Moving Upstream

Virginia's Newsletter for the Primary Prevention of Sexual & Intimate Partner Violence

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Organizational Development and Primary SV/IPV Prevention (Part 1)

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This issue of Moving Upstream is the first of a 2-part series examining organizational development toward primary prevention at sexual and domestic violence agencies. Part 1 focuses on prevention capacity at these agencies. Part 2 will focus on the concept of "institutionalizing" organizational improvements in prevention capacity. The feature articles in both issues will tie these concepts into Virginia's *Guidelines for the Primary Prevention of Sexual Violence & Intimate Partner Violence.*

Also, I want to remind everyone about the primary prevention training we had to post-pone from May to October. *Mobilizing Communities: Developing Culturally Relevant Prevention Projects* will take place on October 13-14, 2010 in Charlottesville, VA. It features a day of training with nationally renowned prevention expert Lydia Guy, and a half-day training with award-winning designer Noah Scalin, the creative force behind the Red Flag Campaign. To learn more, or to register, please visit: www.vsdvalliance.org/secProjects/trainingcalendar.html and scroll down to the appropriate entry.

Willing and Able: *Primary Prevention Capacity at Sexual & Domestic Violence Agencies*

Brad Perry, MA, Sexual Violence Prevention Coordinator
Virginia Sexual & Domestic Violence Action Alliance

Engaging in the complex, long-term work of addressing sexual violence and intimate partner violence (SV/IPV) requires willingness on the part of institutions, partners, and community stakeholders to see this work as "theirs." In the context of preventing first-time perpetration of SV/IPV – primary SV/IPV prevention – the network of organizations and individuals supporting and expanding this work can be referred to as a "prevention system." The dynamics of such prevention systems have rightly become the subject of analyses in states engaging in thorough primary SV/IPV prevention approaches. Within these systems, it is absolutely crucial to understand the dynamics of the organizations predominantly driving primary SV/IPV prevention efforts. Sexual and domestic violence agencies (SDVAs) usually perform this function.

In 2004, and handful of local Virginia agencies addressing domestic violence received funding through the DELTA project, and began exploring how to prevent the first-time perpetration of intimate partner violence using a public health framework. In 2005, fifteen local Virginia agencies addressing sexual violence received RPE funding through a competitive grant application process. A new set of tenets in the RPE funding required that these agencies seek to prevent the first-time perpetration of sexual violence according to several key public health principles. These programmatic shifts toward a primary prevention approach helped accelerate prevention-related organizational development at these local SDVAs and at the statewide coalition of these agencies, the Virginia Sexual & Domestic Violence Action Alliance. Two major processes found to influence this kind of organizational development are capacity and institu-

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Funder's Forum

Engaging Men Training / White Ribbon Campaign

Robert Franklin, MS, Male Outreach Coordinator
Division of Injury and Violence Prevention, VDH

In early September (date and location not yet finalized) VDH will host 2 one-day trainings on how to involve men in sexual violence prevention. These full-day trainings will provide participants with new skills, and help them build on existing skills to more effectively work with men and boys in the primary prevention of violence against women. The training places men's engagement in a framework of masculinity that is broadly applicable, but that participants will then be able to tailor to the dynamics of their particular communities. The training will include practical exercises and activities for engaging men, new approaches and ideas, and awareness of current best practices for how to engage men in the most sustainable way possible. The training objectives include:

- Learn how to better frame sexual assault as a problem men can play a positive role in ending.
- Become more aware of the "Dominant Stories" of masculinity and better understand the importance of "Counterstories," and how these relate to violence against women.
- Explore the challenges of engaging men and learn effective ways to overcome these challenges.
- Learn and strategize about how men can be mobilized to become better allies with women.
- Build skills for speaking with men about sexism and strategies for effectively challenging the culture that supports SV/IPV.
- Provide participants with practice responses to common reactions and questions from male audiences.

Information and resources on hosting a White Ribbon Campaign will also be provided. The White Ribbon Campaign is part of a multinational effort to get men involved in working to end violence against women, to raise awareness of the problem, and to support organizations that deal with the consequences of men's violence against women (www.whiteribbon.ca). For more information on these trainings, contact Robert Franklin at 804.864.7739, or visit www.vahealth.org/injury/sexualviolence for training updates and registration.

