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 2)

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This issue of Moving Upstream is the second of a 2-part series examining organizational development toward primary prevention at sexual and domestic violence agencies. Part 1 focused on building prevention capacity at these agencies. Part 2 will focus on the concept of "institutionalizing" organizational improvements in prevention capacity. One could argue that terms like "sustainability" and "institutionalization" are often spoken across numerous prevention disciplines, but seldom considered with any degree of detail. This issue attempts to begin a deeper conversation about these ideas, and will be informed by organizational development literature from the business world, established prevention principles, and wisdom from the field of primary sexual & intimate partner violence (SV/IPV) prevention.

Also, for an excellent and concise discussion of institutionalization as it applies to the sustainability of primary prevention projects (as opposed to institutionalizing prevention capacity at sexual and domestic violence agencies), see Deborah Fisher's recent training for the Centers for Disease Control & Prevention. You can request an overview of that training, and view her profile at: http://www.search-institute.org/training-speaking/trainers/deborah-fisher.

Built To Last: *Sustaining Prevention Capacity at Sexual & Domestic Violence Agencies*

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The previous issue of *Moving Upstream* examined the elements of organizational capacity relating to primary prevention work at local sexual and domestic violence agencies (SDVAs). This article is a continuation (Part 2 of a 2-part series), and will focus on "institutionalization," or how to ensure that enhancements in organizational prevention capacity endure in all corners of a SDVA. Institutionalization in this context describes the process by which organizational or programmatic improvements relevant to effective primary prevention become standard practice – how they can be made permanent.

Although based in a corporate background rather than the non-profit sector, the model of institutionalization presented by business researchers Cummings and Worley is concise and rational. In defining institutionalization they explain that it:

> …involves the long-term persistence of organizational changes: To the extent that changes persist, they can be said to be institutionalized. Such changes are not dependent on any one person but exist as a part of the culture of an organization. This means that numerous others share norms about the appropriateness of the changes. (2009, p. 200).

The degree to which SDVAs embrace, achieve, *and sustain* necessary organizational changes relevant to building primary prevention capacity, the more likely they will enhance their ability to be effective in preventing first-time perpetration of sexual and intimate partner violence (SV/IPV).

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Funder's Forum

RPE Grant Awards / Project Connect

Erica Williams, MS, Sexual Violence Prevention Specialist
Division of Injury and Violence Prevention, VDH

Rape and Sexual Violence Prevention Education

The Virginia Department of Health (VDH), Division of Prevention and Health Promotion, is pleased to announce the Rape and Sexual Violence Prevention Education contracts for 2010-2011. Funding for this opportunity is provided to VDH from the Center for Disease Control and Prevention (CDC). Potential contractors participated in a competitive request for proposal process. The following twelve agencies have been awarded contracts: Sexual Assault Resource Agency (Charlottesville), Safehome Systems (Covington), Services to Abused Families (Culpeper), Collins Center (Harrisonburg), Loudoun Citizens for Social Justice (Leesburg), Project Horizon (Lexington), Citizens Against Family Violence (Martinsville), Quin Rivers (Quinton), Women's Resource Center of the New River Valley (Radford), Haven Shelter and Services (Warsaw), Laurel Center (Winchester), Family Resource Center (Wytheville).

The proposals covered a variety of primary prevention programming in schools and colleges, faith communities, correctional centers, and other settings. For more information, please contact Erica Williams at 804-864-7741 or erica.williams@vdh.virginia.gov.

Project Connect

Project Connect, a groundbreaking multi-state initiative of the Family Violence Prevention Fund, seeks to develop comprehensive models of public health prevention and intervention that can lead to improved health and safety for victims of sexual and domestic violence (SV/DV). In Virginia, the project's focus lies in family planning and home visiting settings. VDH's Injury, Suicide and Violence Prevention Program, in partnership with the Women's and Infants' Health Program, the Virginia Home Visiting Consortium, and VSDVAA, is developing assessment strategies and tools, training curricula, and educational materials to better enable family planning clinic staff and early childhood home visiting workers to identify and provide support and referral to individuals and families impacted by SV/DV. On October 21, 2010, participants took part in a dynamic and interactive train-the-trainer session. Over the next year, these trainers will facilitate local or regional training sessions across the state for early childhood home visitors and family planning clinics. To be one of the first to receive information about registration, sign up for the VDH sexual violence list sever at::
http://www.vahealth.org/Injury/sexualviolence/listserv.htm.

