

## ***Development and Pilot Test of the Competency Assessment for Sexual Assault Prevention Practitioners***

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Sexual assault is a preventable problem that is widespread and particularly prevalent for certain populations (e.g., female college students, Native American women). Despite the gravity of this public health priority, most individuals tasked with the primary prevention of sexual assault are not adequately trained for the job (e.g., professionals often trained solely in sexual assault response). To achieve optimal outcomes, professionals responsible for implementing sexual assault prevention must possess certain core competencies, or knowledge and skills essential for job performance, which include those needed for any primary prevention effort in addition to those specific to sexual assault prevention. The purpose of this study was to develop and assess the construct validity of a competency assessment tool for sexual assault prevention practitioners. An existing assessment tool, which was designed for injury and violence prevention practitioners, was tailored to reflect competencies needed by sexual assault prevention practitioners as informed by the literature. The newly tailored measure was pilot tested with 33 individuals with varying levels of expertise with sexual assault prevention. These individuals were categorized into three groups based on self-rated sexual assault prevention expertise (low, medium, or high) to assess group differences. As expected, the high expertise group rated higher knowledge in all the competencies than the medium and low expertise groups (except for the competency pertaining to developing and maintaining

competency). Data collection and analyses were conducted in 2020. Implications for how the assessment tool can be used to identify gaps among individual practitioners and teams of practitioners are discussed.

**Keywords:** core competencies; self-assessment; sexual assault; primary prevention; prevention practitioner

Despite growing awareness and public outrage about the problem, sexual assault—that is, unwanted sexual contact of any kind—remains widespread across the United States and has devastating short-term and long-term consequences for the survivors' psychological and physical health as well as their financial well-being (Martin et al., 2011). In the United States, approximately 4.7% of women and 3.5% of men report experiencing sexual assault, which includes attempted or completed rape in addition to other forms of unwanted sexual contact, in the

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preceding year (Smith et al., 2018). The rates for sexual assault occurring for women in the military are comparable (Black et al., 2011). In the latest Workplace and Gender Relations Survey of Active Duty Members, 6.2% of women experienced sexual assault in the preceding year (Davis et al., 2019). In the university setting, one in five women is estimated to have experienced sexual assault since starting college (Muehlenhard et al., 2017).

Sexual assault is considered a public health problem because it is widespread and can be prevented (Dills et al., 2016). In addition, sexual assault disproportionately affects individuals based on sex and gender identity (e.g., women; Smith et al., 2018), sexual orientation (e.g., lesbian, gay, bisexual; Rothman et al., 2011) and race/ethnicity (e.g., Native Americans; Rosay, 2016). Therefore, sexual assault prevention can be considered a health equity issue. The Centers for Disease Control and Prevention (CDC) recommends that sexual assault prevention approaches are rooted in the social ecological model such that comprehensive strategies address modifiable risk and protective factors across the four overlapping levels of analysis (i.e., individual, relationship, community, and societal levels) to decrease the likelihood of sexual assault perpetration/victimization (Dills et al., 2016). Although there is an established process of intervention design and evaluation to demonstrate that interventions are evidence-based (e.g., Lodzinski et al., 2005), no analogous process exists for determining whether the professionals who implement evidence-based interventions (EBIs) are adequately trained and effective at delivering these interventions.

This study utilizes a competency-based approach, which shifts the focus of workplace assessment and training from the job and its associated tasks to the individual and their competency (i.e., knowledge and skills; Chouhan & Srivastava, 2014). Critical for any workforce, competencies foster improved performance (Chouhan & Srivastava, 2014). Various reviews and guidance documents highlight the essential role of well-trained staff in prevention work. A review of various prevention literatures (e.g., substance abuse) found that delivery of content by well-trained staff was strongly associated with intervention effectiveness (Nation et al., 2003). Essential implementation components of interventions include several factors to ensure a well-trained staff (e.g., recruiting qualified staff, conducting training before the intervention is delivered, and evaluating the performance of staff) (Fixsen et al., 2009). Finally, the Society for Prevention Research

identified staff training as a standard for prevention interventions (Flay et al., 2005).

