AN ASSESSMENT OF EAST COUNTY, SAN DIEGO, FOR A RELATIONSHIP VIOLENCE PROGRAM USING THE COMMUNITY READINESS MODEL

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In Partial Fulfillment of the Requirements for the Degree Master of Public Health in Health Promotion and Behavioral Sciences

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October 12, 2010
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by

Christie Colton
DEDICATION

This work is dedicated to my husband and daughter, who patiently waited countless hours for me to be finished, and without whom I could not breathe.
ABSTRACT OF THE THESIS

An Assessment of East County, San Diego, for a Relationship Violence Program Using the Community Readiness Model

by

Christie Colton

Master of Public Health in Health Promotion and Behavioral Sciences
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This study applies the Community Readiness Model and its assessment tool to determine the level of readiness for change regarding domestic violence in the eastern communities of San Diego County, California. Domestic violence is an issue that affects all populations in the United States regardless of gender, race, ethnicity, age, or socioeconomic status. Costs associated with domestic violence are estimated at over $10 billion per year, as well as an increased prevalence of mental and physical health issues compared to non-victims. The East County Domestic Violence Coalition, founded in response to an increase in the incidence of domestic violence in the region, utilized the Community Readiness Model’s key informant interview to identify which of the nine levels of readiness East County ranks. An anchored rating scale is used to score interviewee responses on six dimensions that embody significant influences in a community in regards to knowledge, attitude, and resources. Once a score is computed for each of the six dimensions, those scores are then averaged to determine an overall readiness level. Readiness scores are useful to researchers and program planners as baseline measures, and can be used to determine which programs or activities are most appropriate based on a community’s attitudes and perceptions. Nine key informant interviews were completed and analyzed according to procedures outlined in the handbook entitled Community Readiness: A Handbook for Successful Change, the results of which place East County in the Preplanning stage. This level of readiness indicates that the residents of East County understand that domestic violence is an issue in their community but have not made efforts to correct the problem. East County’s next steps should include: working to make the six dimension scores comparable, building Coalition membership, and creating trust between community members and leaders. Continued use of the Community Readiness Model’s key informant assessment tool will provide East County with the measurement by which to track their progress.
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I would like to thank the East County Domestic Violence Coalition for generously granting me the use of their data set, Debra Loomis for an amazing internship opportunity, and my thesis committee: Paula Usita, Hala Madanat, and Paul Sargent for their support.
CHAPTER 1

INTRODUCTION

Domestic violence is an issue that affects all populations in the United States regardless of sex category, race, ethnicity, age, or socioeconomic status (San Diego Domestic Violence Council, 2009). While traditionally thought to be a woman’s issue (19% of adult American females are victims of domestic violence), 3%, or 1 in 12, victims are adult males (Renzetti, 2009; San Diego Domestic Violence Council, 2009). Children are especially vulnerable to domestic violence, and adverse conditions such as: behavioral problems in school, mental health disorders, and cognitive and physical developmental delays have been documented in children who are victims and/or witnesses to violence in the home (American Psychiatric Association, 2010; San Diego Domestic Violence Council, 2009; U.S. Department of Justice, 2009). Other than a manifestation of aggressive behavior (Child Welfare Information Gateway, 2010), there is little information concerning the long-term effects of males exposed to violence. However, female victims have been shown to develop signs of depression, impaired mental health, and higher rates of illness compared to non-victims (American Psychiatric Association, 2010; Renzetti, 2009; San Diego Domestic Violence Council, 2009). Findings that use socioeconomic status as a risk factor show domestic violence as more prevalent in lower income households; however, income does not appear to be a protective factor against the issue (Renzetti, 2009). Regardless of which risk factors are assessed, with the recent economic downturn causing unemployment rates to
increase, so have the number of domestic violence related calls to law enforcement (Renzetti, 2009).

**THE COST OF DOMESTIC VIOLENCE**

Domestic violence costs the United States approximately $10 to $12.6 billion dollars per year (National Domestic Violence Hotline, n.d.; San Diego Domestic Violence Council, 2009). Costs attributed to domestic violence include loss of wages due to absenteeism in the workplace, medical and legal bills, child care, and loss of productivity both at work and in the home (National Domestic Violence Hotline, n.d.; San Diego Domestic Violence Council, 2009). Of this cost, $858.6 million accounts for “total value of days lost from employment and household chores,” $892.7 million accounts for the loss of “present value of lifetime earnings,” $4.1 billion accounts for direct costs, and $1.8 billion account for indirect costs (San Diego Domestic Violence Council, 2009). In 2008, the U.S. Census Bureau estimated California’s population at over 36.5 million. At an incidence rate of 43.9 per 10,000, the approximated number of domestic violence incidents in California for that year was 160,000, with over 16,000 of those incidents reported in San Diego County (Burke, 2009; RAND, 2008; U.S. Census Bureau, 2008). Considering a population of over 3 million, these statistics indicate a rate for domestic violence incidence at approximately 5.2 per 1,000, or 5% of San Diego County’s population. In view of the Healthy People 2010 goal of no more than 3.3 per 1,000 for victims of physical assaults from current or former intimate partners, San Diego County fails to meet the goal by nearly doubling the desired standard (U.S. Department of Health and Human Services, 2000).
EAST COUNTY, SAN DIEGO, AND DOMESTIC VIOLENCE SERVICES

San Diego County is a large area encompassing 2,000 square miles in Southwestern California (U.S. Census Bureau, 2009). The eastern portion of the county, appropriately named “East County,” includes the cities of La Mesa, El Cajon, Santee, Lemon Grove, and Spring Valley, along with many other small towns and communities (The Chamber, 2010). It has a diverse racial and ethnic population as well as a wide range of socioeconomic status levels (U.S. Census Bureau, 2009). Neighborhoods vary from affluent and walkable with low crime rates, to 900 square miles of “back county” where residents enjoy the freedom of living largely without the presence of law or government (Key Informant Interview 4, 2010). In 2008, El Cajon law enforcement experienced a 3% increase in domestic violence incidents compared to the number of incidents in 2007, and La Mesa’s incidence increased 14%; the highest increase in San Diego County for 2008 (Burke, 2009).

The East County Domestic Violence Coalition (a subcommittee of the San Diego Domestic Violence Council) was founded by agency representatives and community members who identified the need to address the increase in relationship violence in the region. The Coalition receives no funding and remains open to those who have an investment in violence prevention in East County. The term “relationship violence” was chosen by the Coalition to more completely characterize the population they seek to represent. From this point forward, “relationship violence” will be used to describe any violence experienced either primarily or secondarily between any two people who have a defined relationship.

The Coalition’s first action to address the increase in relationship violence in the community was to identify East County’s existing, on-going services, and place them into
four categories: awareness, prevention, screening, and intervention. Once accomplished, an ecological approach was used to further classify services according to the level at which they serve the community. Existing services were divided in five areas: individual level, interpersonal level, organizational level, community level, and public policy. Many services overlapped, while few addressed only one of the four categories on only one level. A breakdown of services and their respective placement as determined by the Coalition is found in Appendix A.

Through the analysis of East County’s services addressing domestic violence, the Coalition found that, although existing services were numerous, evaluations of effectiveness were not conducted. With this in mind, efforts changed from creating more services, to improving messaging and increasing communication between existing services. Coalition members felt that if they did not change strategies, their efforts would only increase the number of services without decreasing East County’s incidence of relationship violence (Debra Loomis, personal communication, January 2010).

In order to create a baseline for measurement of community knowledge and attitudes regarding relationship violence, the Coalition chose to distribute three surveys targeted at populations whose roles generally differ in terms of community involvement and leadership. One survey, adapted from “Safe Futures: Myths and Misconceptions of Domestic Violence” (Boston University Police, n.d.), was distributed to the general population at community events such as health fairs and tribal gatherings. This survey consisted of three sections: the first was used for garnering demographics, the second consisted of 10 true or false questions that measured participant knowledge of relationship violence, and the third asked the participant to select all media sources they use to acquire general information. The second
survey, adapted from the Substance Abuse and Mental Health Administration (SAMHSA),
Goodman and Wandersman tool for community readiness in relation to drug abuse
prevention (as cited in Hogan, 2002), was distributed via email to community leaders such as
club presidents and youth leaders. This survey consisted of 12 questions that assessed the
participants’ personal and organizational efforts dedicated to addressing relationship
violence. In the third survey, key informants were interviewed in accordance with the
Community Readiness Model to determine the community’s level of readiness for change
concerning relationship violence.