Promising Practices

Institutionalizing Primary Prevention Capacity

A brief interview with ***Kristi VanAudenhove***, Co-Director of the Virginia Sexual & Domestic Violence Action Alliance; and **Gianna Gariglietti & Hanna Foster**, Executive Director and former Associate Director of The Collins Center.

The feature article in this issue adapts Cummings and Worley's (2009) theoretical framework for institutionalization to sustaining prevention capacity at sexual and domestic violence agencies. The Virginia Sexual & Domestic Violence Action Alliance (Action Alliance) and The Collins Center in Harrisonburg, VA (formerly Citizens Against Sexual Assault) have both worked to integrate prevention throughout their organizations for 5+ years. This interview with Kristi VanAudenhove (Action Alliance) and Gianna Gariglietti and Hanna Foster (The Collins Center) is a continuation from the "Promising Practices" column in Issue 6-1 of *Moving Upstream*, and will provide examples of how prevention capacity has been successfully sustained at these agencies.

MU: The Action Alliance tries to incorporate key primary prevention principles into all aspects of the agency. What are some examples of how this is accomplished?

KV: When we developed the formal Action Alliance communications plan, we asked ourselves "how do the ways we're communicating with statewide partners, the public, and our members about primary prevention fit with the principles in our *Guidelines for the Primary Prevention of Sexual Violence & Intimate Partner Violence*?" That is, we're not just talking to them about the prevention guidelines, we're using the concepts in the guidelines to steer HOW we're doing it. And how do we take the concepts in the guidelines to other partners, like when we're working with law enforcement to train new officers, maybe we should pilot a curriculum with high saturation - lots of message exposure and room for skills practice - versus doing lots of one-time trainings.

Also, there's been a cultural shift amongst the staff to really be aware of how primary prevention work can fit into "other aspects" of their jobs. We moved from a place where people felt that it was an "add-on" to what we're doing to a place where it's just a part of everyone's

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conception of this work. We've tried to reflect this in how we allocate resources. There are now 3.5 full-time positions engaged in primary prevention work, plus a significant portion of 1 director's job.

MU: Gianna and Hannah, how did The Collins Center go about incorporating primary prevention into its agency mission?

GG: A big shift came when we changed our name from Citizens Against Sexual Assault (CASA) to The Collins Center, and one of the reasons for this was that CASA was associated with "where you go after the violence happens." There were the usual stereotypes too, but we also wanted to get the message out that we are about changing the community for the better, and promoting healthier norms. That's what primary prevention is about to us. And now primary prevention work is maybe the biggest part of our agency.

HF: When you have "against" in your name, it kind of makes it hard to think about what it is you WANT people to DO. And primary prevention is about stating where you want to be going. Our new mission statement is more focused on "promoting healthy" instead of "responding to."

GG: We also decided that EVERYONE on staff should have an understanding of primary prevention, and we make sure that happens by sending all new staff to prevention trainings, etc. Basically, everyone does a little bit of all of the work, and then has a focus area. I think the tools and concepts from primary prevention should be applied in all aspects of our organization, which is why everyone needs to have a basic understanding of it.

"When you have 'against' in your name, it kind of makes it hard to think about what it is you WANT people to DO. And primary prevention is about stating where you want to be going. Our new mission statement is more focused on 'promoting healthy' instead of 'responding to'."

Sustaining Prevention Capacity at SDVAs (from Page 1)

In Virginia's *Guidelines for the Primary Prevention of Sexual Violence & Intimate Partner Violence*, institutionalization is emphasized in the third point under Guideline #9 (see Part 1 of this series to learn more about the first 2 points):

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.