Previous efforts have tried to determine whether prevention practitioners are competent. Specifically, the core competencies needed for prevention practitioners—that is, the essential knowledge and skills for one's work—were developed as part of a collaboration in the prevention science community called the National Training Initiative for Injury and Violence Prevention (Songer et al., 2009). An assessment tool (the Injury Prevention Assessment or IPA) was developed to allow prevention practitioners to self-assess on these competencies as well as to consider the relevance these competencies have on their current position (Villaveces et al., 2010). These competencies include approaching an injury or violence problem with frameworks like the public health model, understanding how to use data for continuous quality improvement, designing and evaluating interventions, and managing a program.

The research suggests that sexual assault prevention practitioners may require additional skills beyond the core competencies needed for violence prevention in general (Songer et al., 2009). One of the factors that makes sexual assault a unique type of violence to prevent is the cultural pervasiveness of survivors being blamed—and internalizing blame—for the event, which results in risk of re-traumatization and underreporting. Combatting culturally ingrained rape myths and avoiding harming participants with a history of sexual assault while administering sensitive program content are only some of the major challenges with which sexual assault prevention practitioners contend. The IPA (Villaveces et al., 2010) does not assess sexual assault-specific prevention competencies. The sexual assault prevention community would benefit from the articulation of core competencies and incorporation of those competencies in an assessment tool, so that gaps in competencies can be identified and addressed with training, reassignment, or hiring new personnel. The purpose of this study was to develop an assessment tool for sexual assault prevention practitioners regarding knowledge about and job relevancy of the core competencies. We first conducted a literature review and thematic analysis of sexual assault prevention-specific competencies to adapt the existing assessment tool (IPA; Villaveces et al., 2010) for use with sexual assault prevention practitioners. We created an alternative version of the assessment tool for military settings. Finally, we pilot-tested the assessment tool with a convenience sample of individuals with varying levels of expertise in sexual assault prevention to assess the construct validity of the measure.

## Study Hypotheses

We hypothesized that pilot test participants with higher levels of self-reported expertise in sexual assault prevention would score higher on the competency assessment tool, reporting greater knowledge in the competencies and perceiving that the competencies were more relevant to their jobs. Specifically, we predicted that:

**Hypothesis 1 (H1):** The High expertise group would have greater knowledge than the Medium expertise group and the Low expertise group.

**Hypothesis 2 (H2):** The High expertise group perceive greater job relevance than the Medium expertise group and the Low expertise group.

**Hypothesis 3 (H3):** The Medium expertise group would have greater knowledge than the Low expertise group.

**Hypothesis 4 (H4):** The Medium expertise group perceive greater job relevance than the Low expertise group.

## ► METHOD

### *Literature Search Strategy and Results*

To identify core competencies needed for sexual assault prevention practitioners and existing competency assessment tools for sexual assault prevention practitioners, we searched the formal and gray literatures in 2020. We searched the Web of Science database for the following search terms: (rape OR sex\* assault\* OR sex\* harassment OR sex\* violen\* OR gender-based violence) AND (primary prevention OR violence prevention or prevent\*) AND (practitioner training OR professional competence\* OR skills OR core competencies) AND (competency assessment\* OR curriculum-based assessment OR assessment OR scale OR measure OR instrument OR questionnaire). In the Web of Science database, 477 references were returned from the search. The references were categorized as follows: descriptions of programs or evaluations ( $N = 224$ ), empirical studies about sexual assault ( $N = 207$ ), trainings or information about best practices for professionals who respond to sexual assault (e.g., forensic nurses, mental health professionals;  $N = 37$ ), assessment tools or competency criteria that can inform a tool ( $N = 5$ ), guidelines or standards for violence prevention practitioners ( $N = 2$ ), or miscellaneous (e.g., validation of a scale) ( $N = 2$ ). We searched Google for the following terms: (sexual assault OR sexual harassment) AND (primary prevention OR prevention) AND (practitioner OR educator OR facilitator) AND (training OR train the trainer) and (assessment OR skills OR core competencies), which returned

approximately 1,630,000 results. We reviewed the first 20 pages of results to find relevant resources. Resources deemed to be irrelevant often described sexual assault response.

