

North Dakota Community Readiness and Prevention System Capacity Assessment

Prepared for

**North Dakota Council on Abused Women's Services
(NDCAWS), North Dakota Department of Health Division of
Injury Prevention and Control and the State Prevention
Team**

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Introduction

In 2010 the North Dakota Council on Abused Women's Services (NDCAWS) in partnership with the North Dakota Department of Health Division of Injury Prevention and Control commissioned World Bridge Research to conduct an assessment of NDCAWS member programs and their partners to explore readiness for primary prevention work and prevention system capacity.

The assessment was conducted with 17 of 21 member programs and 2-3 community partners per agency using a combination of face-to-face and telephone group interviews. To explore prevention readiness the Tri-Ethnic Center Community Readiness Assessment tool¹ was adapted for use in this project. To examine Prevention System Capacity--the capacity of the network of individuals, groups and/or organizations that, through their interaction, have the potential to enhance the primary prevention of sexual and intimate partner violence—eight questions based upon eight dimensions of Community Capacity were also developed.

The assessment reveals that communities have inspired some primary prevention efforts and have some resources dedicated to such efforts. At the same time there appears to be a range when it comes to the comprehensive nature of these efforts as well as the resources allocated. Though primary prevention efforts are being implemented, the readiness areas reported as most challenging by key informants are:

- r Community knowledge of the issue (sexual and intimate partner violence)
- r Community knowledge of existing prevention efforts
- r Community leaders involvement in prevention
- r Positive prevention climate

The level of readiness scores on these dimensions hover around “3” representing “vague awareness”. The overall goal to moving to the next level of readiness would be to **“raise awareness that the community can actually do something about preventing the problem”**.

In terms of Prevention System Capacity the highest area of interest and capacity is “results orientation” where most communities saw evaluation their prevention efforts as key. The lowest reported capacity area across sites is “constituency focus”. Many communities feel they do well representing women and victims, but feel that they could do more to involve youth and perpetrators in prevention efforts.

These assessment scores show us the areas of greatest weakness. These areas need to be addressed before the overall readiness and capacity can be increased. Building community coalitions and engaging already busy people seems to be a barrier to generating interest and motivation to create community change. Disseminating to local communities best practices in coalition building or innovative ways to engage busy people would be helpful in building prevention capacity and increasing readiness.

¹ Source: Edwards RW, Jumper-Thurman P, Plested BA, Oettig ER, Swanson L. (2000). Community readiness: Research to practice. *Journal of Community Psychology*, 28(3), 291-307. Further information on the Community Readiness Model is available from the Tri-ethnic Center for Prevention Research at 1-800-835-8091 or <http://triethniccenter.colostate.edu>

Community Readiness Model

The Community Readiness Model is a method for assessing the level of readiness of a community to develop and implement prevention programming. Developed at the Tri-Ethnic Center at Colorado State University to assess how ready a community is to address an issue, the basic premise 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 or as a tool to guide prevention efforts at the individual community level.

The Community Readiness Model is a 6-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 reassess communities to help detect change over time.

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 (see Interview Guide in Appendix A).

Step 2: Define “community” with respect to the issue. For this assessment the geographical community is the State of North Dakota with data being supplied by 17 of 21 communities that have sexual assault/domestic violence programs that are members of North Dakota Council on Abused Women’s Services (NDCAWS). Below is a chart of the communities and the resources toward primary prevention that each currently or have formerly received:

Communities with NDCAWS Member Programs	Primary Prevention Funding Resources: Rape Prevention Education (RPE); Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA)
Bottineau	Current - RPE
Fargo	Current - RPE and DELTA

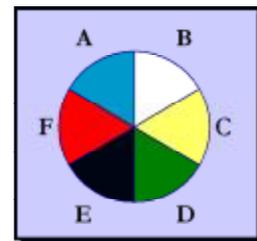
Communities with NDCAWS Member Programs	Primary Prevention Funding Resources: Rape Prevention Education (RPE); Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA)
Grand Forks	Current - RPE and DELTA
Jamestown	Current - RPE
Mercer County	Current - RPE
Minot	Current - RPE
Stanley	Current - RPE and DELTA
Valley City	Current - RPE
Bismarck	Current - RPE and DELTA
Dickinson	Former - DELTA
First Nation Women's Alliance (representing 4 tribal NDCAWS member programs)	Former - RPE
Grafton	Former - RPE
McLean County	Former - RPE
Ransom County	Former - RPE