But how does a SDVA arrive at an "agency-wide commitment" to primary prevention work, and what factors influence the strength and duration of that commitment? Cummings and Worley describe numerous factors influencing the institutionalization of organizational development in the business world, and while not all of them are applicable to the work or culture of SDVAs, there are enough clear parallels that adapting their model should help demystify the process of sustaining enhancements to prevention capacity.

The "Institutionalization Framework" Applied to Prevention Capacity

Cummings and Worley state that there are two main groups of factors affecting the process of institutionalizing improvements within organizations: Organizational Characteristics and Intervention Characteristics [see Figure 1]. Organizational characteristics are certain key attributes of an organization that exist prior to, and along with, any capacity building initiative. Intervention Characteristics describe important qualities of the capacity building initiative itself. (NOTE: The term "intervention" in this context comes from the hierarchical world of corporations, and is perhaps not the best word to describe how organizational changes, such as those resulting from prevention capacity building efforts, would be realized at a local SDVA. However, the concepts underlying many of the "intervention characteristics" described by Cummings and Worley are still quite applicable to institutionalizing gains in prevention capacity at SDVAs, though the term has been replaced in some of the quotations for the sake of semantic clarity.)

Organizational Characteristics

- *Congruence:* Cummings and Worley (2009) describe congruence as "the degree to which [organizational change] is perceived as being in harmony with the organization's [existing] managerial philosophy, strategy, and structure; its current environment; and…other changes taking place" (p. 203). The more that efforts to increase prevention capacity are seen as consistent with the agency's approach to its work - both in terms of philosophy and the way work tasks are distributed and delivered - and its existing system of authority or accountability, the more likely the capacity building will be supported and sustained. The previous issue of *Moving Upstream* partly addressed this concept in terms of how the "moving parts" of an organization (represented by Venture Philanthropy

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Partners 7-level capacity framework) interact with a SDVAs ability to take on primary prevention work. Congruence takes this a step further. It tells us that these same organizational elements also directly impact the extent to which a SDVA will embrace prevention capacity building efforts and incorporate any key improvements into its policy, protocols, and institutional wisdom – the parts of an organization where institutionalization typically "lives."

Prevention capacity building initiatives in Virginia have mostly been driven by the statewide coalition - the Virginia Sexual & Domestic Violence Action Alliance - and the Virginia Department of Health. These efforts have been steady, affirming to a social change framework, varied in format, and usually operating from an "opt-in" model (the exception being a few required prevention capacity building opportunities in which all recipients of a certain set of prevention grants must participate). Consequently, many of the local SDVAs that have demonstrated the most tangible and long-term enhancements in their prevention capacity are agencies that view themselves as more than a "service delivery" organization, and enable multiple staff members to access and utilize prevention capacity building opportunities across a variety of platforms (e.g., trainings, webinars, printed resources, online resources, technical assistance requests, etc.). Examples of these enhancements in prevention capacity include creating an equally-valued prevention "department" within the agency, finding ways to cross-train all staff (including directors) on prevention concepts and skills, and/or permanently committing part of the agency's fundraising to enhance local prevention work.

- *Stability of Environment:* "The degree to which the organization's environment…[is] changing. The persistence of change is favored when environments are stable" (Cummings & Worley, 2009; p. 204). This concept is fairly straight-forward. If an organization is experiencing some kind of volatility in their governing structure, demand for services, or day-to-day work environments, then it will be difficult for them to take on something they might perceive as "new" or "helpful-but-not-vital." Perhaps the board of directors of a local SDVA is locked in an internal power struggle or an agency suddenly becomes critically under-staffed, and its future is disruptively uncertain. In such circumstances, it would likely be difficult for an agency to focus on enhancements to any of its programs while struggling to maintain work at existing levels. Likewise, a SDVA that is running smoothly should be able to expend the time and energy it takes to consider what types of organizational development need to occur to build prevention capacity on an ongoing basis. A stable organizational environment should be able to more easily absorb and maintain enhancements to its prevention capacity, such as prevention training protocols for new staff or the development of a board-staff prevention committee.

