

Indiana's Commitment to Primary Prevention: A State Free of Sexual Violence ~ 2010-2015

Background of Indiana's Planning Process and Needs and Resources Assessment Summaries

A. Context of the Planning Process

At the beginning of Year Two (December 2007) of Indiana's Sexual Violence Prevention and Education Cooperative Agreement with the Centers for Disease Control and Prevention, the Indiana State Department of Health (ISDH) faced two main tasks:

- To demonstrate leadership in the public health approach to sexual violence primary prevention; and
- To organize a statewide coalition around sexual violence primary prevention for the purpose of developing and implementing a state plan.

The Indiana Sexual Violence Primary Prevention Council convened for the first time in December 2007. Over the next year, Council members became acquainted with one another, learned how their work and the work of their colleagues aligned with preventing sexual violence, identified additional partners to bring to the table, and developed a common understanding of primary prevention of sexual violence. By bringing sexual violence prevention to the forefront as a public health issue, the ISDH was able to facilitate discussion around the importance of dedicating resources to primary prevention. The group agreed that it would be necessary to learn about the state of sexual violence in Indiana before formulating a prevention plan, and that a needs and resources assessment would be in order as the first step of the state planning process.

The Council used Step 1 (Needs and Resources Assessment) and Step 2 (Goals and Outcomes) of *Getting to Outcomes* (GTO), the CDC-recommended planning tool, to help guide the planning process. Although some of the recommendations provided in the first two steps of GTO were not applicable to Indiana's planning process, GTO provided a useful framework for the state plan. The Council also used some of the principles included in Step 3 (Selection of Evidence-Informed Strategies), Step 4 (Strategy Adaptation for State/Community Context), and Step 5 (Capacity Building for Strategy Implementation) to identify and contextualize state-level strategies to accomplish the identified outcomes.

Many Council members were involved from the very beginning and have actively assisted with the needs and resources assessment and with the formulation of the goals, outcomes, and strategies for the plan. Other Council members have been involved only briefly or on an "ad hoc" basis due to staff turnover, competing priorities, or the timeframe at which they became involved with plan development. As the ISDH oversees the implementation of the state plan, Council leadership will continually assess its

makeup to ensure appropriate representation from major stakeholders. Additionally, the Council will be restructured during the implementation phase to ensure that needed resources and expertise are allocated to accomplish the goals of the plan. (See Appendix A for acknowledgement of Council members).

B. The Needs and Resources Assessment Summaries

The Rape Prevention and Education Program Director led the needs and resources assessment in partnership with the Sexual Violence Primary Prevention Council and many other state and community-level stakeholders. The Council completed the majority of the work of the needs and resources assessment between September 2008 and April 2009.

Going through the needs and resources assessment process served the purpose of increasing stakeholders' involvement and analyzing quantitative and qualitative data about the dynamics of sexual violence in Indiana. The needs and resources assessment is comprised of six distinct components:

- Demographic and economic data;
- Current sexual violence primary prevention efforts in Indiana;
- Indiana sexual violence magnitude data/Data and surveillance assessment;
- Qualitative risk and protective factor data from Indiana citizens and professionals;
- Focus groups with selected populations; and
- Prevention system capacity assessments.

A very brief summary of each component and its findings is given below. (See plan appendices B through H2 referenced in the descriptions below for in-depth detail of the assessments' findings.)

B-1) Demographic and Economic Data¹

The first step of the needs and resources assessment was to gather demographic and economic data for the state and for its eleven Economic Growth Regions, as defined by the Indiana Department of Workforce Development. Because research has shown that certain demographic and economic variables can serve as risk factors for or protective factors against being a perpetrator or a victim of sexual violence, the Centers for Disease Control recommended collecting this data to create a basic understanding of broad contextual factors in the state.

Indiana population data assisted in identifying certain age groups that should be addressed for sexual violence prevention efforts. More than a quarter of Indiana's population (34.5%) is between the ages of 0-24. Twenty-seven percent of the population

¹ Demographic and economic data obtained from the U.S. Census Bureau, U.S. Bureau of Economic Analysis, the Indiana Business Research Center, the Indiana Department of Education, the Indiana Family and Social Services Agency, and the Indiana Department of Workforce Development.

is classified as young adults (25-44 years). Older adults (45-64 years) comprise 26% of the population, and adults over 65 make up the remainder (12.5%). Youth are at greater risk for sexual violence than the general population, and violence prevention strategies are most effective when implemented over the lifespan, beginning at a young age when core beliefs and values are being formed. Therefore, youth are a priority population of Indiana's sexual violence prevention state plan. This is reflected in the outcome statements focusing on working through systems that serve youth: K-12 schools, youth and family-serving organizations, and colleges and universities.