**COMMUNITY READINESS MODEL**

The Community Readiness Model was developed by the Tri-Ethnic Center for
Prevention Research at Colorado State University, and funded by the National Institute on
Drug Abuse (Plested, Smitham, Jumper-Thurman, Oetting, & Edwards, 1999). As the name
suggests, this model aims to give researchers and program planners a tool to identify
communities that are ready to accept a program and, depending on the level of readiness,
which kind of program best suits their wants and needs (Donnermeyer, Plested, Edwards,
Oetting, & Littlethunder, 1997). While initially created to address drug and alcohol use, the
model has since been successful in addressing “domestic and sexual violence, head injury,
HIV/AIDS, suicide, animal control issues, and environmental issues” (Edwards, Jumper-
Thurman, Plested, Oetting, & Swanson, 2000, p. 293; Tri-Ethnic Center for Prevention
Research, 2006). The most notable example of the Community Readiness Model used in a
domestic violence related issue (intimate partner violence) was conducted by Brackley et al.
(2009), and resulted in moving the target community three awareness levels from resistance to preparation in the course of 2 years.

The Community Readiness Model utilizes an in-depth, semi-structured interview of key informants to assess six dimensions of a community. The researcher then uses an anchored rating scale to place the community into one of nine readiness levels for each dimension, as well as determining an overall level of readiness for change (Edwards et al., 2000; Tri-Ethnic Center for Prevention Research, 2006). The anchored rating scale originated from the field of industrial psychology and was selected for the Community Readiness Model’s assessment tool based on its history of effectiveness (Edwards et al., 2000). Key informants were chosen as the target population for the interview as they have been found to be especially useful for three aspects of program planning. First, they provide an “initial assessment of an issue” and give researchers a more accurate view of the community’s involvement with that issue. Secondly, the personal nature of a one-on-one interview makes the key informant a likely entry point (for the researcher) into a community through building relationships from the beginning of the process. Lastly, key informants can more readily and accurately reveal the strengths and weakness of a community as well as existing programs (The Access Project, 1999). Donnermeyer et al. (1997) support this description of key informants, describing them as well-placed individuals in the community who affect the decision-making process and serve as a voice for those less active or heard from in the community. P ancest al. (1999) add that key informants are beneficial targets because they are more apt to have knowledge of prevention efforts in their community. Through the Community Readiness Model, key informants are used to score a community for readiness in each of six dimensions designed to embody significant influences in a community in regards
to knowledge, attitude and resources (Plested, Edwards, & Jumper-Thurman, 2006). This scoring technique creates a baseline for evaluation, defines an appropriate starting point for new programs, and provides a measure for change at any point of an evaluation or program (Donnermeyer et al., 1997; Plested et al., 2006). The Tri-Ethnic Center founded the constructs of the Community Readiness Model and its assessment tool on three widely adopted theoretical models: the Transtheoretical Model, the Diffusion of Innovation, and the Social Action Process (Donnermeyer et al., 1997; Thurman, 2000).

**Transtheoretical Model**

The Theoretical Stages of Change or what is commonly called the “Transtheoretical Model” was developed by the psychology community to address behavior change (Prochaska, 2008). The model is comprised of six stages that place an individual in a level of readiness to change their behavior. The first stage, precontemplation, states that the individual has little or no awareness of the problem or may have failed attempts in the past and are no longer considering change. This stage is normally calculated as “the next 6 months.” The next level, contemplation, postulates that the individual is aware of the need for change, and within the next 6 months may go through short periods of modified behavior; however, they have doubts as to how or if they will proceed. An individual has entered the preparation stage when they have formulated a plan for a course of action and intend to make changes within about 1 month. In the action stage, the individual is currently working to change a behavior they have engaged in within the past 6 months. The maintenance stage indicates that the behavior has been changed and the individual is working to prevent a relapse. They are less often tempted to engage in their former behavior and are increasingly more confident they
will not relapse. This stage has been measured to last from 6 months to 1 year (Edwards et al., 2000; Prochaska 2008). The sixth and final stage, termination, acknowledges when an individual has completely changed their behavior and does not consider temptation or risk relapse. This stage is often not included in program planning, as it has been shown in studies with smokers and alcoholics that it is more practical to plan for a lifetime of the maintenance stage (Prochaska, 2008). In this model, an individual must fulfill the requirements of one level to successfully move forward to the next in anticipation of sustained change; however, the path to maintenance is rarely a straight line and individuals may skip, reverse direction, and/or repeat stages along the way (Prochaska & Velicer, 1997).

The Community Readiness Model follows the Transtheoretical Model’s temporal format; however, unlike Prochaska’s model which focuses on the individual, the Community Readiness Model focuses on the community. Also like Prochaska’s model, the Community Readiness Model addresses those who are not aware or motivated to address the problem and those who may be resistant to addressing the issue. Unlike the Transtheoretical Model, the Community Readiness Model does not consider time in form of months or years, but in the time it takes to achieve community buy-in.

**Community Development**

In creating the Community Readiness Model, the Tri-Ethnic Center also incorporated constructs from community development. The two models used were Rogers’ Diffusion of Innovations and Beal’s Social Action Process. Both models have comparable stages that follow a temporal course as in the Transtheoretical Model, but consider the decision-making process of a group of people (Donnermeyer et al, 1997; Edwards et al., 2000; Thurman,
In the social action process, the five stages of decision-making are: (a) *stimulation of interest*: a small part of the community identifies a new problem or need; (b) *initiation*: a larger part of the community contemplate and define the new problem or need and produce alternative solutions; (c) *legitimization*: community leaders determine if action will be taken to address the problem or need; (d) *decision to act*: specific plans are developed and involve an even larger part of the community; and (e) *action*: the plan is implemented (Donnermeyer et al., 1997; Edwards et al., 2000; Thurman, 2000). The stages for the innovation decision-making process are: (a) *knowledge*: an innovation (new idea or practice) is discovered; (b) *persuasion*: an attitude of acceptance or rejection is created about the innovation; (c) *decision*: considering the attitudes in the previous stage, the innovation is either embraced or not embraced; (d) *implementation*: the innovation is tried for the first time; and (e) *confirmation*: the innovation is either discarded or tried again, possibly with modifications (Donnermeyer et al., 1997; Edwards et al., 2000; Thurman, 2000).

The Community Readiness Model reflects these models by considering the range of community interest and involvement. Like the models, it also recognizes that only a few people in the community will take an initial interest in the problem, and plans to make change will only occur when community leaders take notice or action. The Community Readiness Model also addresses the importance of the attitudes and feelings of the community by admitting that, regardless of how comprehensive a program is, it will fail without community support. However, the Community Readiness Model does address three shortcomings of the previously noted founding theories. First, the aforementioned theories do not take into account the community’s previous experience with either the problem or with pre-existing programs. Secondly, they do not sufficiently take the multi-dimensional nature of
a community into account, and lastly, they do not consider the readiness of the community to make change (Donnermeyer et al., 1997; Edwards et al., 2000).

**COMMUNITY READINESS MODEL’S READINESS LEVELS**

Nine levels of readiness are identified in the Community Readiness Model. Level one, “No Awareness,” indicates that the targeted population does not view the issue as a problem in their community. An overall attitude of “This is the way things are” may prevail. Level two, “Denial,” implies that the targeted population has some awareness of the issue and know it is a problem in their community, but there is a general feeling of “It’s not our problem,” or “It only concerns those people.” Level three, “Vague Awareness,” suggests the population understands that the issue is a problem in their community, but they are not motivated to make corrective changes. Level four, “Preplanning,” indicates that the population sees the issue as a problem in their community, and there may be some discussion regarding the issue, but no action is being taken to correct the problem. Level five, “Preparation,” implies that the community is forming corrective action regarding the issue and leaders are being identified; however, information is not based on data collected from the community but is nonspecific in nature. Level six, “Initiation,” suggests that efforts have been initiated, but are still considered “new.” Passionate and motivated leaders have emerged and some community members are beginning to follow suit. In Level seven, “Stabilization,” several efforts have been fully implemented and the community is supportive; however, those efforts have not been evaluated for effectiveness. Level eight, “Confirmation/Expansion,” indicates that leaders and efforts are permanent and sustainable in the community and existing efforts are evaluated for effectiveness. Expansion of those efforts or new efforts are either being
considered or implemented based upon the evaluations. Level nine, “High Level of Community Ownership,” is just what the title implies. The community embraces existing efforts, and involvement from all parties (community, leaders, staff, etc.) is high. Efforts are now concentrated on special populations within the community, evaluation is routine, and results are regularly communicated through mass media vehicles (Plested et al., 2006).

