

An Assessment of and Recommendations for the Prevention of Violence Against Women in Virginia

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Center for Injury and Violence Prevention
Virginia Department of Health



For more information on this report or to obtain additional copies, contact:

Center for Injury and Violence Prevention
Virginia Department of Health
1500 East Main Street, Suite 105
Richmond VA 23219
(804) 692-0104
CIVP@vdh.state.va.us

This report is available online at
<http://www.vahealth.org/civp/domesticviolence>

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I. Introduction

Background

In October 2002, the Center for Injury & Violence Prevention (CIVP), Virginia Department of Health (VDH), received a one-year planning grant from the U.S. Centers for Disease Control and Prevention (CDC) for the prevention of violence against women (VAW). The purpose of the grant was to engage in assessment and planning activities to provide recommendations for strengthening the involvement of state and local health departments and other public and private agencies in the prevention of violence against women, with a special focus on underserved or special populations. For the purposes of this project, violence against women includes intimate partner violence, sexual violence by any perpetrator and other forms of violence committed by acquaintances or strangers.

Scope and Methods

The discipline of public health engages in three core functions to address public health issues and concerns: assessment, policy development and assurance. Assessment is the routine and systematic collection, analysis, interpretation and dissemination of information about the health status and health needs of any population or community. Policy development is the creation and implementation of policies, regulations, plans and strategies to achieve agreed-upon goals. Assurance is making sure that the goals are met by encouraging others to act, by requiring others to act through regulation or by taking action directly¹.

In the context of these functions, and following an initial overview of the status of the prevention of violence against women in Virginia, the CIVP determined that the most useful planning and assessment efforts for this project were:

- An assessment of the quality of state-level surveillance and data collection regarding violence against women, particularly as they relate to prevention (assessment and assurance functions)
- An assessment of current efforts regarding the prevention of violence against women within programs of the Virginia Department of Health (assessment function)
- An assessment of current efforts regarding the prevention of violence against women among key stakeholders state-wide, with particular attention to efforts regarding underserved or special populations of women (assessment function)
- The creation of a logic model as a basic plan for the prevention of violence against women in Virginia (policy development function)
- The identification of existing resources for the prevention of violence against women in Virginia (assessment function)

The methods used to accomplish these tasks were as follows: to assess the quality of surveillance and state-level data regarding violence against women, the CIVP identified relevant data sources and examined their purpose and utility in comparison to national standards and agendas for research and surveillance in the area of violence against women. In addition, nine interviews were conducted with key state-level staff having responsibility for data collection and analysis.

To assess current efforts regarding the prevention of violence against women within programs of the Virginia Department of Health, 21 interviews were conducted with central office and local health department program staff to identify current efforts regarding the prevention of VAW and explore what resources and support would be needed to increase the capacity of VDH to engage effectively in the prevention of violence against women. Additionally, on February 27, 2002 a work session was held, attended by 19 central office and local health department staff. The purpose of the work session was to identify specific existing opportunities for, and interest in, increasing VDH's efforts regarding the prevention of VAW and to discuss what types and level of resources would be needed to take advantage of those opportunities. Finally, in July, 2003, Nurse Managers in local health departments were surveyed by email as to their staff's current activities and efforts regarding the prevention of violence against women, opportunities to increase their involvement in the prevention of violence against women, what additional resources would be needed to further the opportunities identified.

To assess current efforts regarding the prevention of violence against women among key stakeholders statewide, with particular attention to efforts regarding underserved or special populations of women, several approaches were used. Seventy-three interviews were held with staff members of key stakeholder agencies regarding violence against women. All of these stakeholder agencies have at least some of their purpose and/or resources that are focused on violence against women. Interviews were held with staff members from the Office of the Attorney General; the Virginia Department for the Aging and the Virginia Departments of Criminal Justice Services; Education; Health; Health Professions; Mental Health, Mental Retardation and Substance Abuse Services; and Social Services. Staff were interviewed from Virginians Against Domestic Violence (VADV), Virginians Aligned Against Sexual Assault (VAASA), Virginia Commonwealth University and the Medical College of Virginia; the University of Virginia; Virginia Union University; and from 16 Domestic Violence Programs and Sexual Assault Crisis Centers around the state.

Forty-two interviews were conducted regarding the prevention of VAW among women who are members of special or underserved populations. These included interviews with staff from VADV and VAASA as well as from local Domestic Violence Programs and Sexual Assault Crisis Centers. Interviews were also conducted with agencies providing other types of services to women in special populations, that is, services not directly related to domestic violence and sexual assault. These included agencies serving immigrant and refugee women; adolescents; gay/lesbian/bisexual/questioning adults and youth; sex workers; people with disabilities; people with substance abuse and other mental health problems; people who are homeless; women who are in prison; and members of ethnic and cultural groups.

To create a logic model as a basic plan for the prevention of violence against women in Virginia, a logic model development workshop was held on April 22, 2003, attended by 23 people from the key stakeholder agencies listed above, as well as staff representing agencies concerned with special and underserved populations. In addition to the development of a logic model, the workshop also included discussions of the current strengths and weaknesses of VAW prevention efforts and of desired prevention outcomes for the near future. Tom Chapel, MBA, Senior Scientist with the CDC, led the workshop. To identify existing resources for the prevention of VAW, a list of key resources in various areas was developed through the above activities. This resource list is attached as Appendix 1.