We did not find self-assessment tools specific to sexual assault prevention practitioners, but we identified two self-assessment tools for general prevention. One of them, the IPA (Villaveces et al., 2010), consisted of self-ratings of knowledge about and job relevance of the core competencies for prevention work. Since prevention core competencies are the foundation of knowledge for sexual assault prevention practitioners (Runyan et al., 2005), we deemed it appropriate to tailor the IPA to make it specific to sexual assault prevention.

We systematically extracted information from these publications and analyzed that information using constant comparative analysis (or thematic analysis). Four themes emerged: (a) understanding and addressing the oppressive systems underlying sexual assault (Dills et al., 2016; National Sexual Violence Resource Center [NSVRC], 2012), (b) coordinating efforts across prevention and response (Dills et al., 2016), (c) using a trauma-informed approach (Dills et al., 2016), and (d) expanding the prevention focus to include what the program is trying to promote (e.g., safe, respectful and equitable environments), not just what the program is aiming to prevent (NSVRC, 2012). These themes were not adequately covered by the IPA.

### *Assessment Tool Development*

We then tailored the IPA by first deleting and rewording existing items to be more sexual assault-specific and then adding items that reflected any general prevention or specific sexual assault prevention competencies that were missing. Thirteen items were deleted because they were not relevant to sexual assault (e.g., description about biomechanics of injury), were sufficiently addressed in other items, or merged with existing items (e.g., “Describe various levels where prevention activities can be focused”). Five more items were deleted because they were meant to assess specialized expertise on a type of violence, which was no longer relevant since the entire assessment was focused on sexual assault. An item was added for each of the following for the new general prevention items: knowledge of the multiple key elements of effective prevention practice (Nation et al., 2003), ability to use scientific articles (Basile et al., 2016), ability to identify EBIs (Basile et al., 2016), ability to tailor programs (Perkinson et al., 2017), knowledge of best practices concerning effective learning environments (NSVRC, 2012), and ability to convey program goals with a promotion paradigm (NSVRC, 2012; Walden

& Wall, 2014). A single item was added to assess each of the following for the new sexual assault prevention competencies: knowledge of protective factors against sexual assault perpetration and victimization (Basile et al., 2016), understanding how oppressive systems underlie sexual assault (Dills et al., 2016; NSVRC, 2012; Walden & Wall, 2014), understanding special data issues like underreporting (Yung, 2015), coordinating efforts across prevention and response (Dills et al., 2016), and using a trauma-informed approach in program delivery (Dills et al., 2016; NSVRC, 2012).

The resulting assessment tool had 70 items which were sorted into eight competencies: (a) sexual assault as a major public health problem (10 items); (b) working with sexual assault data (10 items); (c) design, adaptation, and implementation of sexual assault prevention activities (9 items); (d) program evaluation (7 items); (e) program management (11 items); (f) dissemination (6 items); (g) ability to foster change related to sexual assault prevention through policy, enforcement, advocacy and education (12 items); and (h) maintaining competency as a sexual assault prevention practitioner (5 items).

The modified assessment tool was renamed the Competency Assessment for Sexual Assault Prevention Practitioners (CASAPP). We created an alternate version of the CASAPP (CASAPP-m) complete with military-specific language for use by the Sexual Assault Prevention and Response Office in the Department of Defense. For example, the text in parentheses in a general CASAPP item “Describe how to establish and maintain an advisory group to assist with the development and monitoring of goals for sexual assault prevention within a population (e.g., a community, a state, among children, among Latinos, etc.)” became “(e.g., at a Military Service Academy, on a submarine or a ship, among service members with alcohol-related conduct offenses)” in the CASAPP-m.