Figure 1 illustrates the Community Readiness Model as shown in the handbook, *Community Readiness: A Handbook for Successful Change* (Plested et al., 2006).


**COMMUNITY READINESS DIMENSIONS**

The first dimension of the interview is “community efforts.” The main goal of this dimension is to have the interviewee identify existing policies, programs, and events in the
community and state how long they have existed. They are also asked to recall which populations these efforts serve and decide if they are inaccessible for specific populations based on gender, age, ethnicity, etc. (Plested et al., 2006).

The second dimension of “community knowledge and efforts” asks the interviewee if they believe the general population is aware of the existing policies, programs, and events identified in the first section. It also asks the interviewee to describe any strengths or weaknesses of those efforts (Plested et al., 2006).

The third dimension examines leadership and asks the interviewee to identify community leaders involved with the issue. They are then asked to rate how concerned the identified leaders are about the issue on a scale of 1-10. Additionally, interviewees are asked if identified leaders are actively involved with existing efforts and if they would welcome additional efforts (Plested et al., 2006).

Community climate, the fourth dimension, asks the interviewee to describe the targeted community, determine if they (the community) would support efforts, and identify any barriers to those efforts. It also asks the interviewee to reflect on the overall attitude of the community toward the issue (Plested et al., 2006).

The fifth dimension asks the interviewee to discuss how knowledgeable the population is concerning the issue. It then asks the interviewee to identify which types of information, local and general, are available to the community and reveal if they believe the population knows how or where to access that information (Plested et al., 2006).

The last dimension, “resources related to the issue,” asks the interviewee to describe resources (such as time, space, and money) the community has available to address the issue. Questions also address the attitudes of business owners concerning the issue, and if the
The purpose of this study is to use the Community Readiness Model, in conjunction with interview results, to determine the level of readiness for change regarding domestic violence in the eastern communities of San Diego County. Based on those scores, an attempt will then be made to suggest a course of action that is comprehensive, culturally competent, and financially sustainable.
CHAPTER 2

METHODS

TARGET POPULATION AND RECRUITMENT

The target population for the study was individuals living in the communities of San Diego’s East County. However, the sample population targeted for in-depth interviews was key informants. Key informants are community members who are selected for attributes such as knowledge of the issue, experience with the issue, or experience working with people involved with the issue. They should represent as wide a variety of knowledge and areas of expertise as organizations resources will allow making sure that the researcher gets a full picture of as many aspects of the issue as possible (The Access Project, 1999). The Coalition identified key informants according to the criteria suggested in the community readiness handbook (Plested et al., 2006), and recruitment strategies outlined in the section labeled “How to Conduct a Community Readiness Assessment” were used. Strategies include choosing four to six people who are “connected to the issue,” and selecting a variety of key informants from as many areas of service as possible, those areas of service being: schools/universities, city/county/ tribal government, law enforcement, health and medical professions, social service, mental health and treatment services, clergy or spiritual community, community at large, youth (Plested et al., 2006). Because of the far-reaching nature of relationship violence, representatives from each of these areas were targeted for East County’s recruitment. Key informants associated with relationship violence were
identified in a brainstorming session at a Coalition meeting, after which, Coalition members then volunteered to interview the identified person(s) based on their personal and professional networks. Those actually recruited for key informant interviews were dependent upon the volunteer following through with their commitment.

The Coalition initially identified over 30 key informants for recruitment but only completed nine interviews. Since this number exceeds the suggested number of interviews necessary for accurate results, and the interviews were extracted from a variety of areas of service, the Coalition considered it appropriate to move to the next step of assessment. Interviews 1 and 7 represented Law Enforcement. Interviews 2, 3, and 8 represented County Government. Interviews 4 and 5 represented the Health and Medical fields. Interview 6 represented the Community at Large, and interview 9 represented Social Services.

**THE ASSESSMENT TOOL**

The assessment tool for the Community Readiness Model is a semi-structured interview that measures the overall readiness of a community to make change regarding a specified issue. It is broken down into six areas of focus, or dimensions, which are comprised of a set of questions; however, not all questions are essential to include for accurate results. Those marked as supplementary questions may be deemed helpful for elaboration, but do not affect the overall score and may be removed. Any additional questions the research team might want to include should be added to the end of the interview for ease in scoring (Plested et al., 2006). No additional questions were added by the East County Coalition, although two supplementary questions were omitted because the Coalition felt that they were “redundant” and “did not necessarily fit the relationship violence theme” (Debra Loomis, personal
communication, September 2010). A breakdown by dimension of questions included in East County’s assessment tool compared to the original tool can be found in Table 1. A copy of the Tri-Ethnic Center’s original assessment tool can be found in Appendix B.

Table 1. East County’s Assessment Tool

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<td>Dimension F</td>
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*Note.* Numbers in bold for Dimensions A and D indicate the removed supplementary questions.

**INTERVIEW AND SCORING PROCEDURES**

Interviews were scheduled and performed by Coalition members, and normally occurred in the work place of the interviewee with the exception of Interview 1, which was conducted via email. All interviews except Interview 1 were tape recorded for accuracy due to the interview being conducted via email. However, since a copy of the email was directly forwarded to the project coordinator with all identifying data omitted, it can be assumed that the interview responses were accurate. Once conducted, the interviewers transcribed their results and emailed them to the project coordinator with only the area of service as an identifier. The project coordinator then numbered the interview results and printed them for scoring.
Scoring was accomplished per the instructions outlined in the community readiness handbook. All interviews were scored individually by both the project coordinator and the author and were documented using the provided scoring sheet. The scoring process began with reading each interview in its entirety. Then a number value (based on the anchored rating scale) was assigned to each of the six dimensions and recorded on the scoring sheet in the section marked “individual scores.” Once this process was completed individually, the scorers met to discuss the results for each of the six dimensions for each interview.

The scoring process produced a wide range of results within each dimension for both the individual and combined scoring process. This range in scores was often the result of incomplete or missing answers, which made it difficult to assign a number value. As a result, questions with no answers were not given any number value, unless an entire section was missing, in which case, the dimension was given the lowest score of 1.0. If a dimension was scored the same by both scorers, there was no discussion. If individual scores did not match for a dimension, the interview answers were re-read and both descriptions chosen by the individual scorer on the anchored rating scale were read aloud. The scorers would then discuss their reasons for their individual score and a consensus would be agreed upon based on a score that most readily matched the interview responses. This final score was often a number between the two individual scores and was recorded in the section of the scoring sheet marked “combined scores.” Once all scores were determined for every section of every interview, the combined numbers were added up and divided by the number of interviews (9) to determine the score that places each dimension into a level of readiness. A copy of the Tri-Ethnic Center’s anchored rating scale can be found in Appendix C.
As shown in Appendix C, a higher score indicates an increasing number of community members (general population, special populations, business owners, program planners, policy makers) and resources (money, time, and space) are dedicated to the issue in question. In general, a readiness score of 1.0 indicates the population is neither aware of the presence of the issue in their community nor are there resources dedicated to the issue. A readiness score of 9.0 indicates that the population is very concerned with the issue, multiple resources are dedicated to the issue, and existing services are consistently evaluated for effectiveness; with those results being made available to the public (Plested et al., 2006).

**VALIDITY AND RELIABILITY**

Although originally developed to address issues related to drugs and alcohol, the Tri-Ethnic Center purports that the Community Readiness Model can and has been successfully used for a multitude of issues and in a variety of circumstances. However, because the variables are never the same in any two assessments, the process for testing for validity is a challenge. Even the same assessment method addressing the same issue and community will change, as a community is never static and conducting the first assessment will likely create some change in the areas of attitude, belief, or knowledge. Therefore, the best way to test the validity of the Community Readiness Model is to establish construct validity where the model is used repeatedly to determine if the assessment procedure does in fact correctly measure the readiness of a community to change (Ouyang, n.d.; Plested et al., 2006).