NDCAWS programs that chose not to participate:

Communities with NDCAWS member Programs	Primary Prevention Resources
Devil's Lake	Former - RPE
Ellendale	Former - RPE
Williston	Former - RPE
Wahpeton	None since RPE prevention focus

Step 3: Interviews. To determine a community's level of readiness to address the issue, interviews were conducted with key informants. For this assessment NDCAWS member programs were asked to assemble at least 3 other individuals from other sectors in their community who are involved with prevention planning and/or implementation. Group interviews were conducted by phone. For currently funded programs, each have been working with Local Prevention Teams (LPTs) for several years and were encouraged to involve members of that body in the group interview. The questionnaire asked key informants about 6 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, is then assigned to each dimension as a readiness "score".

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 problem 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.

Step 4: Analyze. Once the assessment is complete scores for the stages of readiness for each of the six dimensions are generated as well as an overall score. For this assessment each of the 17 community readiness scores were tallied by the research team. To generate the statewide score the local scores were summed and averaged:

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

Findings show that each community has some primary prevention activities that are mostly school-based and educational in nature. To do these programs some resources are dedicated to such efforts, so the **community efforts** and **resources** dimensions of the Community Readiness Model are the highest. With that said, the comprehensive nature of these efforts varies as do the resources. Though primary prevention efforts are being conducted, the readiness areas reported as most challenging by key informants are:

- r Community knowledge of the issue (sexual and intimate partner violence)

- r Community knowledge of the existing prevention efforts
- r Community leaders involvement in prevention
- r Positive prevention climate

Step 5: 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 then relies on these community readiness scores, with dimensions with the lowest levels of readiness typically being addressed first. Given the scores from the statewide assessment it might be best to work on strategies in the “3” range “**vague awareness**”. According to the Community Readiness Model developers, “**vague awareness**” is the general feeling by at least some in the community that there is a concern and that something should be done about it, but there is:

- r No immediate motivation
- r No identifiable leadership
- r Community climate does not motivate action
- r Issue and causes are stereotyped

Some of the biggest obstacles to doing prevention noted by key informants are:

- r “**Funding** is the greatest obstacle. It ‘prevents’ us from doing more prevention.”
- r “A big obstacle is that people are **fearful** of talking about things to do with violence and assault, especially when it comes to youth.”
- r “There a lot of people coming here because of people coming for oil (jobs). The agencies are struggling with the **influx of people**.”
- r “**School administration** can be an obstacle. The superintendent did not think there was any bullying in the beginning.”
- r “**Scheduling** [is an obstacle]. It is hard to get events scheduled because it was hard to find a good day.”

In 2008 North Dakota Department of Human Services conducted a Community Readiness Survey regarding substance use and also found the state of North Dakota in a **vague awareness** stage where most community members recognized that alcohol, tobacco, and other drug use is a local problem, but there is no immediate motivation to do anything about it (<http://www.nd.gov/dhs/services/mentalhealth/prevention/pdf/state-data-booklet.pdf>). Suggested strategies to increase the level of readiness include (see Appendix B for more on Strategies):

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

Step 6: Evaluate. After a period of time, evaluating the effectiveness of efforts is suggested. Conducting another Community Readiness Assessment to see how your readiness is progressing could be helpful in tracking change over time.

Prevention System Capacity

Another way of assessing a community’s prevention readiness is to understand the Prevention System Capacity. Prevention System Capacity is the capacity of the network of individuals, groups and/or organizations that, through their interaction, have the potential to enhance the primary prevention of sexual and intimate partner violence. A survey of prevention system capacity questions exploring the 8 dimensions of system capacity was also included in the key informant interviews across NDCAWS member programs. The following represents the cross-site average of key informants’ self-report rating of Prevention System Capacity.