### **Assessment Tool Pilot Test**

We pilot-tested the CASAPP to assess construct validity of the assessment tool with a convenience sample of 33 researchers at the RAND Corporation, at the Sexual Assault Prevention and Response Office (SAPRO) in the Department of Defense (DoD), and at Portland State University (PSU), all of whom were Masters- or Doctoral-level researchers during the summer of 2020. We requested self-ratings of their expertise in sexual assault prevention and any information that informed that rating (such as relevant trainings and work experience). We then categorized participants into the: Low expertise group, Medium expertise group, or High expertise group. Participants were instructed to take either the CASAPP or CASAPP-m depending on their workplace

(for example, the DoD SAPRO participants opted to self-administer the CASAPP-m). We collected participants' impressions of the tool, which we used to refine the tool.

### **Statistical Analysis**

Given their similarity in content, the analyses conducted combined responses from both versions of the CASAPP. All analyses were conducted in SPSS v22.0 (George & Mallery, 2019). Cronbach's alpha coefficient was calculated for each competency. Then, we conducted hypothesis-testing through a series of ANOVAs and Bonferroni post hoc tests predicting self-reported ratings of knowledge and job relevance for each competency subscale using a categorical coding of self-rated expertise (Low, Medium, and High). Due to the modest sample size, no covariates were included. These analyses were conducted during the summer of 2020.

## **► RESULTS**

Each of the core competency subscales demonstrated adequate reliability for the dimensions of knowledge and job relevance. See Table 1 for reliability information and descriptive statistics. The ANOVAs revealed that there was a significant effect of self-rated expertise for each of the eight core competencies for both knowledge and job relevance. For example, there was a significant effect of self-rated expertise for the 3 groups regarding knowledge for Competency 1,  $F(2, 30) = 34.61, p < .001$ . Once the presence of between-group differences was established, Bonferroni tests were conducted to do specific group comparisons (e.g., High expertise group versus Medium expertise group).

Table 2 displays the full results for the Bonferroni comparisons. Regarding the dimension of knowledge, the High expertise group was significantly higher than the Low expertise group on all the competencies and was significantly higher than the Medium expertise group on all competencies except Competency 8 (ability to develop and maintain competency), thus lending support for H1. For example, the High expertise group ( $M = 43.62, SD = 4.74$ ) had significantly greater knowledge on Competency 1 (understanding sexual assault as a public health problem) than the Medium expertise group ( $M = 30.11, SD = 4.05$ ) with a mean difference of 13.50 ( $SE = 2.62; p < .001$ ) and the Low expertise group ( $M = 23.55, SD = 8.32$ ) with a mean difference of 20.07 ( $SE = 2.50$ ). The Medium expertise group was significantly higher than the Low expertise group on competencies 2, 3, 4, and 8, thus lending partial support for H3. Regarding the dimension of job relevance, the High expertise group was significantly higher than the Low expertise group on all competencies and was

**TABLE 1**  
**Reliability and Descriptive Statistics for Knowledge and Job Relevance in the Eight Competencies of the CASAPP for the Low, Medium, and High Expertise Groups**

Competency	Dimension: Knowledge			Dimension: Job relevance				
	Cronbach's alpha	Low M (SD)	Medium M (SD)	High M (SD)	Cronbach's alpha	Low M (SD)	Medium M (SD)	High M (SD)
1. Understand the problem	0.950	23.55 (8.32)	30.11 (4.05)	43.62 (4.74)	0.968	22.36 (13.46)	33.67 (11.51)	42.46 (5.32)
2. Interpret and use data	0.953	25.00 (8.99)	33.44 (6.86)	45.69 (3.66)	0.962	22.00 (12.08)	37.89 (9.05)	44.46 (6.01)
3. Design, tailor, and implement programs	0.960	16.55 (7.79)	23.22 (4.68)	39.15 (4.10)	0.971	18.73 (13.81)	28.33 (11.51)	38.46 (6.40)
4. Program evaluation	0.972	14.82 (7.34)	22.00 (6.82)	32.46 (2.40)	0.985	14.82 (10.50)	28.89 (7.77)	32.15 (4.62)
5. Build and manage a program	0.968	18.00 (8.23)	21.44 (6.58)	42.46 (8.47)	0.978	20.45 (13.57)	26.89 (14.71)	42.69 (11.70)
6. Disseminate	0.950	11.91 (7.04)	14.44 (3.54)	26.08 (3.48)	0.950	12.73 (8.84)	17.44 (6.91)	26.15 (4.34)
7. Foster change	0.972	21.18 (10.75)	23.44 (7.16)	47.00 (9.45)	0.973	23.27 (16.02)	30.00 (15.79)	47.77 (11.00)
8. Maintain and develop competency	0.937	10.73 (5.76)	14.89 (4.65)	22.54 (2.30)	0.953	9.45 (7.49)	14.89 (6.17)	21.31 (3.35)

