sophisticated knowledge of prevalence, risk factors, and causes of the issue exists. Some efforts may be aimed at general populations, while others are targeted at specific risk factors and/or high-risk groups. Highly trained staff are running programs or activities, leaders are supportive, and community involvement is high.

It should be noted that the most 2nd edition (2014) of the Community Readiness Assessment Tool uses five dimensions. However, the interviewing team chose to use six dimensions to provide a better comparison between 2011 and 2017 scores.

Step 4: Scoring. Six scorers, including representatives from The Improve Group, the Department of Health, CAWS ND, and RPE subgrantees, scored the interviews independently. They were instructed to read through each interview entirely and then highlight statements that fall under each dimension. A rating scale with statements for each stage was used to determine readiness. In order to receive a score at a certain stage, the entire statement needed to be true. After scoring individually, the group met to discuss scores. Individual scores were shared for each dimension. If scores differed, discussion took place until the group came to consensus.

Step 5: Analyze. Once the assessment was complete, scores for the stages of readiness for each of the six dimensions were generated, as well as an overall score. For this assessment, the SCBT tallied the community readiness scores. To generate the statewide score, the local scores were summed and averaged.

Figure 2: North Dakota statewide readiness scores

Statewide Community Readiness Scores	**2011**	**2017**
A. Community Efforts	5	5
B. Knowledge of Efforts	3	3
C. Leadership	3	3
D. Community Climate	3	2
E. Knowledge of the Issue	3	2
F. Resources	4	3
Overall Readiness Score	**3**	**3**

North Dakota's overall readiness score for primary prevention of violence against women is "3," which the Community Readiness Model defines as "vague awareness." This is when most people feel there is a local concern, but there is no immediate motivation to do anything about it.

Two dimensions had scores of "2," which is defined by the model as the "denial/resistance" stage. It is recommended that the State focus on building readiness in these dimensions first. At this stage, some community members recognize the issue as a concern, but there is little recognition that it may be occurring locally. The dimensions in which the State received a "2" are community climate and knowledge of the issue. For community climate, this means community members think, "There's nothing we can do," "Only 'those' people do that," or "We don't think it should change," according to the Community Readiness Model. For knowledge of the issue, this means a community has no knowledge about the issue.

The State scored highest, a "5," in the community efforts dimension. The Community Readiness Model defines this level as when efforts, like programs or activities, are being planned.

The statewide community readiness scores did not increase in any dimensions from 2011 to 2017. This is thought to be due to two factors. First, more agencies were funded for primary prevention in 2011 than in 2017, which means more prevention activities were occurring at the time of the earlier assessment. North Dakota has since lost some of its prevention funding and decided to focus the resources it had on areas that were readier—the eastern side of the state, including Fargo and Grand Forks. Less work occurring on a statewide level may also explain why the State score decreased in community climate and knowledge of the issue. Second, the oil boom in the western part of the state intensified since the 2011 assessment. The changes associated with this, including more crime and many new residents, could have contributed to the lower community climate score. However, it should be noted that the scores for the Rape Prevention and Education-funded agencies in Grand Forks and Fargo increased.

Step 6: Strategies. Once the levels of readiness are established, is it up to groups working on prevention to develop strategies to pursue that are stage-appropriate. Strategy development relies on these community readiness scores, with dimensions having the lowest levels of readiness typically being addressed first. This means North Dakota should first work to raise readiness in dimensions of community climate and knowledge of the issue. Appropriate strategies for this stage have the goal of raising awareness that the issue exists in the community. Appendix B includes the full list of strategies for this level. The strategies should be tailored to the dimensions scoring the lowest, and can include:

- Continue one-on-one visits and encourage those you've talked with to assist with efforts.

- Discuss descriptive local incidents related to the issue.
- Approach and engage local educational/health outreach programs to assist in the effort with flyers, posters, or brochures.
- Begin to point out media articles that describe local critical incidents.
- Prepare and submit articles for church bulletins, local newsletters, club newsletters, etc.
- Present information to local related community groups.

