

Washington State Sexual Violence Prevention Planning Process Advisory Committee

February 26, 2008

Meeting Notes

Present: Golie Jansen, Erin Casey, Kate Rowe-Marloret, Debbie Ruggles, Karen Andrews, Rosalinda Noriega, Mary Anne Preece, Judith Panlasigui, Lindsay Palmer, Gretta Jarolimek, Stephanie Condon, Stephanie Pratt, Grant Stancliff, Kari Kesler, Linda Daniels, Ellen Price, Trista Paulson, Kevin Higgins, Katherine Gechter

Facilitators: Lydia Guy, Gayle Stringer

Discussion Item 1: Historical perspectives of sexual violence in WA State

Stephanie Condon presented on the historical perspectives of sexual violence in Washington State from 1995 to 2007.¹

In 1995 the WA State Sexual Assault Services Plan was completed. This resulted in the consolidation of funding at OCVA, formulaic distribution of funding and service standards and accreditation.

In 1997 after the Federal Rape Prevention and Education Program was established the Washington State SA Prevention Committee, comprised of experts in sexual assault and prevention, convened. These meetings resulted in a statewide sexual assault prevention plan which recommended the adoption of a social change approach to prevention. The plan was implemented in 3 phases:

Phase 1: Pilot Projects 1997 – 2000

- 5 community development demonstration projects. The intent of this phase was to put the Lofquist model into play and note the successes and challenges from such approach.
- Prevention Resource Center established – Gayle worked directly with Lofquist to adapt his model to sexual violence – translated model into concrete steps
- Statewide media campaign – Comprehensive campaign utilizing media firm resulted in Mylar posters and radio spots
- Evaluation – process evaluation, gauging progress and deciding on next steps. ORS found that in many communities, sexual assault was not a salient issue, making the implementation of the model challenging.

Group discussed why the community development model was challenging:

Set up of many of the agencies as DV/SA – often same person doing crisis intervention and prevention. Model requires a lot of time in building relationships. The people who were most successful with model enjoyed doing community organizing. The rewards for doing this type of

¹ See attached powerpoint presentation for full presentation content.

work were different for different personalities. Model as constructed is structural approach for something that is developmental. People were unsure how to document ‘relationship building’ in OCVA reports. Model, which sees people as resources, had to fit into a services delivery model which sees people as clients. Prevention standards implemented at the same time as the community development model. Unique make-up of community – lots of turnover – need staff to do CD work. Difficulty in helping other service providers understand the shift – they want to be told what to do by the experts. People didn’t believe the model was useful and worth the time and effort. The pilot sites had more resources. Model relies on skills to facilitate, navigate and debunk myths around SA. High need for training, TA, and support to do CD.

Phase 2: Statewide Implementation

This phase went beyond what was written in the 1997 plan. Components: 1) prevention added to core services, 2) Wider distribution of funding, 3) In place all across the state, 4) Flexibility in terms of social change work – got to pick their own communities.

The Prevention Resource Center widened its scope from supporting the pilot projects to supporting all programs.

Service Standards

By making prevention a core service it took the education service standard away. The purpose of the education service standard was education about services provided or “information and awareness”. After the replacement, OCVA didn’t create a clear place for outreach that was originally covered by the education service standard.

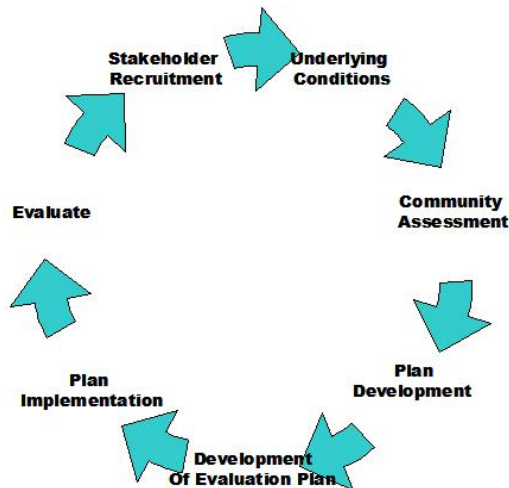
The prevention standards were written by the services committee and the prevention committee. There was a decision to take a gradual approach to implementing the social change goal of the prevention plan. The strategy involved creating a holistic approach to prevention – info/awareness, skills building, in addition to social change.

Community Development

The key to social change is community directed process which takes into consideration the community’s readiness. Stakeholders do not need to be knowledgeable about sexual assault – just willing to learn. Community development is all about facilitating a process.

7-step process²

² See WCSAP publication Intro to Community Development for more detailed explanation of the steps



Items to consider in applying the model: The community should be defined by the community itself. Underlying conditions – trying to get people to move from symptoms to root causes. Community assessment is not a needs assessment – the focus here is only on the positive. Evaluation needs to be tied into the prevention plan – after evaluation the process continues – do you change the underlying condition, reassess readiness, or maybe the CD project moves over to a service.