Note. Low—Low expertise group, Medium—Medium expertise group, and High—High expertise group.



**TABLE 2**  
**Bonferroni Post Hoc Tests Identifying Differences Between the High, Medium and Low Expertise Groups on Knowledge and Job Relevance in the Eight Competencies of the CASAPP**

Competency	Dimension: Knowledge Group comparison: Mean difference (SE)			Dimension: Job relevance Group comparison: Mean difference (SE)		
	Medium and low	High and low	High and medium	Medium and low	High and low	High and medium
1. Understand the problem	6.57 (2.71)	20.07 (2.50)***	13.50 (2.62)***	11.30 (4.65)	20.10 (4.24)***	8.80 (4.49)
2. Interpret and use data	8.44 (3.01)*	20.69 (2.74)***	12.25 (2.90)**	15.89 (4.14)**	22.46 (3.77)***	6.57 (4.0)
3. Design, tailor, and implement programs	6.68 (2.57)*	22.61 (2.35)***	15.93 (2.48)***	9.61 (4.83)	19.73 (4.40)***	10.13 (4.66)
4. Program evaluation	7.18 (2.57)*	17.64 (2.34)***	10.46 (2.48)**	14.07 (3.52)**	17.34 (3.21)***	3.27 (3.40)
5. Build and manage a program	3.44 (3.56)	24.46 (3.25)***	21.02 (3.44)***	6.43 (5.93)	22.24 (5.40)**	15.80 (5.72)*
6. Disseminate	2.54 (2.23)	14.17 (2.04)***	11.63 (2.15)***	4.72 (3.06)	13.43 (2.79)***	8.71 (2.95)*
7. Foster change	2.26 (4.22)	25.82 (3.84)***	23.56 (4.07)***	6.73 (6.36)	24.50 (5.80)**	17.77 (6.14)*
8. Maintain and develop competency	11.81 (1.78)***	7.65 (1.89)**	4.16 (1.96)	5.43 (2.60)	11.85 (2.37)***	6.42 (2.50)*

Note. Low—Low expertise group, Medium—Medium expertise group, and High—High expertise group.  
 \* $p < .05$ . \*\* $p < .01$ . \*\*\* $p < .001$ .

significantly higher than the Medium expertise groups on all the competencies except competencies 5, 6, 7, and 8, thus lending partial support for H2. The Medium expertise group was significantly higher than the Low expertise group on Competencies 2 and 4 for job relevance, thus lending partial support for H4.

In total, 33 out of 48 tests were significant. To determine the likelihood of a Type 1 error rate due to multiple comparisons (Sainani, 2009), we calculated the number of tests that would be expected to be significant by chance. The number of significant tests (34) is higher than the number of tests that would be expected to be significant by chance (48 tests total multiplied by 5%, or 2.4 tests), and, therefore, we are confident in these findings.

## ► DISCUSSION

The CASAPP is informed by prevention science and practical guidance about what competencies sexual assault prevention practitioners should possess beyond those outlined by Songer and colleagues (2009) for general prevention. Our analyses suggest that the assessment tool is valid, with the High expertise group scoring higher in knowledge on all competencies and higher in job relevance on most competencies. The subscales demonstrated good internal consistency. However, certain limitations should be noted. The validity analyses utilized a small sample ( $n = 33$ ) and relied on self-reported expertise. A larger sample with objective measures of expertise should be used for additional psychometric testing. In addition, while the convenience sample we utilized for the pilot test provided preliminary validation of our assessment tool, the CASAPP should next be administered to a random sample of individuals with varying levels of sexual assault prevention expertise.