Promising Practices

Prevention Capacity at VSDVAA

Brad Perry, Sexual Violence Prevention Coordinator
Kristi VanAudenhove, Co-Director
Virginia Sexual & Domestic Violence Action Alliance

The Virginia Sexual & Domestic Violence Action Alliance (Action Alliance) has integrated prevention throughout the agency since its inception in 2004. The agency mission is to create a Virginia free from sexual and domestic violence - a mission with prevention at its core. In 2005 the Action Alliance membership adopted a strategic plan that included seven goals. Preventing sexual and domestic violence was one of those goals, and it included activities ranging from coordinating the DELTA project to drafting and adopting a formal definition of "healthy sexuality" (which was adopted in 2009). Prevention was also embedded in the objectives under each of the other seven goals. For example, the Public Awareness goal included the development and implementation of a campaign focused on bystander responses to unhealthy dating behavior and promoting healthy dating relationships: The Red Flag Campaign.

Out of 25 Action Alliance staff members, there are 3.5 full-time staff whose principal duties are focused on primary prevention, 3 additional staff who have significant responsibilities in carrying forward prevention objectives, 2 interns who assist the prevention team staff, and the 2 Co-Directors who commit a substantial portion of their time to providing support and guidance to the agency's prevention work. Over half of the staff have participated in specialized prevention training, and all new staff will be expected to complete the Action Alliance's Principles of Prevention training. This shared understanding of prevention translates to a shared commitment - to healthy relationships, healthy sexuality and ultimately, to communities free of sexual and domestic violence.

The Action Alliance has also worked to foster primary prevention capacity at local SDVAs through a variety of initiatives, the most recent of which is a campaign to "re-brand" primary prevention. The Action Alliance assessed staff at local SDVAs and found that many - particularly those at SDVAs without prevention funding - were put-off by what they perceived as dense concepts and jargon associated with primary prevention, and overwhelmed by the sheer enormity of the work. The Action Alliance went through a formal social marketing process to determine how to best promote primary prevention work as exciting, accessible, and achievable. The "Yes" campaign is the

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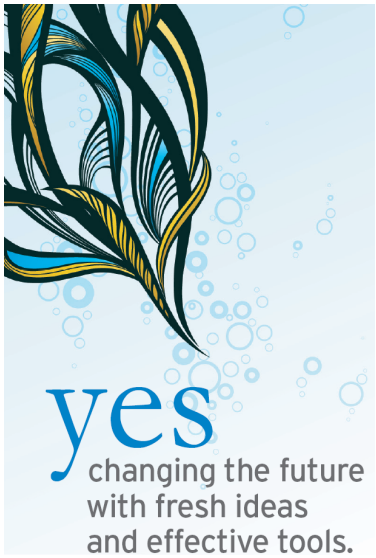
Prevention capacity at VSDVAA (from Page 2)

outcome of this process and is about to be implemented throughout SDVAs in Virginia to enhance their willingness and ability to engage in primary SV/IPV prevention.

Moving Upstream conducted a short interview with Action Alliance Co-Director, Kristi Van-Audenhove to learn more about how the Action Alliance continues to make building its own prevention capacity a priority.

MU: Statewide plans for the primary prevention of intimate partner violence and sexual violence were recently developed, and the Action Alliance was heavily involved in both. How has that interacted with the Action Alliance's organizational prevention capacity?

KV: Coming out of those planning processes, we realized that the Prevention Team [of the Action Alliance staff] was going to need another staff person. We hadn't planned on hiring a new prevention staff person, so we looked at the skills and projects of other staff to see if there was a good fit. We realized that a staff person working on a child and youth advocacy project had received primary prevention training, and had an interest in taking on some primary prevention work, so we retooled her job description to address the new work from the IPV plan that needed to be accomplished and close the gap. The members of the Prevention Team were happy to have another person, and caught her up to speed on the relevant concepts and projects.



MU: What about in the organization as a whole (outside of the staff)?