The same challenge is true when testing for reliability. Because a community is inherently always changing, identical assessment procedures will rarely provide the same outcomes regardless of the number of repetitions. The Tri-Ethnic Center states that, while
this is true, “inter-rater reliability” can be established in two ways. First, the interview questions have been arranged and worded so that the community is generally viewed in the same light. This establishes reliability among interviewee responses. Second, reliability in the assessment tool through consistency in scoring was demonstrated through the Tri-Ethnic Center’s findings that independently scored interviews are given the same exact score 92% of the time (Plested et al., 2006).

**Ethical Considerations**

Transcribed interviews were submitted by the interviewer to the project coordinator with only the area of service for identification. As completed interviews were received, they were numbered 1-9 in the order by which they were received by the project coordinator. This ensured confidentiality of the interviewee, and no interviewer knew the source of any interview except the one(s) they conducted. In regards to the interview questions, risk is low, as interviewees are asked only to express perceived feelings and general attitudes of the community for which they represent, and ask neither personal questions nor questions related to identifying acts of relationship violence.
CHAPTER 3

RESULTS

After careful deliberation, the combined scores for each of the dimensions in each of the interviews were determined by the project coordinator and author. The range of scores for Dimension A, Community Efforts (6.5 to 7.5), was the most consistent of all dimensions, regardless of the interviewees’ area of service. On the anchored rating scale a 7.0 indicates that “Efforts (program/activities) have been running for several years” (Plested et al., 2006). This is confirmed with interviewee responses to the question “How long have these efforts been going on in East County?” Eight of the nine answers indicated that efforts had been in place from “over a year” (Key Informant 1, Law Enforcement) to 34 years (Key Informant 4, Health and Medical Professional). East County did not score an 8.0 because, while community programs include a large demographic range, key informants did not know of “new efforts being developed based on evaluation data” (Plested et al., 2006).

Individual scores for Dimension B, Community Knowledge of the Efforts (mentioned in Dimension A), ranged between 2.0, “Community has no knowledge about efforts addressing the issue” and 5.5, a score between 5.0 “Members of the community have basic knowledge about local efforts (e.g., purpose), and 6.0 “An increasing number of community members have knowledge of local efforts and are trying to increase the knowledge of the general community” (Plested et al., 2006). The resulting averaged score of 3.8 indicates that more than “a few members of the community have heard about efforts, but the extent of their
knowledge is limited” (3.0), but the community is not quite at a 4.0 “some members of the community know about local efforts” (Plested et al., 2006).

Interview responses for Dimension C, Leadership, ranked between 2.0, “Leadership believes that this is not an issue in their community” and 7.5, which indicates that “Leaders are supportive of continuing basic efforts and are considering resources available for self-sufficiency” (7.0) but are not “supportive of expanding/improving efforts through active participation in the expansion/improvement” (8.0; Plested et al., 2006). The resulting averaged score was a 4.8 indicating that “leaders are trying to get something started” (4.0) but they are not all “part of a committee or group that addresses the issue” (5.0; Plested et al., 2006). The lowest score of 2.0 was assigned to Key Informant 4 (Health and Medical Professional) who addressed a large area called the ‘back country’ and stated that in this area of East County “there really isn’t leadership . . . they don’t have town halls, mayors, or a governing group.”

Scores for Dimension D, Community Climate, had the largest variation from 1.0 “The prevailing attitude is that [relationship violence] is not considered, is unnoticed or overlooked within the community” to 8.0 “Some community members or groups may challenge specific programs, but the community in general is strongly supportive of the need for efforts. Participation level is high” (Plested et al., 2006). The highest scores of 8.0 came from Key Informant 5 (Health and Medical Professional) and Key Informant 8 (County Government), of whom both were named by the other key informants as leaders in relationship violence. Lower scores came from Key Informant 6 (Community at Large) 1.0 and Key Informant 9 (Social Services) 2.0, whose organizations may work in outcomes related to relationship violence, but were not considered by the other key informants as leaders in the field. The
resulting averaged score of 4.2 indicates that the community’s attitude is “beginning to reflect interest in the issue” (4.0) but they are not quite “concerned about this” (5.0; Plested et al., 2006).

Dimension E’s individual scores for Community Knowledge of Relationship Violence ranged between 2.0 “No knowledge about the issue” and 8.5 in which “Community members have knowledge about the prevalence, causes, risk factors, and consequences” (8.0) but do not have “detailed information about the issue as well as information about the effectiveness of local programs” (9.0; Plested et al., 2006). The resulting averaged score of 4.1 indicates that “some community members recognize the signs and symptoms of the issue” (4.0) but they do not necessarily know that the “signs and symptoms occur locally” (5.0; Plested et al., 2006).

Individual scores for Dimension F, Resources Related to Relationship Violence, ranged between 4.0 “The community has individuals, organizations and/or space available that could be used as resources” and 7.0 “A considerable part of support of on-going efforts are from local sources that are expected to provide continuous support. Community members and leaders are beginning to look at continuing efforts by accessing additional resources.” An average score of 5.8 indicates that “some members of the community are looking into the available resources” (5.0) but they have not “been obtained and/or allocated for this issue” (6.0; Plested et al., 2006).

Once each of the six dimensions for all interviews were averaged, that number was used to determine the readiness level of East County for each individual dimension. The score of 29.7 (the sum of the individual dimensions) was then divided by 6 (the number of
dimensions) to ascertain the Average Overall Community Readiness Score. The results of this process are shown in Table 2.

Table 2. Community Readiness Scores for East County, San Diego

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Total Score for Dimension</th>
<th>Divided by # of Interviews</th>
<th>Stage Score</th>
<th>Average Overall Community Readiness Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dimension A</td>
<td>63</td>
<td>9</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Dimension B</td>
<td>35</td>
<td>9</td>
<td>3.8</td>
<td></td>
</tr>
<tr>
<td>Dimension C</td>
<td>43.5</td>
<td>9</td>
<td>4.8</td>
<td></td>
</tr>
<tr>
<td>Dimension D</td>
<td>37.5</td>
<td>9</td>
<td>4.2</td>
<td></td>
</tr>
<tr>
<td>Dimension E</td>
<td>37</td>
<td>9</td>
<td>4.1</td>
<td></td>
</tr>
<tr>
<td>Dimension F</td>
<td>52.5</td>
<td>9</td>
<td>5.8</td>
<td></td>
</tr>
</tbody>
</table>

29.7 4.95
CHAPTER 4
DISCUSSION

The Community Readiness Model proved to be an effective tool for assessing East County’s level of readiness in regards to relationship violence. When presented with the readiness scores of both the individual levels of readiness for the dimensions as well as the overall level of readiness (with an explanation of each score), Coalition members generally agreed that the results were an accurate assessment of East County. The success in accurately assessing East County’s level of readiness increases the reliability and validity of the assessment tool and model.

SIMILARITIES IN INTERVIEWS

When asked to define relationship violence, all but one interviewee used at least one of the terms: violence, harm, or abuse. Within the context of this same question, all but one interviewee specified that the violence, harm, or abuse occurred between at least two people in a defined relationship. A typical response was, “Any violent behavior between people in an intimate relationship” (Key Informant 2, County Government). The response that did not use these terms was, “Any time intimidation is used. When a person makes someone do something they do not want to” (Key Informant 4, Health and Medical Professional). Although the latter response uses different wording, it conveys an overall view of relationship violence as highly undesirable behavior.
The East County Family Justice Center is mentioned over 15 times. Interviewee responses indicate that they view this organization as a leader in the community, as making progress in addressing relationship violence, and as a valuable community resource. However, when considering the aforementioned roles, the majority of referenced agencies pertained to law enforcement and governing organizations such as: police and sheriff departments, the judicial system, public defenders and attorneys, and county government. When addressing community efforts, six of the nine interviewees named law and governing agencies as the major forces addressing relationship violence. “The police department has the Domestic Violence Response Team (DVRT)” (Key Informant 1, Law Enforcement), “... the prosecutor’s office [which] reviews all cases related to domestic violence referred ... by agencies like Sheriff’s Department and the Police department” (Key Informant 2, County Government), “There are also DV courts which deal exclusively with family violence” (Key Informant 3, County Government). Unfortunately, of all agencies noted, only the East County Family Justice Center is specifically involved in relationship violence prevention efforts. Law enforcement and other agencies such as crisis houses and counseling services only address the issue once an incident has been reported.