Group discussed more challenges to community development

If the facilitator doesn't like the community, the community development project will fail. Very few qualified people who know how to do community development. You need someone who can build relationships and facilitate a process – these skills are very different from clinicians. If agency's leadership doesn't understand the model, it will not give longevity to the project. Also, people don't understand prevention at all, let alone social change or community development. The willingness to engage in change is important to this process. It is overwhelming to help people understand the model. WCSAP needs ongoing, formalized training around prevention and community development. The orientation-level training is outdated and needs to be updated after the report in October.

We are the one state doing community development work. This is the problem with being on the cutting-edge.

Phase 3: Marginalized Communities

The Community Voices Project recommended the establishment of a services and prevention funding pool for marginalized communities. In 2005 implemented 2 new service standards for services and prevention work in marginalized communities. The standards were similar to the other 3 prevention standards

Phase 4: Where we are now

Small Group Discussion on the 1997 prevention plan

The advisory group was split into 4 predetermined groups to discuss the questions below. The “ex officio” members formed a 5th small group to also discuss the following questions.

1. What have been the “successes” in implementing the 1997 prevention plan?
2. What have been the “challenges” in implementing the 1997 prevention plan?
3. How should we address these into our 2008 plan?

Red Group’s Answers

1. Successes

a) Many successful projects: PCN – project wouldn’t have happened without the CD model. **b)** Building relationships – importance of building; ability to leverage relationships; legitimizing buying pizza and going to barbeques. **c)** Made us pay attention to community readiness and stages of change. **d)** Legitimizing community organizing and giving it language. **e)** Encouraging agencies to prioritize prevention. **f)** Putting focus on ownership, sustainability, collaboration and accountability. **g)** Can legitimize anti-oppression work. **h)** Impact of this model on direct services – people seen as resources and how that informs advocacy; services becoming CD project.

2. Challenges

a) CD requires a lot of skills and support to learn and do – can seem overwhelming and confusing at first. **b)** Supervisors and EDs may not understand – hard to institutionalize. **c)** Hard for staff to let go of idea of themselves as “expert” – people must believe that people are resources. **d)** Balancing prevention and crisis intervention. **e)** Everyone (CSAPs) don’t buy into the CD model. **f)** Some projects don’t address root causes. **g)** Balancing different levels of readiness between stakeholders. **h)** Both evaluation and assessing readiness is difficult. **i)** Lack of immediate results. **j)** Lack of training.

3. Ways to address

a) More structured and ongoing training for prevention staff – including community readiness and evaluation and stages of change. **b)** Maintain focus on underlying conditions and ensure issues of anti-oppression are included. **c)** Ensure staff in job classes receive training on CD model. **d)** Assess agencies on knowledge of model. **e)** Input on new plan from Community Voices group.

Blue Group’s Answers

1. Successes

a) Has been implemented successfully in many communities. **b)** Widespread **c)** Focus is on process not a product. **d)** Media campaign resulted in tangible goods. **e)** Demonstration projects provided leadership, tangible goods. **f)** RC TA has enabled statewide sharing of goods and knowledge. **g)** Involvement of a focus on youth. **h)** Enhanced intervention programs through greater community involvement. **i)** CD process

builds authentic relationships – opens more doors, provides more opportunities, engage outside the box. **j)** Increases resources for community. **k)** Shared language: struggles

2. Challenges

a) Documentation. **b)** Telling the story – beyond bullet points. **c)** Training – Introduction (theory), Advanced (interactive) – facilitation and difficulties. **d)** Keeping up interest of trainings. **e)** Balancing behind the scenes with direct service. **f)** Keeping community's confidence. **g)** Tools to keep meetings fresh, fun and process oriented. **h)** Helping other service providers to understand differences between community development and service delivery. **i)** Teens – getting and maintaining consistent access to schools; uncertainty around mandated reporting; willingness to building relationships with teens; empowering teens; informing them of mandated reporting. **j)** Challenge finding resources – time = money. **k)** Dealing with community structures; **l)** Ageism; **m)** Learning to be flexible around teens developmental level.

3. Ways to address

a) More regularly scheduled trainings on: facilitation, documentation, articulating community development, fun activities, telling “whole story” – quantitative and qualitative, interactive training with peers, different levels of experience, empowering teens and in relation to mandated reporting; youth focus, lifting voices of youth, developing evaluations for all, meeting planning (all factors), techniques to pass-off ownership (CD for social change not for year end report). **b)** Increased communication of CD to other state agencies in order to increase likelihood of successful partnerships and collaboration. **c)** Solidify risk and protective factors for SA field. **d)** Increased assistance with evaluations for everyone. **e)** Resource sharing among HR and EDs regarding prevention educators. **f)** Articulating/discovering similarities and differences between CD and youth development.

Green Group's Answers

1. Successes

a) Shifting of ownership, worked in some groups, i.e. communities found solutions – different form service providers. **b)** Stakeholders held 2 weekend retreats a year (parent to parent peer training to reduce bullying – sexual harassment among teens. So successful. **c)** Training video for high school students regarding gangs and rape (former gang member women) still showing in high schools. **d)** WSU and U of I worked with men put together Men Against Violence group. Young men realize that VAW is a problem. **e)** 44 non-profit agency coalition (family-children partnership). **f)** Stakeholders prevention committee with 5 task groups (resource, community, assessment, birth to death, grant writing). **g)** Lofquist model helps to slow down – facilitate the process in patience.