While it can also be true that volatility in an organization is sometimes a vehicle for change (e.g., a "shake-up occurs" and staff or board members resistant to taking on prevention work happen to be the ones who leave and are replaced with people more open to prevention work), such scenarios can also be fraught with problems, especially if any consensus built around developing prevention capacity is forgotten or swept over in the midst of the agency attempting to find its footing. In the example of a staff "shake-up," there might be an increased number of folks interested in prevention work, but they will lack the benefit of any trust that was built with existing stakeholders, which could then inadvertently create a more entrenched atmosphere. Cummings and Worley (2009) describe this problem: "[Volatility]…can lead to reductions in personnel that may change the composition of the groups involved in the [capacity building efforts], or bring new members on board at a rate faster than they can be socialized effectively" (p. 204).

<u>"Intervention" Characteristics</u>

- *Goal Specificity:* The extent to which the desired effects of an organizational development initiative are well defined. Organizational prevention capacity is more likely to be sustained at a SDVA if the activities to build that capacity specifically define a set of new practices for staff, and outcomes for the agency. More concretely, "specificity of goals helps direct socializing activities (for example, training)…to particular behaviors required to implement the [organizational changes]" necessary to enhance prevention capacity. (Cummings and Worley, 2009; p. 204). In Virginia, most of the prevention capacity goals are tied to the *Guidelines for the Primary Prevention of Sexual Violence & Intimate Partner Violence*. The guidelines document provides clear goals for both the manner in which SDVAs engaged in prevention work operate (e.g., Guideline #9), and the manner in which these agencies implement their primary prevention projects (e.g., Guidelines #1-8). The

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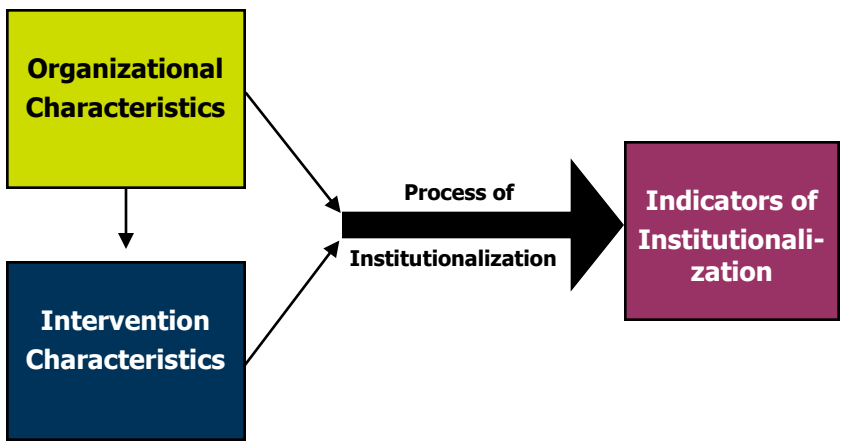
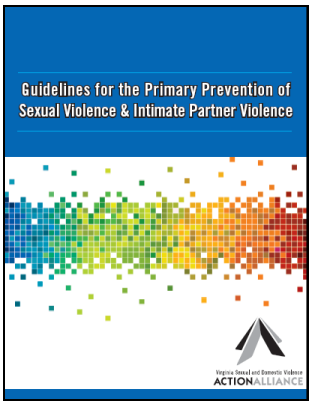
Figure 1: Institutionalization Framework

(Adapted from Cummings & Worley, 2009)



Sustaining Prevention Capacity at SDVAs (from Page 4)

assessment tool (Appendix D in the guidelines document) also provides specific examples of how an agency or prevention project might look at "Low," "Moderate/Mixed," or "High" magnitudes of each guideline. Operationalizing each guideline at each of these levels of magnitude provides a set of unambiguous benchmarks for prevention capacity at SDVAs, and in doing so presents any assessed agency with a specific set of goals for building their own prevention capacity. This allows the SDVA to more efficiently devise a capacity building plan that makes sense for them, which in turn makes such efforts more relevant, apparent, and likely to stick.