Indiana's population has become more racially and ethnically diverse over the years. An expanded focus on culturally appropriate prevention strategies is necessary to better serve the Hispanic and Latino demographic (5% of the current population, and projected to grow in the future with the changing immigration and economic dynamics in the state). Additionally, 9% of Indiana's total population identifies as Black or African-American. This percentage is significantly higher in the urban regions of the state: 17.1% in Economic Growth Region 1 (includes Lake County) and 14.6% in Economic Growth Region 5 (includes Marion County).

The national economic conditions of the past two years have adversely affected every state's economy, and Indiana is no exception. The Centers for Disease Control and Prevention (CDC) has identified a lack of employment opportunities and poverty as risk factors for sexual violence perpetration. As is the case with every other state, the current economic recession has deeply impacted Indiana's unemployment rate. In January 2008, Indiana's seasonally adjusted unemployment rate was 5%; in January 2009, the unemployment rate had almost doubled to reach 9%. It will be important to recognize that psychological stress, financial hardship, and poverty can contribute to a host of social problems, including increased risk for sexual violence.

(See Appendix B for a detailed breakdown of state and regional demographic and economic data and noted influential contextual circumstances in Indiana.)

B-2) Current Sexual Violence Primary Prevention Efforts in Indiana

Another crucial step of the needs and resources assessment was to assess the quantity and quality of sexual violence primary prevention programming in Indiana. There are four agencies/organizations/initiatives whose efforts make up the state-level sexual violence primary prevention efforts in Indiana:

- Indiana State Department of Health (ISDH);
- Indiana Coalition Against Sexual Assault (INCASA);
- Multicultural Efforts to End Sexual Assault (MESA); and
- Indiana Campus Sexual Assault Primary Prevention Project (INCSAPPP).

The partners listed above will work to strengthen collaboration and coordination efforts with additional partners over the course of the plan. They will also be charged with ensuring program sustainability at state and community levels.

Indiana State Department of Health (ISDH)

The Indiana State Department of Health (ISDH) provides statewide leadership in the public health approach to sexual violence prevention. Several outcomes of the state plan are designed to maintain the ISDH's commitment to prevention efforts in Indiana: coordinating and managing the work of the Sexual Violence Primary Prevention Council, providing guidance on program and strategy implementation, informing policymakers, and cultivating state-level strategic partnerships that are critical to accomplishing many outcomes in the state plan.

Indiana Coalition Against Sexual Assault (INCASA)

The Indiana Coalition Against Sexual Assault (INCASA), serves four primary functions for statewide sexual violence primary prevention efforts: 1) Distributing funding to communities implementing primary prevention programs (thirteen community-based programs in 2010); 2) Providing professional training and technical assistance to providers; 3) Formulating and disseminating Indiana's sexual violence prevention social marketing campaign; and 4) Providing statewide leadership and support in engaging men to prevent sexual violence at the state level and in communities. INCASA serves as a primary prevention resource both for communities that receive CDC Cooperative Agreement funding and those who do not.

INCASA will take a leadership position on the majority of the outcomes for the state plan, including those set forth to build capacity to prevent sexual violence in various sectors, increasing the quality of technical assistance provided to communities, and supporting community and state-level efforts to engage men in the work of preventing sexual violence.

(See Appendix C for additional description of INCASA's work.)

Multicultural Efforts to End Sexual Assault (MESA)

Multicultural Efforts to End Sexual Violence (MESA) prioritizes engaging non-mainstream, marginalized populations in sexual violence prevention through a culturally appropriate framework. Currently, the demographics primarily served are Indiana's migrant farm workers and American Indian populations.

MESA has built a strong rapport with the special populations it has served over the years. These populations were chosen based on the expertise and connections of the MESA staff. The rationale behind the fifth goal of the state plan is to conduct further research to determine which selected populations are not included in mainstream sexual violence primary prevention efforts and prioritize leadership in violence prevention in those communities.