There is also a general consensus among interviewees that the citizens of East County are not aware of relationship violence in their community and are, therefore, not aware of existing efforts to address the problem. When asked to rate the residents of East County on their awareness of existing community efforts on a scale of 1-10, eight of the nine interviewees responded with a score of 6 or below, with the ninth interviewee providing no score. Explanations of their scores included remarks such as, “Clients are not aware” (Key Informant 6, Community at Large) and “If you aren’t in the court system, or have people who
are, you are probably not aware of DVRT [Domestic Violence Response Team]” (Key Informant 8, County Government).

**DIFFERENCES IN INTERVIEWS**

The tone of interviews completed by law enforcement and government agency representatives are markedly different from the other interviews in their responses pertaining to the effectiveness of existing programs. These interviews read with a general feeling that existing programs are effective and cannot be improved upon. When asked if there were segments of the community for which policies, practices, or laws may not apply, all five of the interviewees associated with these areas of service stated, “No,” while Key Informant 4 (Health and Medical Professional) named the Indian reservation. When asked if there was a need to expand existing policies, practices, or laws, two of the five responses from law and government interviews simply stated “No.” This response may result from the interviewees’ close proximity to the issue as well as their role in an incident. Those in law and government eventually deal mainly with perpetrators of relationship violence and may feel that they are doing all they can with their clients. In contrast, those in other areas of service (social services, health and medical professionals, community at large) may work mainly with the victims and witnesses of relationship violence and may feel that more should or could be done for their clients.

Interviewees differ in their opinions of the weaknesses of existing efforts. Answers to this question included: language barriers (Key Informant 6, Community at Large), financial issues (Key Informant 3, County Government, Key Informant 6, Community at Large), getting resistant people to address their issue (Key Informant 7, Law Enforcement), accessing
unreachable populations (Key Informant 4, Health and Medical Professional), and creating public awareness (Key Informant 9, Social Services). While all key informants agree that existing programs are meant to include everyone, six interviewees identified at least one demographic they do not believe is being reached through current efforts. Populations for which resources may seem inaccessible are those who speak Farsi, Arabic, or Chinese, those from the Middle East, and recent immigrants (Key Informants 2 and 3, County Government, Key Informant 6, Community at Large). Key Informant 4 (Health and Medical Professional) felt that the segment of the population aged 20-47 (neither children exposed to efforts through school nor seniors enrolled in a new program that addresses the issue) are not being reached through current efforts, and Key Informant 7 (Law Enforcement) feels the handicapped are not included due to transportation challenges.

While eight of the nine interviewees believe that there is a need to expand efforts or services, examples of what should be expanded differed. Key Informant 3 (County Government) stated that more funding is needed and church affiliated groups should be used as resources. Key Informant 4 (Health and Medical Professional) responded that job placement would help decrease the incidence of domestic violence. The interviewee clarified the response by stating that, by losing jobs, people lose transportation, which may lead to depression, and may lead to other things (such as relationship violence). Key Informant 5 (Health and Medical Professional) suggested that efforts should include keeping resources for referral up to date. Key Informant 6 (Community at Large) believes that language and cultural issues should be addressed, as well as access to transportation. Lastly, Key Informant 9 (Social Services) implies that anonymity is a concern, and preventive measures should be expanded to include information posted in bathroom stalls for privacy.
ASSessment of Dimension Results

Dimension A, Community Efforts, received the highest score for any dimension of 7.0. To move the community of East County to a score of 8.0, existing programs would have to be evaluated, perhaps using a tool that utilizes the Delphi method. The Agency for Healthcare Research and Quality (2002a), under the U.S. Department of Health and Human Services, has created an evaluation tool using the Delphi method to assess domestic violence related programs in health care settings such as hospitals or clinics. Although created for health care facilities, adaptations from evaluation tools such as this may be useful to evaluate East County’s existing domestic violence programs. Articles and websites such as Evaluating Domestic Violence Programs created by the Agency for Healthcare Research and Quality (2002b) may also be helpful because they offer comprehensive instructions on how to evaluate programs. The National Resource Center for Community-Based Child Abuse Prevention (2010), also supported by the U.S. Department of Health and Human Services through the Administration for Children and Families, Children’s Bureau, provides an assessment tool for the evaluation of child and family based domestic violence prevention programs.

Dimension B, Community Knowledge of Efforts, received a score of 3.8 on the anchored rating scale. To increase East County’s score to 4.0, those community members involved in existing efforts (like the Coalition) could conduct a survey much like the one already executed for the general population using the “Safe Futures: Myths and Misconceptions of Domestic Violence” adaptation (Boston University Police, n.d.). This method is relatively inexpensive and has proven to be well received in East County. The new survey could list existing agencies and services in East County and ask the participant to
indicate the one with which they are familiar. Upon completing the survey, participants could receive a listing of services with a brief description and contact information for each. This exercise would not only inform the participant but, through demographic questions such as age or zip code, could reveal the level of agency or service influence within the general population and allow the researcher to see who the services are not reaching. Additionally, the preparation and creation of the survey will increase contact with like-minded agencies and services creating the opportunity for increased participation and collaboration.

Dimension C, Leadership, received a 4.8 on the anchored rating scale. To move East County’s leadership score to a 5.0 “Leaders are part of a committee or group that addresses this issue” members of the Coalition should reach out to those key informants identified in the brainstorming session and extend an invitation to join efforts, such as the Coalition, in an attempt to find a representative for each service that addresses domestic violence in East County. It may be possible to support subgroups of members based on area of service who would then send a representative to Coalition meetings. This approach could be especially effective for those who would like to participate but cannot make regular Coalition meetings.

Dimension D, Community Climate, averaged a 4.2 on the anchored rating scale. To move East County to 5.0 “the attitude in the community is ‘we are concerned about this,’ and community members are beginning to reflect modest support for efforts” East County should continue to support existing efforts in East County such as the annual Not-To-Be-Forgotten rally held for the County of San Diego in October for Domestic Violence Awareness Month. Through reaching out to agencies and organizations whose priorities are not necessarily domestic violence-related such as Masonic affiliations, Rotary Clubs, and Youth Clubs,
existing services may reap a broader base of support which may cause an increase in overall awareness (Plested et al., 2006).

Dimension E, Community Knowledge of Relationship Violence, averaged 4.1 on the anchored rating scale. East County’s next step in this dimension is to move the community to 5.0 “Community members know that the signs and symptoms of this issue occur locally, and general information is available” (Plested et al., 2006). The Coalition has already begun to address this through their general population survey. The survey utilized true/false questions to assess community knowledge and has been tallied for examination. Their next step should include using those questions most incorrectly answered as a basis for messaging.

Dimension F, Resources Related to Relationship Violence, scored a 5.8 on the anchored-rating scale. This is the only score where the Tri-Ethnic Center’s Community Readiness Model did not provide an accurate assessment. All nine of the key informants named agencies who allocate people, time, money, and space to address relationship violence in East County. Resources included: East County Family Justice Center, police, the Health and Human Service Agency, school, sheriff, primary care provider, medical clinic, crisis houses, hospital, and battered women’s shelters. At this time there are resources allocated to relationship violence in East County; however, when asked if they know of plans to request additional resources for this cause, all but one of the key informants said “No,” or indicated that additional resources were requested but denied. In addition, this dimension had the most blank responses or responses such as “I don’t know.” In light of the economic downturn, it does not seem likely that this dilemma will change in the near future. Instead, many programs have or will be facing cuts in San Diego County, including the closing of the Office of Violence Prevention in June 2010, which provided the support for this assessment of East
County. In order to move East County to a score of 7.0 “A considerable part of support of on-
going efforts are from local sources that are expected to provide continuous support. 
Community members and leaders are beginning to look at continuing efforts by accessing additional resources,” Coalition, agency, and community members will have to find innovative ways to garner local resources (Plested et al., 2006). Perhaps, in the attempt to increase leadership in the community (Dimension C) through agency collaboration, existing services can pool their resources to achieve similar goals.