- *Level of Change:* This factor in the institutionalization of a capacity building initiative is most relevant to larger organizations (e.g., SDVAs with multiple staff teams or departments). Cummings and Worley (2009) explain:

> Each level of [an] organization has facilitators and inhibitors of persistence. Departmental and group changes are susceptible to countervailing forces from others in the organization. These can reduce the diffusion of the [capacity building initiative] and lower its ability to [make a lasting] impact....However, this does not preclude institutionalizing the change within a department that successfully insulates itself as a subculture within the organization….Targeting the [capacity building intervention] toward wider segments of the organization, on the other hand, can also help or hinder change persistence. A shared belief about the [capacity building initiative's] value can be a powerful incentive to maintain the change, and promoting a consensus across organizational departments exposed to the change can facilitate institutionalization. But targeting the larger system also can inhibit institutionalization. The [capacity building initiative] can become mired in political resistance because of the "not invented here" syndrome or because powerful constituencies oppose it (p. 204-205).

If a SDVA has 5 distinct groups of staff who handle 5 different areas of work (e.g., crisis intervention and sheltering, legal advocacy, long term mental health, primary prevention, and administration), then where should prevention capacity building efforts begin? Do all of these groups need to engage in a process of building prevention capacity, or can such efforts be largely concentrated on primary prevention staff and directors? The answers to these questions will be as varied as the culture and configuration of each individual SDVA. The impact that these decisions will have on the permanency of gains in prevention capacity should be carefully considered before a SDVA engages in any structured prevention capacity building effort.

- *Sponsorship:* "This concerns the presence of a powerful sponsor who can initiate, allocate, and legitimize resources for the intervention. Sponsors must come from levels in the organization high enough to control appropriate resources, and they must have the visibility and power to nurture the [capacity building practices] and see that [they] remain viable." (Cummings & Worley, 2009; p. 205). If organizational prevention capacity at a SDVA is continually enhanced, then there is most likely a "prevention champion" within the organization who has the influence to make it so.

In Virginia, most SDVAs that have demonstrated sustained gains in organizational prevention capacity have had an experienced Executive Director and/or a program manager who understood the importance of primary prevention work. They were able to promote the concepts, secure the resources, and implement the organizational changes necessary for the creation of an environment where this work can thrive. Sometimes the impetus for these shifts comes from frontline prevention staff expressing the need for more support, thus these workers are also usually a force for putting enhancements in SDVA prevention capacity into motion, and keeping them going. Though without the support of more powerful figures in an agency, the concerns of frontline prevention staff will not likely result in any kind of meaningful and persistent increase in organizational prevention capacity.

It is important to note that the presence of an influential prevention champion in an agency is not, by itself, a way to institutionalize gains in organizational prevention capacity. Cummings and Worley are unequivocal on this point: "There are many examples of organizational development interventions that persisted for several years and then collapsed when the sponsor, usually a top administrator, left the organization" (2009; p. 205). Other key stakeholders in the SDVA (e.g., board members, community supporters, and other long-term staff) should ultimately be engaged in prevention capacity building efforts so that gains are not lost when the initial "sponsor" is no longer affiliated with the agency. Changes in organizational policy that frame prevention work as vital to the agency will also help keep enhancements in prevention capacity stable (see previous article for more information).

Indicators of Institutionalization

Cummings and Worley (2009) emphasize that, "Institutionalization is not an all-or-nothing concept, but reflects degrees of persistence in a change" (p. 206), and offer 5 indicators that signify how much an organization is incorporating a given set of changes. Each of these factors corresponds well to building organizational prevention capacity at SDVAs, and the, "extent to which these indicators are present or absent indicates the degree of institutionalization" (p. 206).

1) Knowledge: "This involves the extent to which organization members have knowledge of the behaviors associated with [capacity

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*NOTE: Cummings and Worley describe a 3rd organizational characteristic, Unionization, and 2 other intervention characteristics: Programmability and Internal Support/Consultant. The 5 processes of institutionalization were also omitted. These concepts were not discussed here because they lack a clear parallel to prevention work at SDVAs, and/or because they were too specific to a corporate environment.