Step 7: Evaluate. After a period of time, evaluating the effectiveness of efforts is suggested. Conducting another Community Readiness Assessment to see how the State's readiness is progressing could be helpful in tracking change over time.

Discussion

The Improve Group conducted training on interviewing and scoring based on the Community Readiness Model for the interview team. The goal was to hear from "in-the-know" informants in each community across different sectors. There was some confusion about who "in-the-know" informants would be in some communities and in some cases, members of the local CAWS North Dakota agency did not participate or offer insight about prevention efforts or resources in the group interview. Members of the interview team also served as "in-the-know" persons during the scoring sessions and added supplementary information, mostly in the prevention and resources dimensions. This helped add context into the scoring discussion wherever possible.

Interviewers reported challenges scheduling interviews with busy informants. It was difficult to find a two-hour time period that worked for an entire team of community members to do a group interview. Local interviewers also noted difficulties in finding time away from their usual work in the community. The importance of and struggle around finding the right people to interview was also noted. For example, some selected individuals did not know much about primary prevention. Interviewers also noted the scoring process was one of the more time-consuming aspects of the assessment, with one recommendation to break up scoring into two days. Increased coordination—for scheduling, raising awareness of the assessment, and identifying the right informants—could benefit future Community Readiness Assessments.

Participating community members agreed that some of the informants did not know what primary prevention was and had confusion about the terminology used in the interview, especially if they did not have a public health background. Many of the domestic violence/rape crisis programs did not realize that they were to participate in the interviews so their perspective was often missed. Some key informants did not understand the purpose of the assessment or why they were answering these questions. Perhaps a webinar explaining the purpose and process could be utilized as part of the recruitment process.

The fact that the State did not increase its readiness scores in any dimensions is notable. This may be attributable to two factors. One is funding—eight agencies across the state were receiving primary prevention funding from three federal sources and some State General Funds at the time of the 2011 assessment. Now, as funding has decreased to one federal source and some State General Funds, the State has concentrated resources on regions most ready for primary prevention, the eastern communities of Fargo and Grand Forks. This decrease and concentration of funding could have contributed to the State's resources dimension score lowering from 4 (2011) to 3 (2017).

One new prevention funding source that emerged during 2011-2017 timeframe is the Catholic Health Initiatives (CHI). CHI is a faith-based effort operating in 18 states, including North Dakota, and supports eight hospitals in preventing intimate partner violence and promoting healthy relationships.

While the Bakken oil boom had begun at the time of the 2011 assessment, it reached its peak in the time since. This community change and upheaval, which led to increased population and crime, could have contributed to the lower community climate score from 3 (2011) to 2 (2017). Additionally, the oil boom most dramatically affected the western side of the state. Combined with the redirection of primary prevention funding to the eastern side of the state, this creates two ways in which western North Dakota has been impacted since the 2011 assessment.

Conclusion

The State of North Dakota is looking ahead at primary prevention strategies that fit its levels of readiness. Based on its level of readiness, the State plans to implement Green Dot, an evidence-based program for high school, campus, and community programing, in some communities. The program involves certification for a coordinator and community implementers, a community launch event, bystander training with key influencers, and social norms messaging. Green Dot is most appropriate for high readiness communities. Local readiness scores will be used to determine which communities are ready for this program. RPE funds will support the implementation of Green Dot Community. The State will continue to support primary prevention efforts such as Safe Dates, Coaching Boys into Men, antibullying programs, and other evidence based-strategies. The State will promote the use of evidence-based strategies via the ND Intimate Partner and Sexual Violence Toolkit and Listserv.

In addition, the State is working through an action plan to increase readiness in communities with lower levels of readiness. The State will take guidance from the Community Readiness Handbook's recommended strategies and approaches with efforts to increase readiness levels across the State.