The assessment tool fills an important gap in the existing literature and is the first tool that includes specific competencies needed for sexual assault prevention in both military and civilian settings. A previous need assessment has found that practitioners working in the fields of sexual assault and domestic violence focused most of their efforts on response (e.g., counseling) rather than primary prevention and that they did not have adequate training in primary prevention despite being their interest (Martin et al., 2009). Although there are training programs for general prevention practitioners [PREVENT (Preventing Violence Through Education, Networking, and Technical Assistance) Program] (Runyan et al., 2005) and sexual assault prevention practitioners like those offered by the CDC (VetoViolence) to fill the learning gaps, there are no self-assessment tools for teams of sexual assault prevention practitioners to first identify gaps in knowledge and task assignments.

The advantages of a well-trained prevention practitioner workforce would be significant. Well-trained staff would best use prevention funding, which is often limited, by adopting the most appropriate EBIs and delivering them in the most effective way (e.g., Nation et al., 2003). Conducting prevention in this manner would help potential victims avoid sexual assault's devastating consequences (Martin et al., 2011). Furthermore, trauma-informed prevention work would avoid causing additional harm to program participants with a history of sexual assault. Finally, rigorously conducted research about sexual assault prevention has been sparse which has resulted in only a handful of strategies being proven effective while many other promising strategies remain untested with rigorous methods (DeGue et al., 2014; Orchowski et al., 2018; Wright et al., 2020). There is a need for competent professionals to conduct this research so that effective programs can receive needed investments.

Sexual assault is an issue that disproportionately affects certain groups (e.g., women, Native American women) and must be addressed to protect their health and ability to fully pursue opportunities at school and work. Beyond the inherent value of sexual assault prevention, universities and the military have a particularly vested interest to have well-trained sexual assault prevention practitioners because sexual assault thwarts the core missions driving these institutions. Sexual assault threatens education at universities as it hinders academic performance and has been found to be more predictive of dropping out of college than other types of violence (Mengo & Black, 2016). The American College Health Association (ACHA, 2011) cautioned that students cannot learn in an unsafe environment. The ACHA (2011) and the CDC (Dills et al., 2016) galvanized universities to address sexual assault with a comprehensive approach and provided recommendations for trauma-informed prevention and response. Sexual assault also threatens the military's mission of having an effective force because it can result in personnel loss and undermined unit cohesion, military readiness, and ultimately military effectiveness (Davis et al., 2019; Klein & Gallus, 2018). Important steps have been taken to improve the military's response to sexual assault like the providing the option of restricted reporting, which enables the sexual assault victim/survivor to confidentially disclose the details of their assault (without triggering an official investigative process) and to receive care such as medical treatment and counseling. We believe that the CASAPP-m would serve the military in their prevention efforts. Historically in military settings, individuals working in prevention have not been trained but are assigned these tasks as collateral duty (i.e., in addition

to a full-time duty). Therefore, this assessment is critical for determining whether on-the-job training is appropriately preparing these professionals to succeed.

The assessment tool could be used by entities at both the individual and team levels, as this work is often conducted by teams. At the individual level, the assessment tool could be used to identify areas where additional training would be beneficial. The assessment tool can be used to identify and reassign individuals possessing specific sets of knowledge that might not yet be fully utilized when used at the team level. In addition, this assessment could also be used to structure job announcements and assess the quality of training programs.

## ► CONCLUSION

High-quality sexual assault prevention requires certain competencies to ensure programming is optimally conducted, evaluated, and sustained. The CASAPP is a tool that can help both individuals and prevention teams monitor and improve those skills. The two versions (general and military) of the assessment tool and instructions can be requested from the corresponding co-author.

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