1. Leadership (buy-in for primary prevention)	Medium
2. Human resources (adequate staffing)	Low
3. Community and constituency focus (community is involved in prevention efforts)	Low
4. Results orientation (thinks evaluation is important)	High
5. Strategic planning (approaches prevention in planful manner)	Medium
6. System Profile (positive prevention culture and climate)	Medium
7. Information (access to and use of data)	Medium
8. Infrastructure for primary prevention to continue (system operations)	Medium

The highest area of interest and capacity is “results orientation”. Most communities rated a high interest in evaluation of their prevention efforts with sentiments such as, “High, very high, we want to know that [our efforts] work.”

In the low capacity area communities report “human resources”. This is characterized as a funding issue as well as and how programs are set up from a staffing perspective to perform both prevention work as well as crisis intervention. “Infrastructure for primary prevention to continue” was rated “medium” overall, but had the most variation in responses. This capacity is also said to be to more funding in order to achieve success in this area.

Another low capacity area reported across sites is “constituency focus”. Many communities feel they do well representing women and victims, but feel that they could do more to involve youth and perpetrators

Conclusion

What is exciting about this report is that the NDCAWS member programs have another vantage point from which to continue to build their communities' capacity for primary prevention work. It is somewhat disappointing that not all communities with NDCAWS programs wanted to participate in group or individual interviews. Some program indicated they are willing to take a survey and NDCAWS is committed to administering an organizational capacity survey to all programs in the near future.

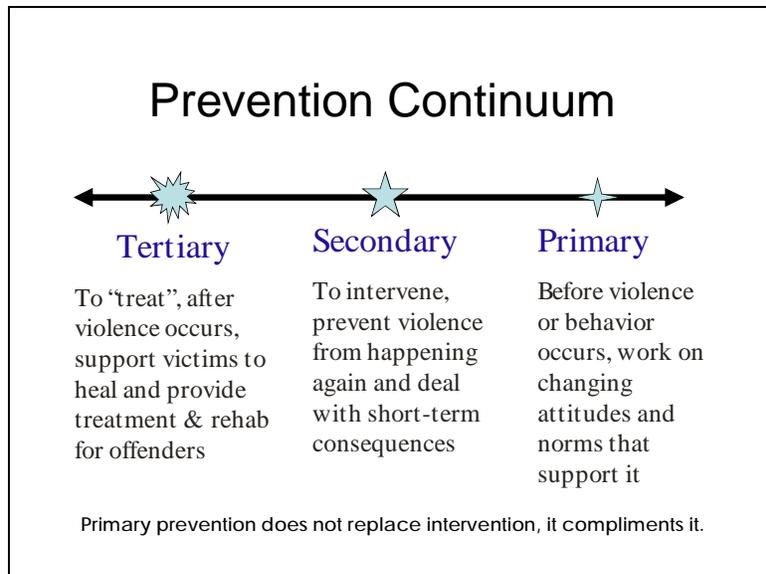
One thing that turned out to be surprising is that there was an expectation that the larger cities would have more prevention capacity than smaller communities. However, it appears that size or population is not related to prevention capacity. Prevention capacity and readiness seems to be related to a community's interest and motivation to address sexual and intimate partner violence.

Another important note this project unveiled is that communities are filled with busy professionals and paraprofessionals working on these issues. Building community coalitions and engaging already busy people seems to be a barrier to generating interest and motivation to create community change. Disseminating to local communities best practices in coalition building or innovative ways to engage busy people would be helpful in building prevention capacity and increasing readiness.

It is also recommended that any strategy development to increase prevention system capacity and community readiness should start with the areas that rank lowest. In other words these assessment scores show us the areas of greatest weakness and that is where strategies need to be focused. These areas need to be addressed before the overall readiness and capacity can be increased.

Appendix A – Interview Guide

Community Readiness Assessment Interview Questions



NOTE: Laminate the slide for each interview or email to them for phone interviews.

Warm-Up with Introductions—Name, where you work, etc...

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.

Community Knowledge About the Issue of Primary Prevention

Review the slide above...

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?
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?
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. On a scale from 1-10 how aware are most people the efforts or programs mentioned (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 their 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")?

Prevention System Capacity Questions

Let's talk more about the group of people who are doing prevention work in your community.

1. Earlier we talked about the leadership in your community. Let's talk about your prevention leaders. Who in your community is doing prevention work or are actively involved in thinking about what it takes to do prevention work?