**Assessment of Overall Readiness Score**

Averaging the six dimension scores gives East County an overall readiness score of 4.95. In accordance with the community readiness handbook, this number is rounded down to 4.0, placing East County in the Preplanning stage. The Tri-Ethnic Center’s description of this stage indicates that the community is aware of the problem and understands that action should be taken to correct it. There may be groups in the community that already address the issue, but efforts are neither consistent nor comprehensive (Plested et al., 2006). Strategies for moving East County to the Preparation stage in which leaders are active and the community is supportive of both leaders and efforts, along with goals and strategies for subsequent stages, are outlined in the handbook *Community Readiness: A Handbook for Successful Change* and are presented in Table 3. Should the East County Coalition choose to follow the advice presented by the author, many of the strategies recommended by the Tri-Ethnic Center will be addressed.
<table>
<thead>
<tr>
<th>Stage</th>
<th>Goal</th>
<th>Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1: No Awareness</td>
<td>Raise awareness of the issue</td>
<td>• Make one-on-one visits with community leaders/members</td>
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<td></td>
<td></td>
<td>• Visit existing/established small groups to inform them of the issue</td>
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<td></td>
<td>• Make one-on-one phone calls to friends and potential supporters</td>
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<tr>
<td>Stage 2: Denial/Resistance</td>
<td>Raise awareness that the problem or issue exists in the community</td>
<td>• Continue one-on-one visits, encourage them to assist</td>
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<td></td>
<td>• Discuss descriptive local incidents related to the issue</td>
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<td></td>
<td>• Approach and engage local educational/health outreach programs to assist in the effort with flyers, posters, or brochures</td>
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<tr>
<td></td>
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<td>• Share media articles that describe local critical incidents</td>
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<td>• Prepare and submit articles for church bulletins, local newsletters, club newsletters, etc.</td>
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<td></td>
<td></td>
<td>• Present information to local related community groups</td>
</tr>
<tr>
<td>Stage 3: Vague Awareness</td>
<td>Raise awareness that the community can do something</td>
<td>• Get on local community event agendas for presenting information to unrelated community groups</td>
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<td>• Post flyers, posters, and billboards</td>
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<td>• Begin to initiate events (pot lucks, potlatches, etc.) and use those opportunities to present information on the issue</td>
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<td>• Conduct informal local surveys and interviews with community people by phone or door-to-door</td>
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<td>• Publish newspaper editorials and articles with general information and local implications</td>
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<tr>
<td>Stage 4: Preplanning</td>
<td>Raise awareness with concrete ideas to combat condition</td>
<td>• Introduce information through presentations and media</td>
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<td>• Visit and invest community leaders in the cause</td>
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<td></td>
<td></td>
<td>• Review existing efforts in community to determine target populations and the degree of success of efforts</td>
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<td></td>
<td>• Conduct local focus groups to discuss issues and develop strategies</td>
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<td></td>
<td></td>
<td>• Increase media exposure through radio and television public service announcements</td>
</tr>
<tr>
<td>Stage 5: Preparation</td>
<td>Gather existing information with which to plan strategies</td>
<td>• Conduct school and community surveys</td>
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<tr>
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<td>• Sponsor a community picnic to kick off the effort</td>
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<td>• Conduct public forums to develop strategies from the grassroots level</td>
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<td>• Utilize key leaders and influential people to speak to groups and participate in local radio and television shows</td>
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<td></td>
<td>• Plan how to evaluate the success of your efforts</td>
</tr>
<tr>
<td>Stage</td>
<td>Goal</td>
<td>Strategies</td>
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<td>----------------------------</td>
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</table>
| Stage 6: Initiation        | Provide community-specific information  | • Conduct in-service training on Community Readiness for professionals and paraprofessionals  
• Plan publicity efforts associated with start-up of activity/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  |
| Stage 7: Stabilization     | Stabilize efforts and programs           | • Plan community events to maintain support for the issue  
• Conduct training for community professionals and 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/submit articles detailing progress and future plans  
• Network among service providers and community systems  |
| Stage 8: Confirmation/Expansion | 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  |
| Stage 9: High Level of Community Ownership | 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 reassessment 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  |

IMPLICATIONS FOR EAST COUNTY

Because the levels of readiness for each of the six dimensions are different, it is suggested that the community work to first get all dimensions approximately equal before implementing efforts to move the community to the next overall level of readiness (Plested et al., 2006). Therefore, the next step for the East County Coalition is to attempt to raise their lowest score of 3.8, rounded down to 3 for Dimension B, Community Knowledge of Efforts. In doing so, it is likely that the other dimension levels will also increase, as all parts of a community are inter-related and changing one will invariably change another. Should East County attempt to increase community knowledge of efforts in the manner previously suggested, a pre/posttest should be administered to evaluate the technique for effectiveness. After which, East County should reassess all dimensions using the Community Readiness assessment tool using different key informants to determine their new level of readiness. The outcome of that reassessment will determine the next course of action. If the dimensions are grossly unequal, the Coalition should again work to make them comparable. If the dimensions are generally equal, efforts should concentrate on increasing the community’s overall level of readiness to the next stage. This process should be repeated until East County receives a readiness score of stage 9 indicating a “high level of ownership” where there exists “detailed and sophisticated knowledge about prevalence, causes, and consequences” and “effective evaluation guides new directions” (Plested et al., 2006).

When considering the angle at which to tackle these problems, the Coalition should attempt to implement as many suggestions from key informant responses as possible in addition to following the Community Readiness Model guidelines. Through this strategy the Coalition could expect some level of initial buy-in from the informants and quite possibly
from the areas of service they represent. Buy-in from the community’s leadership may make Coalition efforts more readily accepted and implemented, which in turn will likely increase the buy-in and participation of the general population.

One such suggestion that should be considered before implementing programs comes from Key Informant 4 (Health and Medical Professional) who addressed East County’s back country. When asked how leaders were involved with relationship violence the interviewee stated “There are no leaders . . . so getting community members involved is very difficult. Because they [program planners, etc.] are all outside organizations trying to come in and fix them, they don’t really work. There is no trust because they don’t know you. Even the health clinics are seen as ‘outsiders,’ and are only accessed when there is an absolute need.” The question of trust may also apply to other populations in East County and should be addressed by the Coalition. One program created to address trust is the PRC Partnership Trust Tool. This program was created by the Centers for Disease Control and Prevention (CDC) and attempts to open the lines of communication, thereby creating or increasing trust, between the entire community including program planners, academia, and the general population. The survey and its handbook are free online through the CDC website (CDC, 2009).

Many community programs are available to the Coalition that are free of charge and have histories of effectiveness. The Healthy Communities Program, also made available through the CDC, offers tools pertaining to community action such as “planning guides, evaluation frameworks, communications materials, health risk factors data and statistics, fact sheets, scientific articles, key reports, and state and local program contact information” (CDC, 2010). Additionally, the Domestic Violence Awareness Project (2009) offers resource information for campaigns that increase community awareness of domestic violence.
Campaigns such as Purple Ribbon and Silent Witness are described, and strategies and resources for implementation are provided.

**LIMITATIONS OF STUDY**

Limitations of this study include a need for clarifying knowledge of key informant recruiting methods. As a result of coming late into the process and a lack of interviewee or interviewer identification, several questions cannot be answered such as: Were all identified key informants contacted? How many attempts were made to contact them? Of those who were contacted, how many accepted or declined the interview?

A limitation of the interview process is the lack of providing interviewers with training in interviewing techniques other than a suggestion to tape record the interview for accuracy. This may have resulted in an inconsistency in the interview process, recording and/or transcribing. Also, since the interview tapes were not collected, interviewee responses cannot be verified. One example of the lack of training is Interview 1 (Law Enforcement). The interviewer allowed the interview to be conducted via email so that it cannot be certain if the interviewee understood all of the questions, and elaboration of questions could not be requested.

Because of the length of the interview, time may have also been a limitation to accurate results. Interview 6 (Community at Large) is evidence supporting this premise where the response for eight questions stated, “Due to time constraints, interviewee was unable to answer.” It is possible that the unanswered questions affected the overall and dimension, creating unreliable outcomes.
Lastly, law enforcement and county government key informants represented just over one half of all interviews. It is possible that the unbalanced number of interviews from these areas of service may have affected the accuracy of scores where prevention efforts are concerned. Those dimensions that assessed prevention efforts were scored much higher by those in law enforcement and county government than those in other areas of service.

**Implications for Future Research**

Because of the nature of the Community Readiness Model, East County will require a continuous number of evaluations and reassessments to move the community into ever increasing stages of readiness for relationship violence. Considering the initial lack of funding accompanied by the cut in support from the San Diego Office of Violence Prevention it is imperative that Coalition members, researchers and existing agencies and services pool their resources to aid East County in attaining their goals. This work will not only increase the reliability and validity of the Community Readiness Model, but may also aid in supporting resources used to accomplish goals.