Appendix A: Interview Guide

Issue	Promoting healthy relationships
Community	Agency's service area
Key Informants	
Date of interview	

Preamble

"Hello! Thank you so much for taking the time to meet with me today. I'm [interviewer's name], a [title] with [organization], [description of organization]. This interview will take up to an hour. Does that still work for your schedule?"

"I'm conducting a Community Readiness Assessment to learn what communities are ready for in addressing **healthy relationships**. The findings from this study will help us make decisions about future efforts as well as help inform the extent to which the readiness among communities in our state have changed over the years."

"Your participation is voluntary; you can decline to answer any questions or stop taking part at any time without giving any reason."

Ask:

- **Are you okay with me recording the audio on our call today? I will only use it to ensure accurate notetaking.**
- **Do you have any questions for me before we begin?**

Warm-up

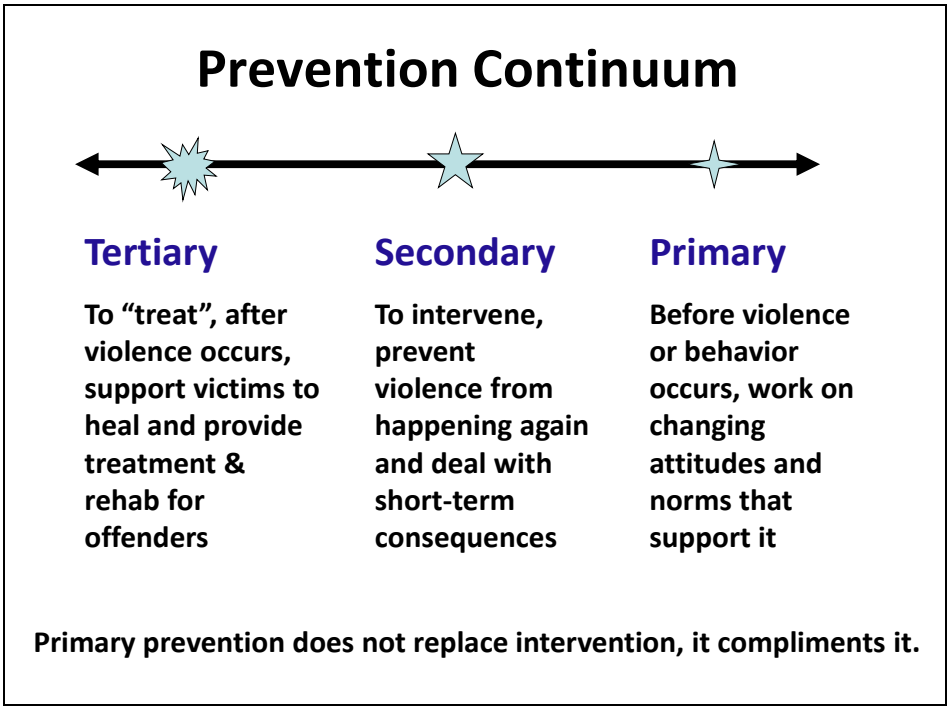
I'd like to start with introductions. Please share your name, the organization you work for and your role there, with me and the others on the call today.

1. When you think about your work, who are you defining as the people in your community? It can be geographical, organizational, cultural, any group that comes together around a common identity.	

"Great, thanks. We will use those descriptions going forward in referencing 'community.'"

Community knowledge about the issue of primary prevention

Review the prevention continuum:



2. When I say the term "primary prevention of violence against women" what are some words and phrases that come to mind?	

3. Who do you think is most at-risk for becoming a perpetrator?	

4. What about victimization—who is most at-risk?	

5. What type of information do you have that lets you know who is at-risk? In other words--what local data is available regarding risk groups?	

6. On a scale from 1-10, how accessible/available is this data information to others in the community (with 1 being "not at all" and 10 being "very available")?	

7. How knowledgeable is the average community member about primary prevention or promoting healthy relationships?	

8. How knowledgeable are community leaders about primary prevention or promoting healthy relationships?	

9. Using a scale from 1-10, how aware are community members of what it would take to prevent perpetration and promote healthy relationships (with 1 being "not at all" and 10 being "a very aware")?	