KV: There were a lot of cases where knowledge and lessons from the statewide prevention planning process informed the Action Alliance's strategic planning process (which had begun in the midst of the prevention planning process). Best example: The lack of perpetration data - data that we need to plan strategies to prevent the first-time perpetration of IPV/SV. Our governing body understood the importance of that, and were intrigued once we explained it, so they made it a priority even in the absence of current funding...they made it a priority to seek out the resources to do that. I guess that's really an example of our broader prevention capacity building efforts paying off...we didn't have to push, and had pretty immediate buy-in from these folks to adopt an important prevention goal.

MU: Has building the Action Alliance's prevention capacity paid off in non-prevention areas of its work?

KV: Yes. During that same strategic planning process, we realized that instead of going in 100 different directions it would be better to narrow it down and "saturate not sprinkle" - a concept that was ingrained from our work with the DELTA primary IPV prevention project. And our anti-racism has been informed by the social ecological model. There is work being done at the staff level, and policy work with governance and with membership.

Other portions of the interview with Kristi, as well as interviews with local SDVA staff will be included in the next issue of Moving Upstream.

Primary Prevention Capacity at SDVAs (from Page 1)

tionalization, and they are important to understand if such shifts are to be managed smoothly. Part 1 of this article will focus on organizational capacity.

Organizational Prevention Capacity in Virginia

The Action Alliance has worked closely with state and federal public health authorities to build the "prevention capacity" of itself, and of local SDVAs. Generally, the "capacity" of organizations has been defined as, "the ability of…organizations to fulfill their missions in an effective manner" (McPhee & Bare, 2001; p. 1). Organizational prevention capacity at SDVAs can be defined as: The ability of a sexual & domestic violence agencies to engage in mission-driven efforts seeking to prevent first-time SV/IPV perpetration in an effective manner.

Applying public health approaches to eliminating or reducing future occurrences of SV/IPV is still a relatively new idea. Many SDVAs are response-oriented; they are primarily concerned with serving the people in their locality who have been directly or closely affected by acts of SV/IPV that have already occurred. Sheltering victims of IPV, providing crisis response for victims of SV, and advocating for victims of SV and IPV in criminal justice and healthcare systems are examples of the vital day-to-day activities traditionally performed by these organizations. While complimentary to this response-oriented work, the proactive agenda of primary prevention is somewhat different.

Primary prevention work tends to emphasize different knowledge bases than those favored by victim services (e.g., public health and social psychology rather than criminal justice and social work), typically involves a more methodical, scientific approach (e.g., applying tested public health theories and using evidence-informed strategies to elicit desired behaviors relevant to SV/IPV prevention), and necessitates making connections with causes and collaborators that may not be traditionally associated with SV/IPV victim services work (e.g., since

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positive connections to caring adults influence boys' abilities to peacefully resolve conflicts, a prevention project might partner with a fatherhood initiative to develop a corresponding program). So when SDVAs undertake primary prevention work, they might have to re-examine and/or add to their mission, expand the types of work and skill sets that are valued, facilitate the acquisition of new skills and knowledge for staff, and shift the agency's identity - both internally and for its constituents. Indeed, the agency may also need to expand who it defines as "constituents" in the first place. SDVAs are ultimately the best places to house this work because of their expertise on the issues of SV/IPV, origins in social change work, and typically deep connections within their service areas. So the overall organizational capacity of a given SDVA is usually well-suited to take on the incredibly challenging and ambitious work of primary SV/IPV prevention. However, many SDVAs will still need assistance in building the organizational *prevention-specific* capacity necessary to develop and implement effective primary SV/IPV prevention efforts.

Various models of organizational capacity have been proposed to better understand and explain how it operates. One model of capacity that seems to lend itself well to prevention work at SDVAs is that of *Venture Philanthropy Parters (VPP)*, which expresses capacity as:

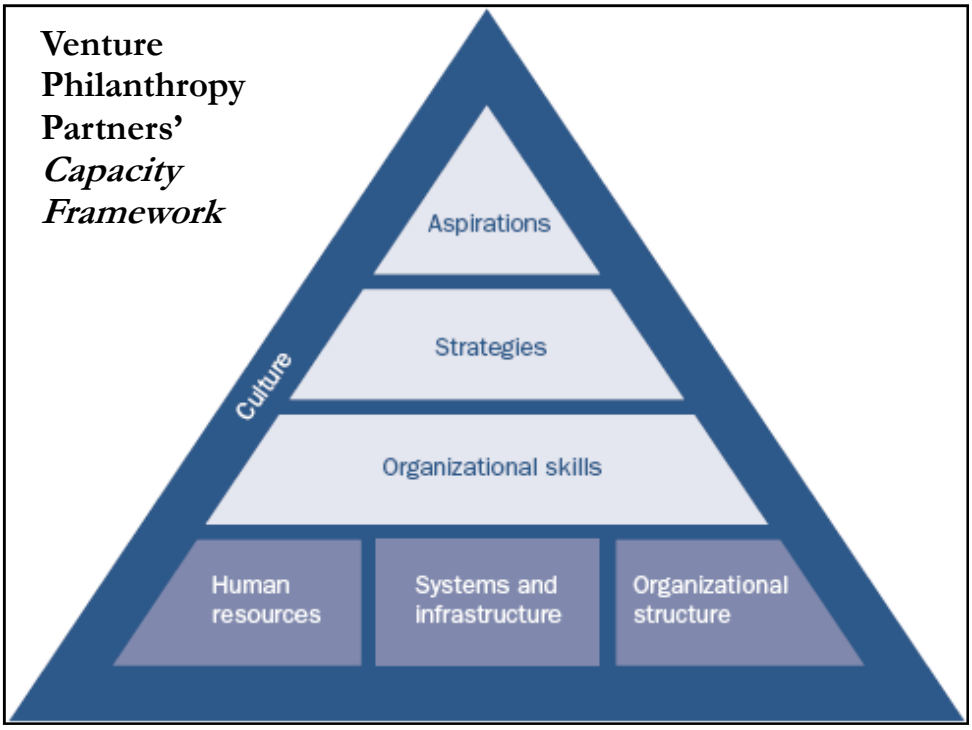
> …a pyramid of seven essential elements: three higher-level elements – aspirations, strategy, and organizational skills – three foundational elements – systems and infrastructure, human resources, and organizational structure – and a cultural element which serves to connect all the others. (McKinsey & Company, 2001, p. 33).

This 7-element capacity framework can help disentangle where and how change needs to occur to increase the prevention capacity of SDVAs.

Applying the Capacity Framework to Prevention Capacity at Sexual & Domestic Violence Agencies

Nation, et al.'s (2003) review of effective prevention approaches for substance abuse, risky sexual behavior, school failure, and juvenile delinquency has been invaluable in explaining many crucial concepts in primary prevention work, and one such concept they emphasize is the importance of adequate training for individuals implementing prevention initiatives. They state that even the best prevention programs, "can produce disappointing results…if the program providers are poorly selected, trained, or supervised. The implementation of prevention programs is enhanced when the staff members are sensitive, are competent, and have received sufficient training, support, and supervision" (p. 454). However, they go on to point out that, "Even when staff members are sufficiently competent, their effectiveness can be limited by high rates of turnover, low morale, or a lack of 'buy-in'"(p. 454). Enhancing the prevention-relevant knowledge and skill sets of SDVA staff is important, but will not be enough to ensure quality. It is necessary to look to models of organizational capacity and institutionalization that are able to account for all of the "moving parts" of an organization – including, but bigger than, the competencies of the staff. *VPP's* 7-part capacity framework can help clarify the essential components of prevention capacity at SDVAs.

Aspirations & Strategy: Aspirations are defined as, "an organization's mission, vision, and overarching goals, which collectively articulate its common sense of purpose and direction" (McKinsey & Company, p. 33), and strategy is defined as, "the means for reaching those aspirations" (p. 41). According to *VPP's* study of non-profit organizations, "…aspirations drive everything….the organizations that made the greatest gains in social impact were those which tackled high-level questions of mission, vision, and goals" (p. 37). The clarity and quality of an agency-wide primary prevention agenda – and how they plan to realize it – will convey much about a SDVA's prevention capacity. SDVAs need to devise an overarching purpose and framework to guide their primary prevention work in order for prevention initiatives to be nuanced, intentional, coordinated, and effective . An agency's aspirations and strategy will also help shape other elements of prevention capacity, such as "the necessary organizational skills that can be delivered only with the proper design of human resources, systems, and organizational structure" (p. 33).