2. Challenges

a) Sustainability. **b)** Lack of training, limited training (self learning) and technical support. **c)** Staff turnover and community turnover. **d)** Developmental nature: process has no end, yet “product” is expected. **e)** Money. Spending of money not allowed for the

work. **f)** Model takes a lot of time and energy. Work is not valued – quantifiable. **g)** You cannot expect expertise from video and limited training. **h)** Recruitment of core group and stakeholders. **i)** tension between CO and advocacy. **j)** Big Words

3. Ways to address

a) Revisit words and vocabulary. Social change vs. change, community development, beliefs and values, etc. **b)** Create mandatory core training and follow-up for additional skills and support. **c)** Training for administrators in model and service integration with CD model. **d)** More money. **e)** Revisit accreditation standards. **f)** Develop job description for CD workers. **g)** Improve networking and peer exchange and support. **h)** WCSAP conference: Progression in content of prevention tracks. **i)** Define skills and qualifications.

Yellow Group's Answers

1. Successes

a) Supported more awareness across community. **b)** Supported education, safety efforts – generated resources to support this work. **c)** Created access to funding. **d)** Made prevention a standard part of the conversation – re-conceptualized it as “core” to our work. **e)** CDC now sees CD/community mobilization as a legitimate prevention strategy. **f)** Integrated multiple levels of prevention into an integrated model – shows interrelation steps between activities. **g)** Pushed agencies to move into the community while honoring what work they’d been doing. **h)** Increased contacts and connections and support for agencies as they develop relationships with new communities. **i)** Brought SA into crime prevention arena. **j)** More people doing “the work” – schools taking it on. **k)** Created linkages across issues/disciplines – DV, childcare, safety, youth, etc.

2. Challenges

a) Money. **b)** Difficulty doing prevention work around an issue that still has so much shame/victim-blaming/myths/lack of willingness to talk about it. **c)** Overlapping issues – teen pregnancy, poverty, alcohol use, etc. How to incorporate all these? **d)** Challenges in readiness in communities – i.e. schools without focus on abstinence, small communities where its not safe to come forward, etc. **e)** Broadness of social change and lack of clarity about what exactly were are trying to prevent. SA? Lack of reporting? **f)** Hard to move away from needs – how to get social change. **g)** Turnover and burnout. **h)** Very hard to evaluate in any systematic way. **i)** Very difficult to communicate success. **j)** Difficult to communicate “prevention” and “social change” to EDs, co-workers, communities. **j)** Changes in technology: how to evolve as risks change.

3. Ways to address

a) Changes in technology. **b)** Specific training for CD workers – train the trainers. **c)** Improved evaluation, data collection tools that are clearly linked to standards/work itself. **d)** Increase resources for developing CD skill, i.e. training in social work. **e)** Increase # of diversity of people at the table talking about prevention. **f)** Take a look at how funding is allocated, i.e. is money spread too thin, are agencies getting money and not using it? **g)**

How to work across issues, i.e. alcohol and drugs. How does plan account for intersecting/embedding social issues. **h)** Encourage inclusion of positive/diverse role models to engage in CD projects. **i)** Money. **j)** Refining/narrowing eligible activities – link to evidence at this point about what is most likely to create change.

Ex-officio Group's Answers

1. Successes

a) Prevention throughout state – every region. **b)** CSAPs partnered with a wider array of groups/communities, new relationships, visibility. **c)** Support infrastructure worked for many, was available for all. **d)** As a state, we talked about norm or culture change in a meaningful way (root causes).

2. Challenges

a) Dosage – difficult to do meaningful prevention work with available money/40 CSAPs. **b)** Theoretical approach not always intuitive. **c)** Limited evidence in violence prevention, especially WA model. **d)** Push/pull between DV/SA, intervention/prevention.

3. Ways to address

a) New strategy for highly encouraging programs to integrate theory, promising practices, and good planning. **b)** Build mechanism into plan that codifies and supports infrastructure (DOH, WCSAP, OCVA). **c)** Leadership development – leverage growing skill/leadership at programs.

Discussion Item 3: What makes a sexual violence prevention strategy compelling?

Group discussed what would make the prevention plan compelling and relevant for those doing the work:

a) Useful – more than theory; **b)** Acknowledging challenges; **c)** Broken into sections; **d)** Provide hope to ending SA; **e)** Connect to daily work or experience; **f)** Progressive; **g)** Inspirational point of entry; **h)** Something to do with core values – empowerment, inclusiveness; **i)** Talking points/Bullet points/cheat sheet – root causes, youth development, appendix, how do we know it works, what to look for; **j)** Success stories; **k)** Resource – living, breathing document. HOPE – Helping Ourselves Provide Prevention Education; **l)** Power and control our own relationships; **m)** Limitations of only focusing on services. **n)** Dissemination in person and with media; **o)** Examples of evaluations/way of quantifying process; **p)** Careful about being honest; **q)** Rationale based on solid experience; **r)** Honest discussion of time/experience; **s)** Not everything is social change; **t)** Everything is not prevention.