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building efforts] (p. 206). In the context of SDVA prevention capacity, questions to assess the knowledge indicator could include:

- Do all staff (including management) have a basic understanding of primary prevention and how it is complementary to, but distinct from, other work traditionally associated with SDVAs?
- Are staff - and perhaps even board members - able to identify and describe key prevention principles, such as the importance of working at more than the individual level of the social ecology, concentrating (AKA "saturating") prevention strategies, and planning systems of evaluation?
- Do the staff members working directly on primary prevention projects have a nuanced knowledge of the approaches they are implementing? For example, if a SDVA is doing (or is planning to do) a community mobilization project in a neighborhood, are the staff primarily responsible for that project well-acquainted with an established model of community mobilization, including all stages in the process and the kinds of activities that should be occurring at various points in the project's development?

2) Performance: This refers to the extent to which the aforementioned points of knowledge are actually put into action. In the context of SDVA prevention capacity, performance could be assessed by discerning if staff at a SDVA demonstrate prevention knowledge, and how competently it is being applied. If staff at a SDVA have created primary prevention projects that are intentionally consistent with prevention principles and exhibit competent implementation, it is one indication that the prevention capacity of that agency is fairly substantial and stable.

3) Preferences: "This involves the degree to which organization members privately accept the organizational changes. This contrasts with acceptance based primarily on organizational sanctions or group pressures. Private acceptance usually is reflected in people's positive attitudes toward the changes and can be measured by the direction and intensity of those attitudes…" (p. 207). In the context of SDVA prevention capacity, the preference indicator is fairly straight-forward. How much worth do individual staff members place on building organizational prevention capacity at the SDVA, and to what degree do they like or dislike / agree or disagree with the processes used to develop this capacity? The more that the individuals comprising an organization personally endorse prevention capacity building efforts, the more likely it is that gains in organizational prevention capacity will be sustained.

4) Normative consensus: "This focuses on the extent to which people agree about the appropriateness of the organization changes…. [Organizational changes] would become institutionalized to the extent that employees support it and see it as appropriate to organizational functioning" (p. 207). In the context of SDVA prevention capacity, this indicator could be described as the aggregate of the aforementioned preferences indicator. The level of agreement or disagreement amongst the individuals who make up the SDVA about the necessity and methods of prevention capacity building will help predict the duration of any enhancements. Again, this is a clear-cut indicator: If most of the people in an organization value improvements in prevention capacity to a high degree, then those improvements will likely persist. But if most people do not value this, or if there is a wide range of opinions, then any gains in organizational prevention capacity will be less likely to last. Since consensus building can be a lengthy process, this indicator illustrates the importance of SDVAs dedicating an equitable amount of time and energy to prevention capacity building efforts relative to other areas of organizational capacity (such as administration or direct services).

5) Value consensus: "Values [in this context] are beliefs about how people ought or ought not to behave. They are abstractions from more specific norms" (p. 207). The extent to which new skills and agency protocols resulting from prevention capacity building efforts are consistent with, or contradictory to, larger philosophical values shared across individuals in the organization will help indicate the persistence of gains in prevention capacity. For instance, if a SDVA generally values staff autonomy and personal responsibility for getting work completed – both of which fit with the nature of most primary prevention work, since most of the day-to-day tasks take place out in communities – then building and maintaining prevention capacity will likely be easier to accomplish. Conversely, SDVAs with a more rigidly hierarchical and highly supervised environment might struggle with the demands of prevention work, and thus be challenged to build and maintain prevention capacity.

Conclusion

Understanding the factors that influence how prevention capacity can be more robustly internalized and sustained at SDVAs can improve the impact of these capacity building efforts, and provide a degree of perspective to SDVAs as to how ready they are to embrace organizational development initiatives to this effect. Applying "Congruence" and "Stability of Environment" to one's own organizational context can help tell a SDVA what in-house changes may need to occur before prevention capacity can be built to last. Likewise, using concepts like "Goal Specificity," "Level of Change," and "Sponsorship" to inform prevention capacity building initiatives can increase the persistence of any resulting organizational development. Monitoring changes within the SDVA using the "Indicators of Institutionalization" offers valuable benchmarks for determining the extent to which gains in prevention capacity are integrated within a SDVA.

References:

Organization Development & Change, 9th Edition. (2009) By: Thomas G. Cummings & Christopher G. Worley. South-Western Cenage Learning: Mason, OH.