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Primary Prevention Capacity at SDVAs (from Page 4)

How to incorporate an *enduring* prevention-oriented vision and set of goals into the defining characteristics of a SDVA goes to the heart of institutionalization which will be covered in Part 2 of this article in the next issue of *Moving Upstream*.

Organizational Skills: "The sum of the organization's capabilities, including such things…as performance measurement, planning, resource management, and external relationship building" (p. 33). The range, depth, and specific types of organizational skills present or absent in a SDVA will impact the, "process through which they develop, implement, fund, and measure programs" (p. 44). For prevention work, this translates to the SDVA staff's abilities to conceive of, map-out, execute, and regularly adjust the implementation of primary prevention initiatives. This includes both how management equitably prioritizes this work relative to other projects of the SDVA, and the extent to which staff are using prevention-specific promising practices – such as those contained in Virginia's primary prevention guidelines – to inform primary prevention initiatives.

The foundational elements of organizational capacity – human resources, systems and infrastructure, and organizational structure – are tightly interlaced, and permeate all aspects of organizations. As such, the examples below correspond to these 3 capacity elements as a group.

Human Resources: "The collective capabilities, experiences, potential and commitment of the organization's board [if applicable], management team, staff, and volunteers" (p. 33).

Systems & Infrastructure: "The organization's planning, decision making, knowledge management, and administrative systems, as well as the physical and technological assets that support the organization" (p.34).

Organizational Structure: "The combination of governance, organizational design, interfunctional coordination, and individual job descriptions that shapes the organization's legal and management structure" (p. 34).

Most prevention staffers at SDVAs are bright people who come from a wide variety of backgrounds. However, the sentiment that "I didn't know what I was getting into when I took this job" is not rare amongst this group. The more that SDVA managers understand the knowledge and skill sets necessary for prevention positions, and are able to accurately represent that understanding in recruitment for these positions, the more likely it is that the people who are hired to coordinate primary prevention work will be happy, effective, and a good fit with the job.

"[One concern should be] the SDVA staff's abilities to conceive of, map-out, execute, and regularly adjust the implementation of primary prevention initiatives. This includes both how management equitably prioritizes this work relative to other projects of the SDVA, and the extent to which staff are using prevention-specific promising practices – such as those contained in Virginia's primary prevention guidelines – to inform primary prevention initiatives."

A separate but related issue is that existing organizational structures and management systems at many SDVAs evolved out of their traditional response-oriented work. This can lead to the isolation of prevention staff, in that the content and methods of their work do not always easily fit into this mold. For example, prevention work often entails more time to be spent out of the office, a greater degree of public interaction, and collaboration with new and perhaps unusual community partners. This work can look and feel quite different than that of shelter-based staff, or the case-by-case work of sexual assault crisis response staff. If managers are not able to adapt supervision habits, organizational hierarchy, and staff development strategies to include these requirements of primary prevention work, then the SDVA's prevention work will likely face additional and needles obstacles from within the organization, and prevention staff might turnover at a higher rate. One very basic and concrete example of such an adaptation would be a commitment for all staff to be trained on the basics of primary prevention, just as they are trained on the basics of victim advocacy and crisis intervention. This will help incorporate primary prevention concepts and approaches throughout the organization. It would also have the immediate benefit of minimizing the isolation of prevention staff, and fostering a network of co-workers who can all "sell" primary prevention to their community alongside of their traditional services, consequently building their community's prevention capacity.

Culture: "The connective tissue that binds together the organization, including shared values and practices, behavior norms, and… the organization's orientation towards performance" (p. 34). The shared values of everyone meaningfully affiliated with the SDVA engender its culture, which then loops back and influences the decisions made by those individuals with respect to the SDVA, and so on. Organizational culture is complex and multi-dimensional, but one example relevant to primary prevention concerns whether the SDVA and its affiliated individuals (especially staff) view themselves as a primarily a service delivery organization, a social change organization, or neither/other. A study by the Urban Institute expounds: "An organization established primarily to serve the needs of its members is likely to engage in a very different set of…activities than one that seeks to advocate for social change" (McPhee & Bare, 2001, p. 17).