Indiana Campus Sexual Assault Primary Prevention Project (INCSAPPP)

The Indiana Campus Sexual Assault Primary Prevention Project (INCSAPPP) offers sexual violence primary prevention technical assistance to all Indiana campuses and mini-grants and specialized training to certain campuses working on one or more of the INCSAPPP's six components of comprehensive programming: social marketing, male involvement, bystander intervention, policy analysis, data collection, and coalition building.

The Indiana Campus Sexual Assault Primary Prevention Project has cultivated long-standing, strong relationships with many colleges and universities in Indiana. Five campuses have been designated "model campuses," working simultaneously on all six components. Others are focusing on one or more components. This model has worked well, and the state plan includes an outcome dedicated to increasing the percentage of Indiana's campuses that incorporate at least four of the six comprehensive approaches.

B-3) Indiana Sexual Violence Magnitude Data/ Data and Surveillance Assessment

An assessment of the magnitude, prevalence, and occurrence of sexual violence in Indiana's population was also necessary to gauge the true impact of the problem. Unfortunately, in Indiana as well as nationally, the true magnitude and impact of sexual violence on the population is difficult to assess because of fragmented data collection systems and under-reporting of sexual violence crimes.

Indiana is one of only three states that lack a centralized state crime data collection program certified by the Federal Bureau of Investigation (New Mexico and Mississippi are the other two). Additionally, there is no state legislation that mandates collection of crime data. Thus, law enforcement agency crime data collection is voluntary and unregulated. Crime reporting to the FBI's Uniform Crime Report varies considerably among Indiana law enforcement agencies and the jurisdictions they cover.² Under-reported crime data from local Indiana agencies, compounded by the incredibly low reporting of rape and sexual assault to law enforcement in general, compromises the accuracy of the Uniform Crime Report's figure of 1,720 rapes reported to participating law enforcement agencies in Indiana in 2008.³

Because of the limitations of reported crime data, prevalence surveys are often used to estimate the true magnitude of sexual violence. In 2007, the Indiana Coalition Against Sexual Assault partnered with the Indiana University Public Opinion Lab to design and conduct the first Female Victimization in Indiana Survey. The survey data provided lifetime prevalence rates of sexual assault, rape and other crimes among Indiana women over the age of 18, as well as the nature of the relationship between the victim and the perpetrator and whether or not the crime was reported to the authorities. The survey found that 13% of Indiana women over the age of 18 have experienced a completed rape at some point in their lives. Eighteen percent of the sample reported experiencing

² Stucky, Thomas and Thelin, Rachel. "Timely and Accurate Data Reporting Is Important for Fighting Crime." Center for Urban Policy and the Environment. May 2007.

³ "Indiana Crime Rates 1960-2008", Uniform Crime Report, Federal Bureau of Investigation

another type of sexual assault in their lives, and 20% reported experiencing attempted rape.⁴

Consistent with what is known nationally about the relationships of sexual assault perpetrators to victims, the 2007 Female Victimization in Indiana Survey found that most women who reported being a victim of attempted and/or completed rape knew the perpetrator, most often as a friend. Only 12.3% of the women who experienced a completed rape actually reported the crime to legal authorities. (See Appendix C for a detailed analysis of the State Victimization Survey).

The major limitations of the Female Victimization in Indiana survey were threefold: 1) Prevalence of sexual violence against males was not measured; 2) Only those who had land-line telephones were eligible to be in the sample, leaving out a significant segment of the population (exclusive cell phone users and those without any telephone access); and 3) Geographic analysis was not used to map the results.

Some 2007 data on sexual violence prevalence among Indiana high school students is also available through the Youth Risk Behavior Survey, which included one question about forced sexual intercourse and another about intimate partner violence. This data confirms what has been documented in the research: sexual violence is affecting youth at alarming rates. The 2007 Youth Risk Behavioral Survey found that 9.4% of Indiana high school students (grades 9-12) reported having been physically forced to have sexual intercourse when they did not want to. Breaking the question down by gender, 13.2% of female high school students and 5.3% of male high schools students indicated that they had been physically forced to have sexual intercourse. Data from the 2009 Youth Risk Behavioral Survey will be available soon.