2. How much are your prevention leaders "bought into" preventing perpetration and promoting healthy relationships?	Low, Medium or High
3. How adequate are your resources for preventing perpetration and promoting relationships?	Low, Medium or High
4. How much are members of the risk groups you care about involved with finding ways to prevention perpetration and promote healthy relationships?	Low, Medium or High
5. How important is evaluation to the folks doing prevention work?	Low, Medium or High
6. How much do the folks doing prevention value strategic planning for the work?	Low, Medium or High
7. How much do the folks doing prevention prioritize prevention work over intervention?	Low, Medium or High
8. How much data about the risk groups mentioned earlier do preventionists have access to and use?	Low, Medium or High
9. How adequate is your Infrastructure for maintaining ongoing work to prevention perpetration and promote healthy relationships?	Low, Medium or High

Appendix B – Strategies By Level of Readiness

From: 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.

Using The Assessment To Develop Strategies

With the information you've gained in terms of dimensions and overall readiness, you're now ready to develop strategies that will be appropriate for your community. This may be done in a small group or community workshop format.

The first thing to do is look at the distribution of scores across the dimensions. Are they all about the same? Are some lower than others?

To move ahead, readiness on all dimensions must be at about the same level - so if you have one or more dimensions with lower scores than the others, focus your efforts on strategies that will increase the community's readiness on that dimension or those dimensions first. **Make certain the intensity level of the intervention or strategy is consistent with, or lower than, the stage score for that dimension. To be successful, any effort toward making change within a community must begin with strategies appropriate to its stage of readiness**

On the next three pages, you will find a list of generic strategies appropriate for each stage of readiness to guide you in developing strategies for your community.

Following the list of generic strategies, you will find blank forms for recording community strengths, concerns and resources, and samples of completed forms.

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.

4. Preplanning

Goal: Raise awareness with concrete ideas to combat condition

- Introduce information about the issue through presentations and media.
- Visit and invest community leaders in the cause.
- Review existing efforts in community (curriculum, programs, activities, etc.) to determine who the target populations are and consider the degree of success of the efforts.
- Conduct local focus groups to discuss issues and develop strategies.
- Increase media exposure through radio and television public service announcements.

5. Preparation

Goal: Gather existing information with which to plan strategies

- Conduct school drug and alcohol surveys.
- Conduct community surveys.
- Sponsor a community picnic to kick off the effort.
- Conduct public forums to develop strategies from the grassroots level.
- Utilize key leaders and influential people to speak to groups and participate in local radio and television shows.
- Plan how to evaluate the success of your efforts.

6. Initiation

Goal: Provide community-specific information

- Conduct in-service training on Community Readiness for professionals and paraprofessionals.
- Plan publicity efforts associated with start-up of activity or efforts.
- Attend meetings to provide updates on progress of the effort.
- Conduct consumer interviews to identify service gaps, improve existing services and identify key places to post information.
- Begin library or Internet search for additional resources and potential funding.
- Begin some basic evaluation efforts.

7. Stabilization

Goal: Stabilize efforts and programs

- Plan community events to maintain support for the issue.
- Conduct training for community professionals.
- Conduct training for community members.
- Introduce your program evaluation through training and newspaper articles.
- Conduct quarterly meetings to review progress, modify strategies.
- Hold recognition events for local supporters or volunteers.
- Prepare and submit newspaper articles detailing progress and future plans.
- Begin networking among service providers and community systems.

8. Confirmation / Expansion

Goal: Expand and enhance services

- Formalize the networking with qualified service agreements.
- Prepare a community risk assessment profile.
- Publish a localized program services directory.
- Maintain a comprehensive database available to the public.
- Develop a local speaker's bureau.
- Initiate policy change through support of local city officials.
- Conduct media outreach on specific data trends related to the issue.
- Utilize evaluation data to modify efforts.

9. High Level of Community Ownership

Goal: Maintain momentum and continue growth

- Maintain local business community support and solicit financial support from them.
- Diversify funding resources.
- Continue more advanced training of professionals and paraprofessionals.
- Continue re-assessment of issue and progress made.
- Utilize external evaluation and use feedback for program modification.
- Track outcome data for use with future grant requests.
- Continue progress reports for benefit of community leaders and local sponsorship. At this level the community has ownership of the efforts and will invest themselves in maintaining the efforts.