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As previously discussed, many SDVAs have evolved an organizational culture that heavily emphasizes services to victims. If that manifests in a manner that excludes or devalues any work not immediately related to victim advocacy or crisis response, then building prevention capacity might be difficult, slow, and/or unlikely. If a SDVA's culture is based more in a social change model, then primary prevention might be more readily embraced since it seeks to counter-act root causes of SV/IPV while promoting positive social norms. While primary prevention's public health terminology might at first seem incongruous with the language of social change activists, the concepts are remarkably compatible. For example, one could easily argue that the public health field's social/socio-ecological model is essentially a more calculated and delineated articulation of the social change axiom, "the personal is political." Both convey the fundamental concept that factors underlying SV/IPV are not only perpetuated by individual people, but by relationship patterns, community institutions, and societal norms as well. For more about this connection, read Lydia Guy's excellent series on prevention frameworks in the 2006-2007 issues of *Partners In Social Change*. They are free and easily accessible online at: www.wcsap.org/prevention/PreventionNewsletter.htm.

One additional point to consider with regard to organizational capacity is a SDVA's organizational type (e.g., non-profit, governmental, private, etc.). This can be closely related to how its culture, human resources, systems and infrastructure, and organizational structure operate, and perhaps to a lesser extent, how it expresses its organizational aspirations and strategies. Primary SV/IPV prevention can find a supportive base in any type of SDVA, but prevention capacity building efforts would likely need to account for organizational type in order to be effective.

Virginia's Primary Prevention Guideline #9

Virginia's *Guidelines for the Primary Prevention of Sexual Violence & Intimate Partner Violence* are the product of a 4-year collaboration between VSDVAA staff, member agencies, and the Virginia Department of Health. The hope is that the guidelines document will help Virginia's sexual and domestic violence agencies - and possibly other community organizations - develop effective primary prevention initiatives. The guidelines are based on a combination of research and experience, borrowing heavily from the concepts and format outlined in Nation, et al.'s (2003) article as well as work conducted under the CDC's DELTA project that sought to apply Nation's work to primary IPV prevention.

Organizational prevention capacity (as well as institutionalization) is emphasized in Guideline #9 of Virginia's prevention guidelines:

Develop prevention strategies as an integral part of the agency mission to end sexual violence /intimate partner violence.

- Effective prevention programs are part of an organization's strategic plan.

- Effective prevention programs are given the financial and personnel resources needed to achieve the desired outcomes.

- Effective prevention programs are based on an agency-wide commitment to prevention in accordance with the aforementioned principles.

Aspirations and strategy – key points of organizational capacity – are addressed in Guideline #9's first point. As previously discussed, the prevention capacity of a SDVA is strongly linked to its mission and strategic plan, and how that plan includes and prioritizes primary prevention work. The second point of Guideline #9 addresses those 3 foundational components of organizational capacity. It underscores the significance of adequate infrastructure and human resources (including management of those resources), and implies functional organizational structure and systems. Guideline #9's third and final point articulates the value of institutionalizing enhancements in prevention capacity. Building the prevention capacity of SDVAs will take substantial organizational investment, so it is vital that these enhancements "stick" throughout all corners of the agency. Part 2 of this article, which will appear in the next issue of *Moving Upstream*, will provide a more in-depth exploration of institutionalizing prevention capacity at SDVAs.

References:

McKinsey & Company (2001). *Effective Capacity Building in Nonprofit Organizations*. Washington, DC: Venture Philanthropy Partners.

McPhee, P. & Bare, J. (2001). "Introduction." In C. J. DeVita & C. Flemming, (Ed.), *Building Capacity in Nonprofit Organizations* (pp. 1-4). The Urban Institute.

Nation, M., Crusto, C., Wandersman, A., Kumpfer, K.L., Seybolt, D., Morris ey-Kane, E., & Davino, K. (2003). What works in prevention: Principles of effective prevention programs. American Psychologist, 58, 449-456.

This article will continue in Part 2 of this series on organizational development toward primary prevention at sexual and domestic violence agencies: Institutionalizing prevention capacity.