Reliable and accurate data informs the development of any effective public health intervention. Sound data is the basis of knowing where to focus efforts, as well as a tool that can be used to garner support from policymakers and the general public and to evaluate the impact of interventions over time. Enhancing Indiana's capacity for better sexual violence data collection, usage, and sharing is absolutely essential in moving the understanding of sexual violence and potential prevention solutions forward. Therefore, the sixth goal of Indiana's state plan focuses on making the best use of available data collection and analysis tools to guide efforts, as well as keeping up with the newest and best tools that will emerge in the future to track the incidence and prevalence of sexual violence nationally and in Indiana.

(See Appendix D for the analysis report of the data currently available on sexual violence prevalence and magnitude in Indiana.)

B-4) Qualitative Risk and Protective Data from Indiana Citizens and Professionals

⁴Sidenbender, S., Wolf, J., & Jolliff, A. "Female Victimization in Indiana-2008: Summary of Methods and Findings". Survey Research Center at IUPUI. 2008.

To gain greater insight into dynamics of sexual violence in Indiana, a qualitative data gathering process was planned as an important part of the needs and resources assessment. The parameters of the qualitative data gathered were defined by the Sexual Violence Primary Prevention Council and included: perceived risk factors for and protective factors against sexual violence in communities, potential prevention solutions, and suggestions for priorities to include in Indiana's sexual violence primary prevention plan. PeopleWork Associates, a consulting company experienced in issues pertaining to sexual violence, led this part of the needs and resources assessment. In partnership with the ISDH, local health departments, service providers, and other partners throughout the state, PeopleWork Associates planned and facilitated a series of ten public forums designed to capture the types of qualitative data mentioned above.

The ten geographically diverse forums took place in November and December 2008. The forums drew a broad attendance, including service providers (representatives from community rape crisis centers, law enforcement, members of the criminal justice system, medical professionals and public health professionals, etc), as well as many other stakeholders including: faith leaders, representatives from organizations serving marginalized populations (including the homeless) teachers and school administrators, college students, legislators, media representatives, and concerned community members. The Council assisted in planning the forums and inviting groups and individuals to attend. (See Appendix E for a detailed description of the process used to recruit forum participants.)

Forum participants made interesting observations about risk factors for sexual violence perpetration and victimization. (There was not a specific, targeted question about risk and protective factors during the forums, but some of this information emerged during responses to the question: Why do you think sexual violence occurs?) The majority of the observations about risk factors for sexual violence perpetration mirrored those that have been identified by the CDC, and additional discussion provided contextual perspective for Indiana. Risk factor themes that arose continuously during the forums are outlined in Table 1.

Table 1: Forum Participants’ Identified Risk Factors for Sexual Violence Perpetration

Level of Social Ecological Model	Risk Factors: Sexual Violence Perpetration
Individual	<ul style="list-style-type: none"> • Alcohol and drug use • Low self-esteem and self-efficacy • Lack of empathy
Relationship	<ul style="list-style-type: none"> • Lack of supportive and positive family environments modeling healthy relationships and parenting • Poor peer influences
Community	<ul style="list-style-type: none"> • Lack of collective efficacy, positive role models and youth empowerment opportunities in communities • Lack of healthy relationships and bystander education opportunities in schools and other organizations • Poverty, economic disenfranchisement and unemployment • Lack of criminal justice system efficacy around the problems of sexual violence and other forms of crime
Society	<ul style="list-style-type: none"> • A culture that tolerates sexual entitlement and promiscuous behavior (for both men and women) • Societal and cultural norms in certain non-mainstream populations • Normalization of violence and linkage of violence and sexuality in the media

Often, forum participants who identified risk factors implied that the opposite of a risk factor would be a protective factor—i.e., while a lack of a supportive and positive family environment modeling healthy relationships and parenting would be considered a risk factor, the presence of such would be considered a protective factor.

Clearly, this large list of risk factors is too broad to address comprehensively in the next six years, and many of these factors go beyond the scope of what the state plan is able to address. The Sexual Violence Primary Prevention Council prioritized goals and outcomes to address identified risk factors that seem to be the most modifiable from a state-level, population-based standpoint. The Council gave careful consideration to public opinion on risk and protective factors when identifying plan priorities. At the same time, Council leadership applied practical knowledge about the scope and capabilities of the plan and capacity of the current infrastructure when making final decisions about goals and objectives.