**Summary and Conclusion**

The East County Domestic Violence Coalition was formed in response to the rise in incidence of domestic violence in East County. Along with other assessments, the Coalition utilized the Tri-Ethnic Center’s Community Readiness Model and key informant assessment tool to assess the readiness of East County to address relationship violence. While not scoring as high as they would have liked, the Coalition agreed that the overall score, placing the community in the Preplanning stage was an accurate assessment. Despite a general lack of funding and, recently, the lack of a larger organizations’ support, efforts continue to address
relationship violence in East County. Coalition members are passionate and eager to move their community towards the highest readiness stage possible. If the attitudes of the Coalition members are a reflection of the general population of East County, increasing the overall readiness level in a way that is both culturally competent and financially sustainable is a goal that is not only plausible but attainable. This project demonstrates the usefulness of the Community Readiness Model in assessing domestic violence and, with the use of the community readiness handbook along with efforts founded in established measures, East County’s next steps are clear.
REFERENCES


APPENDIX A

DOMESTIC VIOLENCE SERVICES/
EAST COUNTY
Awareness at the Individual Level:
East County Family Justice Center (ECFJ) (DV services)
Catholic Charities (social services, immigrant/refugee assistance)
CCS Prevention and Education Programs (counseling/therapy, DV shelter/housing)
Head Start (child/youth programs)
Probation (child/youth programs)
ACE study, (research – awareness)
Shadow Mountain (faith based)
Project PEACE/SHIELD (child/youth programs)
Incredible Years (child/youth programs)
YMCA (social services, child/youth programs, DV shelter/housing)

Awareness at the Interpersonal Level:
Center for Community Solutions (counseling/therapy, DV shelter/housing)
Child Welfare Services – Social Worker (social services)
East County Family Justice Center (DV services)
Shadow Mountain (faith based)
Project PEACE/SHIELD (child/youth programs)
Incredible Years (child/youth programs)

Awareness at the Organizational Level:
Center for Community Solutions (counseling/therapy, DV shelter/housing)
Raising the Bar (systems advocacy)
Institute for Public Strategies (trainings, policy support)
East County Family Justice Center (DV services)
Project PEACE/SHIELD (child/youth programs)
Safe Start- Train the Trainer (counseling/therapy, training/education, systems advocacy)

Awareness at the Community Level:
Raising the Bar (systems advocacy)
Institute for Public Strategies (training, policy support)
East County Family Justice Center (DV services)
Shadow Mountain (faith based)

Awareness in Public Policy:
Institute for Public Strategies (training, policy support)

Prevention at the Individual Level:
Center for Community Solutions (counseling/therapy, DV shelter/housing)
211 Hotline (referral services)
Head Start (child/youth programs)
Catholic Charities (social services, immigrant/refugee assistance)
YMCA (social services, child/youth programs, DV shelter/housing)
Incredible Years (child/youth programs)
East County Family Justice Center (DV services)
Probation (child/youth programs)  
Girl Scouts (child/youth programs)  
ACE Study (research-prevention)  
Project PEACE/SHIELD (child/youth programs)

**Prevention at the Interpersonal Level:**  
Child Welfare Services – Social Worker/TDM (social services)  
Incredible Years (child/youth programs)  
East County Family Justice Center (DV services)  
Girl Scouts (child/youth programs)  
Project PEACE/SHIELD (child/youth programs)  
Center for Community Solutions (counseling/therapy, DV shelter/housing)

**Prevention at the Organizational Level:**  
Safe Start (train the trainers) – (counseling/therapy, training/education, systems advocacy)  
Raising the Bar (systems advocacy)  
Institute for Public Strategies (training, policy support)  
East County Family Justice Center (DV services)  
Project PEACE/SHIELD (child/youth programs)  
Shadow Mountain (faith based)

**Prevention at the Community Level:**  
East County Family Justice Center (DV services)  
ACE Study (research-prevention)  
Institute for Public Strategies (training, policy support)

**Prevention in Public Policy:**

- **Identification at the Individual Level:**
  
  - Law Enforcement Protocol (ID methods)  
  - Rady Children’s Hospital – Chadwick Center (counseling/therapy, ID methods, screening methods, assessment tools)  
  - School Counselors/Nurses (ID methods, counseling/therapy)  
  - Child Welfare Services – Social Worker/TDM (id methods, screening methods)  
  - Public Health Nursing Standard Screening (id methods, social services)  
  - Girl Scouts (ID methods, child/youth programs)  
  - Family Resource Centers (ID methods, social services)  
  - Domestic Violence Hotline (ID methods, referral services)  
  - Project PEACE/SHIELD (ID methods, child/youth programs)

- **Identification at the Interpersonal Level:**
  
  - Project PEACE/SHIELD (ID methods, child/youth programs)  
  - Child Welfare Services – Social Worker/TDM (id methods, screening methods), Girl Scouts (ID methods/child/youth programs)  
  - Family Resource Centers (ID methods, social services)

- **Identification at the Organizational Level:**
  
  - Law Enforcement Protocol (ID methods)
Public Health Nursing Standard Screening (ID methods, social services)
Child Welfare Services – Social Worker/TDM (ID methods, screening methods)

- **Identification at the Community Level:**
  
  Public Health Nursing Standard Screening (ID methods, social services)
  Law Enforcement Protocol (id methods)
  Child Welfare Services – Social Worker/TDM (ID methods, screening methods)

**Identification in Public Policy:**

- **Screening at the Individual Level:**
  
  Child Welfare Services – Social Worker/TDM (screening methods)
  Rady Children’s Hospital – Chadwick Center (counseling/therapy, ID methods, screening methods, assessment tools)
  Public Health Nursing Standard Screening (ID methods, screening methods, social services)
  Law Enforcement Protocol (ID methods, screening methods)
  Domestic Violence Hotline (screening methods, referral services)
  School Counselors/Nurses (screening methods)

- **Screening at the Interpersonal Level:**
  
  Child Welfare Services – Social Worker/TDM (screening methods)
  Law Enforcement Protocol (ID methods, screening methods)
  Public Health Nursing Standard Screening (ID methods, screening methods, social services)

- **Screening at the Organizational Level:**
  
  Child Welfare Services – Social Worker/TDM (screening methods)
  Law Enforcement Protocol (ID methods, screening methods)
  Public Health Nursing Standard Screening (ID methods, screening methods, social services)

**Screening at the Community Level**

**Screening in Public Policy**

**Assessment at the Individual Level:**

Public Health Nursing Standard Screening – Danger Assessment (assessment tools)
Rady Children’s Hospital – Chadwick Center (counseling/therapy, ID methods, screening methods, assessment tools)
Head Start- First 5 Grant (assessment tools, social services)
School Counselors/Nurses (assessment tools)

**Assessment at the Interpersonal Level**

**Assessment at the Organizational Level**

**Assessment at the Community Level**

**Assessment in Public Policy**

**Intervention at the Individual Level:**

Center for Community Solutions (counseling/therapy)
211 Hotline (referral services)
Catholic Charities (social services, immigrant/refugee assistance)
YMCA (social services, child/youth programs, DV shelter/housing)
Rady Children’s Hospital – Chadwick Center (counseling/therapy, ID methods, screening methods, assessment tools)
Shadow Mountain (faith based)
East County Family Justice Center (DV services)
County Probation (child/youth programs)
Incredible Years (child/youth programs)
Child Welfare – Social Workers/TDM (social services)

**Intervention at the Interpersonal Level:**
Center for Community Solutions (counseling/therapy, DV shelter/housing)
Incredible Years (child/youth programs)
East County Family Justice Center (DV services)
Child Welfare – Social Workers/TDM (social services)
Shadow Mountain (faith based)
Rady Children’s Hospital – Chadwick Center (counseling/therapy)

**Intervention at the Organizational Level:**
East County Family Justice Center (DV services)

**Intervention at the Community Level:**
East County Family Justice Center (DV services)

**Intervention in Public Policy:**
Mental Health Services Act (designated resources)
APPENDIX B

TRI-ETHNIC CENTER’S ORIGINAL ASSESSMENT TOOL
A. COMMUNITY EFFORTS (programs, activities, policies, etc.)
AND
B. COMMUNITY KNOWLEDGE OF EFFORTS

1. Using a scale from 1-10, how much of a concern is this issue in your community (with 1 being “not at all” and 10 being “a very great concern”)? Please explain. (NOTE: this figure between one and ten is NOT figured into your scoring of this dimension in any way – it is only to provide a reference point.)