Community knowledge about prevention efforts

10. What do you think are great ways to prevent perpetration and promote healthy relationships?	

11. What are prevention of perpetration and promotion of healthy relationships efforts or programs in your community? (probe: healthy relationships programs, school programs, bullying programs, parent-child communication programs)	

12. How long have these efforts been going on?	

13. In what ways do the programs mentioned promote healthy relationships and address the root causes of violence?	

14. What are the strengths of these efforts?	

15. What are the weaknesses of these efforts?	

16. How knowledgeable is the average community member about the efforts mentioned?	

17. How knowledgeable are community leaders?	

18. Using a scale from 1-10, how aware are community members of what it would take to prevent perpetration and promote healthy relationships (with 1 being “not at all” and 10 being “a very aware”)?	

Community climate

19. Describe the tension between intervention and prevention in your community.	

20. How does the community support preventing perpetration and promoting healthy relationships?	

21. What are the primary obstacles to efforts or programs addressing the prevention of perpetration and promoting healthy relationships in your community?	

22. On a scale from 1-10, how receptive would your community be to doing more or expanding work around preventing perpetration and promoting healthy relationships (with 1 being “not at all” and 10 being “a very receptive”)?	

Leadership

23. Who are the "leaders" specific to prevention in your community?	

24. How are these leaders involved in efforts to promote healthy relationships and prevent perception? (probe: Are they involved in a committee, task force, etc.? How often do they meet?)	

25. In what ways would the leadership support additional efforts?	

26. Using a scale from 1 to 10, how important is prevention perpetration and promoting healthy relationships to the leaders in your community? In other words--how much of a priority is this issue to the leadership in your community (with 1 being “not at all” and 10 being “of great concern”)?	

Resources

27. How are prevention programs funded in your community?	

28. Are you aware of any proposals or action plans that have been submitted for funding that address prevention perpetration and promoting healthy relationships? If yes, please explain.	

29. What kind of efforts are there for fund raising and in-kind donations?	

30. Where would someone go if they wanted to get involved or volunteer with the primary prevention efforts mentioned earlier?	

31. What evaluation efforts are in place for the programs mentioned earlier?	

32. On a scale from one to ten, how would you rate the number of resources available for primary prevention in your community (with 1 being “not at all” and 10 being “a great deal”)?	

“Those are all my questions. Thank you so much for your time and input today.”

For more information, please contact:

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Appendix B: Strategies for "2" Level of Readiness

Goals And General Strategies Appropriate For Each Stage

1. No Awareness

   Goal: Raise awareness of the issue

   - Make one-on-one visits with community leaders/members.
   - Visit existing and established small groups to inform them of the issue.
   - Make one-on-one phone calls to friends and potential supporters.

2. Denial / Resistance

   Goal: Raise awareness that the problem or issue exists in this community

   - Continue one-on-one visits and encourage those you've talked with to assist.
   - Discuss descriptive local incidents related to the issue.
   - Approach and engage local educational/health outreach programs to assist in the effort with flyers, posters, or brochures.
   - Begin to point out media articles that describe local critical incidents.
   - Prepare and submit articles for church bulletins, local newsletters, club newsletters, etc.
   - Present information to local related community groups.

   (Note that media efforts at the lower stages must be lower intensity as well. For example, place media items in places where they are very likely to be seen, e.g., church bulletins, smaller newsletter, flyers in laundromats or post offices, etc.)

3. Vague Awareness

   Goal: Raise awareness that the community can do something

   - Get on the agendas and present information at local community events and to unrelated community groups.
   - Post flyers, posters, and billboards.
   - Begin to initiate your own events (pot lucks, potlatches, etc.) and use those opportunities to present information on the issue.
   - Conduct informal local surveys and interviews with community people by phone or door-to-door.
   - Publish newspaper editorials and articles with general information and local implications.

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