While there were intensive efforts to recruit broad representation at the public forums, it is necessary to acknowledge the limitations of this method of collecting qualitative data. The individuals in attendance at the forums self-selected; that is, a scientific method of recruiting participants to reflect the demographics and dynamics of Indiana's population was not utilized. Most of the participants were highly educated and at least somewhat familiar with sexual violence and related issues, so the data collected cannot be assumed to be reflective of the beliefs and attitudes of Indiana's population. However, this methodology did provide an opportunity to gain insight on the dynamic and context of sexual violence prevention in Indiana.

(See Appendix E and its various attachments for a detailed report on the process and results of the public forums).

B-5) Focus Groups with Selected Populations

Council members and program staff solicited input from several different selected populations during the needs and resources assessment process. The MESA (Multicultural Efforts to End Sexual Assault) Director conducted a series of three focus groups with migrant farm workers and migrant farm worker service providers to examine farm workers and professional farm worker service providers' perceptions about sexual violence and how it could be prevented. The discussion concentrated upon the experiences of farm workers with sexual harassment and sexual violence in their work and personal lives. (Appendix F features a summary report of the qualitative data gathered from the migrant farm worker and farm worker service provider focus groups). The MESA director also conducted Talking Circles (a culturally relevant Native American technique for discussing issues and conducting research) with the intertribal American Indian community in Indiana to assess perceptions of and potential prevention solutions to sexual violence. The Talking Circles revealed how sexual violence intersects with different forms of economic and social oppression that the Native community experiences. In addition, Indiana's intertribal Native community has identified the need for healing from past abuses as the next step in moving prevention forward.

A representative of the Indiana Minority Health Coalition (IMHC) serves on the Sexual Violence Primary Prevention Council. The IMHC representative suggested that local coalitions would have valuable input on how to mobilize racial and ethnic minorities in the sexual violence prevention movement. On January 22, 2009, the ISDH hosted a small meeting for several local minority health coalitions to learn about sexual violence primary prevention efforts in the state of Indiana and give input on strategies to make sexual violence primary prevention programming and messaging culturally salient. A recurring point in this discussion was working through faith communities to reach many minority populations, particularly African-Americans and Latinos. (See Appendix G for the notes from the meeting with representatives from local minority health coalitions).

B-6) Prevention System Capacity Assessments

A survey for professionals working directly or indirectly in the field of sexual violence primary prevention was developed to assess the prevention system capacity in Indiana. It was distributed through the Sexual Violence Primary Prevention Council, as well as through various networks of other professionals who work either directly or indirectly in sexual violence prevention. Survey respondents were asked to answer a series of questions about their perceptions of the support system for sexual violence primary prevention efforts in Indiana, including financial resources, training and technical assistance, use of evidence-informed strategies/programs, evaluation capacity, partnerships and collaboration, policy, and data collection.

The survey was analyzed in two different ways: 1) Using all respondents' answers and 2) Using respondents who answered "yes" to the filtering question "Are you directly involved in the management or execution of a state or community-based sexual violence primary prevention program?" The rationale for these two separate analyses was that those who were directly involved in a state or community-based comprehensive sexual violence prevention program would offer different insight than other professionals who work more indirectly on the issue. Those who answered affirmatively to the question stated above were directed to answer a more specific series of questions about evidence-informed strategies/programs, program evaluation capacity, and the strengths of partnerships and collaboration. All respondents answered questions about financial resources, training and technical assistance, policy, and data collection.

Findings of the survey as they relate to several components of Indiana's prevention system capacity are described below. Appendix H-1 is a summary of all respondents' answers. Appendix H-2 is a summary from respondents who affirmatively answered the filtering question "Are you directly involved in the management or execution of a state or community-based sexual violence primary prevention program?"

Current State and Local Evaluation Efforts and Capacity

While the majority of respondents who were not directly involved in managing a sexual violence primary prevention program responded that they could not rate evaluation

efforts and capacity, those who were directly managing programs rated current state and local evaluation efforts as “somewhat strong.” The majority indicated they understood “well” or “moderately well” how to use common program evaluation tools, such as process measures, pre/post tests, key informant interviews, focus groups, surveys, and magnitude, prevalence, and occurrence data. The majority cited a lack of financial resources as the main barrier to improved evaluation capacity.