2. Please describe the efforts that are available in your community to address this issue. (A)

3. How long have these efforts been going on in your community? (A)

4. Using a scale from 1-10, how aware are people in your community of these efforts (with 1 being “no awareness” and 10 being ”very aware”)? Please explain. (NOTE: this figure between one and ten is NOT figured into your scoring of this dimension in any way – it is only to provide a reference point.) (B)

5. What does the community know about these efforts or activities? (B)

6. What are the strengths of these efforts? (B)

7. What are the weaknesses of these efforts? (B)

8. Who do these programs serve? (Prompt: For example, individuals of a certain age group, ethnicity, etc.) (A)

9. Would there be any segments of the community for which these efforts/services may appear inaccessible? (Prompt: For example, individuals of a certain age group, ethnicity, income level, geographic region, etc.) (A)

10. Is there a need to expand these efforts/services? If not, why not? (A)

11. Is there any planning for efforts/services going on in your community surrounding this issue? If yes, please explain. (A)

12. What formal or informal policies, practices and laws related to this issue are in place in your community, and for how long? (Prompt: An example of “formal” would be established policies of schools, police, or courts. An example of “informal” would be similar to the police not responding to calls from a particular part of town, etc.) (A)
13. Are there segments of the community for which these policies, practices and laws may not apply? (Prompt: For example, due to socioeconomic status, ethnicity, age, etc.) (A)

14. Is there a need to expand these policies, practices and laws? If so, are there plans to expand them? Please explain. (A)

15. How does the community view these policies, practices and laws? (A)

C. LEADERSHIP

16. Who are the "leaders" specific to this issue in your community?

17. Using a scale from 1 to 10, how much of a concern is this issue to the leadership in your community (with 1 being “not at all” and 10 being “of great concern”)? Please explain. (NOTE: this figure between one and ten is NOT figured into your scoring of this dimension in any way – it is only to provide a reference point.)

18. How are these leaders involved in efforts regarding this issue? Please explain. (For example: Are they involved in a committee, task force, etc.? How often do they meet?)

19. Would the leadership support additional efforts? Please explain.

D. COMMUNITY CLIMATE

20. Describe ________________________________ (name of your community).

21. Are there ever any circumstances in which members of your community might think that this issue should be tolerated? Please explain.

22. How does the community support the efforts to address this issue?

23. What are the primary obstacles to efforts addressing this issue in your community?

24. Based on the answers that you have provided so far, what do you think is the overall feeling among community members regarding this issue?

E. KNOWLEDGE ABOUT THE ISSUE

25. How knowledgeable are community members about this issue? Please explain. (Prompt: For example, dynamics, signs, symptoms, local statistics, effects on family and friends, etc.)

26. What type of information is available in your community regarding this issue?

27. What local data are available on this issue in your community?
28. How do people obtain this information in your community?

F. RESOURCES FOR PREVENTION EFFORTS (time, money, people, space, etc.)

29. To whom would an individual affected by this issue turn to first for help in your community? Why?

30. On a scale from 1 to 10, what is the level of expertise and training among those working on this issue (with 1 being “very low” and 10 being “very high”)? Please explain. (NOTE: this figure between one and ten is NOT figured into your scoring of this dimension in any way – it is only to provide a reference point.)

31. Do efforts that address this issue have a broad base of volunteers?

32. What is the community’s and/or local business’ attitude about supporting efforts to address this issue, with people volunteering time, making financial donations, and/or providing space?

33. How are current efforts funded? Please explain.

34. Are you aware of any proposals or action plans that have been submitted for funding that address this issue in your community? If yes, please explain.

35. Do you know if there is any evaluation of efforts that are in place to address this issue? If yes, on a scale of 1 to 10, how sophisticated is the evaluation effort (with 1 being “not at all” and 10 being “very sophisticated”)? (NOTE: this figure between one and ten is NOT figured into your scoring of this dimension in any way – it is only to provide a reference point.)

36. Are the evaluation results being used to make changes in programs, activities, or policies or to start new ones?
APPENDIX C

TRI-ETHNIC CENTER’S ANCHORED RATING SCALE
Dimension A. Existing Community Efforts

1 No awareness of the need for efforts to address the issue.

2 No efforts addressing the issue.

3 A few individuals recognize the need to initiate some type of effort, but there is no immediate motivation to do anything.

4 Some community members have met and have begun a discussion of developing community efforts.

5 Efforts (programs/activities) are being planned.

6 Efforts (programs/activities) have been implemented.

7 Efforts (programs/activities) have been running for several years.

8 Several different programs, activities and policies are in place, covering different age groups and reaching a wide range of people. New efforts are being developed based on evaluation data.
9 Evaluation plans are routinely used to test effectiveness of many different efforts, and the results are being used to make changes and improvements.
Dimension B. Community Knowledge Of The Efforts

1 Community has no knowledge of the need for efforts addressing the issue.

2 Community has no knowledge about efforts addressing the issue.

3 A few members of the community have heard about efforts, but the extent of their knowledge is limited.

4 Some members of the community know about local efforts.

5 Members of the community have basic knowledge about local efforts (e.g., purpose).

6 An increasing number of community members have knowledge of local efforts and are trying to increase the knowledge of the general community about these efforts.

7 There is evidence that the community has specific knowledge of local efforts including contact persons, training of staff, clients involved, etc.

8 There is considerable community knowledge about different community efforts, as well as the level of program effectiveness.

9 Community has knowledge of program evaluation data on how well the different local efforts are working and their benefits and limitations.
Dimension C. Leadership (includes appointed leaders & influential community members)

1 Leadership has no recognition of the issue.

2 Leadership believes that this is not an issue in their community.

3 Leader(s) recognize(s) the need to do something regarding the issue.

4 Leader(s) is/are trying to get something started.

5 Leaders are part of a committee or group that addresses this issue.

6 Leaders are active and supportive of the implementation of efforts.

7 Leaders are supportive of continuing basic efforts and are considering resources available for self-sufficiency.

8 Leaders are supportive of expanding/improving efforts through active participation in the expansion/improvement.

9 Leaders are continually reviewing evaluation results of the efforts and are modifying support accordingly.
**Dimension D. Community Climate**

1. The prevailing attitude is that it’s not considered, unnoticed or overlooked within the community. “It’s just not our concern.”

2. The prevailing attitude is “There’s nothing we can do,” or “Only ‘those’ people do that,” or “We don’t think it should change.”

3. Community climate is neutral, disinterested, or believes that the issue does not affect the community as a whole.

4. The attitude in the community is now beginning to reflect interest in the issue. “We have to do something, but we don’t know what to do.”

5. The attitude in the community is “we are concerned about this,” and community members are beginning to reflect modest support for efforts.

6. The attitude in the community is “This is our responsibility” and is now beginning to reflect modest involvement in efforts.

7. The majority of the community generally supports programs, activities, or policies. “We have taken responsibility.”

8. Some community members or groups may challenge specific programs, but the community in general is strongly supportive of the need for efforts. Participation level is high. “We need to keep up on this issue and make sure what we are doing is - effective.”
9 All major segments of the community are highly supportive, and community members are actively involved in evaluating and improving efforts and demand accountability.
Dimension E. Community Knowledge About The Issue

1 Not viewed as an issue.

2 No knowledge about the issue.

3 A few in the community have some knowledge about the issue.

4 Some community members recognize the signs and symptoms of this issue, but information is lacking.

5 Community members know that the signs and symptoms of this issue occur locally, and general information is available.

6 A majority of community members know the signs and symptoms of the issue and that it occurs locally, and local data are available.

7 Community members have knowledge of, and access to, detailed information about local prevalence.

8 Community members have knowledge about prevalence, causes, risk factors, and consequences.
9 Community members have detailed information about the issue as well as information about the effectiveness of local programs.
Dimension F. Resources Related To The Issue (people, money, time, space, etc.)

1 There is no awareness of the need for resources to deal with this issue.

2 There are no resources available for dealing with the issue.

3 The community is not sure what it would take, (or where the resources would come from) to initiate efforts.

4 The community has individuals, organizations, and/or space available that could be used as resources.

5 Some members of the community are looking into the available resources.

6 Resources have been obtained and/or allocated for this issue.

7 A considerable part of support of on-going efforts are from local sources that are expected to provide continuous support. Community members and leaders are beginning to look at continuing efforts by accessing additional resources.

8 Diversified resources and funds are secured and efforts are expected to be ongoing. There is additional support for further efforts.
9 There is continuous and secure support for programs and activities, evaluation is routinely expected and completed, and there are substantial resources for trying new efforts.

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