An understanding of evaluation methods does not always translate into using them effectively. Outcome evaluation measures comprise the basis for quality improvement in a program. Process measures (activities conducted, numbers of participants reached, etc.) are important, but cannot capture whether or not an intervention has been successful in changing behaviors. A consultant who planned and conducted a primary prevention training series for Indiana in summer 2009 reported that among many local programs, process evaluation was strong, but outcome evaluation was weak.

State-level primary prevention efforts vary in terms of the level of evaluation capacity. To address the need to strengthen program evaluation in Indiana, trainings provided to community and state-level programs will include evaluation modules. The third goal of the plan includes an outcome charging the Sexual Violence Primary Prevention Council with developing a resource guide for state and local programs that includes evidence-based evaluation tools. Programs will be required to demonstrate how they plan to integrate these tools into their program evaluation methods, with the ultimate goal of being able to better assess the effectiveness of the strategies they are using to prevent sexual violence.

State Data and Surveillance Capacity

See page 5, Section B-3) Indiana Sexual Violence Magnitude Data/ Data and Surveillance Assessment.

State Prevention Funding Capacity

In Indiana, the main source of funding for sexual violence prevention originates from the Centers for Disease Control and Prevention in the form of the Rape Prevention and Education Cooperative Agreement. The estimated amount of Indiana’s Cooperative Agreement for 2010 is a little more than \$800,000. Currently, Indiana’s state budget does not include any state dollars allocated to sexual violence prevention. State and community-level programs have become proficient in supplementing the CDC prevention funds by applying for grants from other sources, including local foundations and charities, soliciting support from businesses and individuals in the community, and partnering with other organizations to pool resources.

It has become increasingly clear that Indiana cannot continue to rely solely on the Sexual Violence Prevention and Education Cooperative Agreement funds to support prevention efforts for the entire state. For this reason, the Council prioritized increased funding for sexual violence prevention in the state plan (as an outcome under the second goal). There

are various strategies that stakeholders can employ to achieve this outcome, including presenting data on the economic impact of sexual violence to policymakers and businesses to encourage investment in prevention and collaborating with partners who have access to other funding streams to integrate sexual violence prevention priorities. Data and templates will be provided to community programs to assist them in leveraging resources on a local level.

The economic recession has created increased funding challenges. However, by demonstrating the value of investment in prevention, it is possible to increase support of primary prevention and emerge with a stronger funding system despite the economic downturn.

State-Level Training and Technical Assistance Capacity

Because the field of prevention science and the environments practitioners seek to impact evolve constantly and rapidly, continued learning and professional development is critical to the success of prevention initiatives. Currently, each of the three major components of the Indiana RPE program provides opportunities for professional trainings to their constituents and practitioners. Additionally, they provide on-site, customized technical assistance to community programs, college campuses, and other groups. The survey for professionals asked respondents involved in the management or execution of a state or community-based sexual violence primary prevention program (essentially, the recipients of INCASA, MESA, and INCSAPPP services) to assess the quality and quantity of training and technical assistance available to assist them in constantly improving their efforts.

Overall, the responses highlighted that training and technical assistance capacity was “somewhat strong.” Respondents were asked to rate the quality and quantity of training and technical assistance on the following topics: male involvement/engagement in sexual violence prevention, special strategies for reaching diverse and special-needs populations, community collaboration/coalition building, policy development, funding and grant applications, use of evidence-informed strategies and programs, and program evaluation. On all of the topics, at least some of the respondents replied that they were not familiar with the quantity and quality of the training and technical assistance, and that they were unable to rate them. The majority of respondents said that the sufficiency of all but the topic of community collaboration/coalition building was “somewhat lacking” and that the quality was only “fair.” This information was complemented by comments from professionals prioritizing a need for improved assistance with program evaluation and use of research and evidence-based strategies. Clearly, there is room for improvement in provision of training and technical assistance for sexual violence prevention in Indiana.

Conclusion

This section chronicles the strategic assessment process the Sexual Violence Primary Prevention Council went through to determine the strategic priorities for the state plan. Additional sections describe the rationale behind the goals of the plan, lay out the Centers

for Disease Control and Prevention's scientific framework for sexual violence prevention and outline the goals, outcome statements, strategies and action steps, and logic models for Indiana's sexual violence primary prevention state plan.