Before presenting the findings and recommendations from the above activities, a discussion of public health and violence against women is necessary so that the project's results can be framed and understood properly.

Public Health and Violence Against Women

Violence against women is a public health problem because it causes large numbers of deaths, injuries and disabilities among women, because it is a learned behavior that can be prevented and because its prevention requires collective action. Public health in general is concerned with the health and well being of any population or community in its entirety, unlike medical or health care services where the focus is on the individual. Finally, the main focus for public health efforts is *preventing* death, injury and disability, with an emphasis on *primary* prevention.

The focus of primary prevention is to keep adverse health consequences from ever happening and to promote optimum health. This dual focus is captured in a definition of prevention adapted from the work of William Lofquist: "Prevention is an active, assertive process of creating conditions and/or personal attributes that promote the well-being of people and communities"².

Public health's violence prevention efforts are complementary to those of the criminal justice system, which typically engages in apprehending, sentencing, incarcerating and rehabilitating offenders. Public health also complements the efforts of the social service, medical care and mental health systems that provide treatment to those women who have been victims of violence. However, as valuable and necessary as the criminal justice and social service/medical/mental health responses are, it must be noted that *only effective prevention can **end** the perpetration of violence against women, because only through prevention can new cases of violence against women be kept from occurring.*

A useful model for understanding complex and multi-causal public health problems such as violence against women is the Social Ecology Model^{3,4}. The Social Ecology Model looks at the causes of problems at four levels – individual, interpersonal, community and society. At each level, the factors and conditions that create the problem can be identified through research and analysis. Through the richness and detail of the analysis, the description of the problem will match its actual complexity, thus allowing the development of prevention strategies to address causes at all levels and in many ways.

Regarding violence against women, some examples of factors that can be analyzed using the Social Ecology Model are as follows:

- Individual: Personal attitudes about gender roles; level of social isolation; presence of alcohol and drug use; presence of violence in family of origin
- Interpersonal: Peer attitudes towards gender roles and violence; presence of power and control conflicts; level of communication skills
- Community: Attitudes and norms about gender roles and violence against women, level of tolerance for violence against women; institutional policies towards violence against women
- Society: Historical patterns of attitudes towards women; gender inequality; religious and other cultural values and beliefs; economic, legal and social policies affecting violence against women

Once the causes of a problem are identified, prevention strategies can be developed to address them at all levels. One useful model for prevention strategies is the Spectrum of Prevention, developed by the Community Wellness & Prevention Program of Contra Costa County, California. The Spectrum of Prevention is a framework of seven strategies that can be used to conceive, plan, implement, coordinate and evaluate a large variety of public health programs at all necessary levels. The following strategies are included in the Spectrum of Prevention:

- Influencing policy and legislation
- Mobilizing neighborhoods and communities
- Fostering coalitions and networks
- Changing organizational practices
- Educating providers
- Promoting community education
- Strengthening individual knowledge and skills

While most of these strategies are individually familiar to public health practitioners and others, combining them into a unified approach for public health problems brings several benefits. Using the Spectrum of Prevention can improve coordination and collaboration within and across the many agencies addressing a particular problem or issue.

The efforts to address any public health problem often are organized by categorical programs, that is, programs focused by a limited definition of the target population or problem to be addressed (e.g., women only, sexual violence only). These programs, in turn, will be linked to a separate funding source and mandated scope of work. This results in the response to problems being fragmented and inconsistent over time, even among programs within the same organization that are addressing the same problem. Using the Spectrum or any model that takes a multi-level, multi-factorial approach can reduce this fragmentation by providing "...a framework and common language for people from diverse backgrounds to come together, share information, highlight gaps in [prevention] service, and develop joint plans...The Spectrum helps facilitate these partnerships by illustrating that short-term, seemingly free-standing activities are connected and part of a broader context"⁵.

It is important to note that any agency's development of prevention strategies for a public health problem must reflect not only a full and adequate assessment, but also be appropriate for the role of that agency and for its resources.

II. Surveillance and Data

Background

Timely, complete and accurate surveillance and other data are essential for the prevention of violence against women in several ways. For the purpose of this report, “surveillance” is defined as the ongoing and systematic collection, analysis and interpretation of health-related data. First, such data help us to understand the scope and magnitude of the VAW problem in and of itself and also in relation to other public health problems. Knowing the detailed scope and magnitude of the VAW problem is necessary:

- To identify those who may be at risk for VAW for use in planning effective prevention and intervention programs; and
- To monitor changes over time in the incidence and prevalence of VAW as a measure of the effectiveness of prevention and intervention programs.

Understanding the relationship of VAW to other public health problems is critical so that VAW can hold its proper place in the prioritization of these problems. Once the scope of the problem of violence against women is known, this information helps advocates influence policymakers, researchers and media professionals to ensure that VAW receives an appropriate response in terms of law, policies, resources, research and public awareness efforts.

Unfortunately, surveillance and other data systems for VAW have been plagued by several key problems over the years^{6,7}. The first is that there has not been consensus at the national level on the definition of what is meant by “violence against women”. This lack of consensus has meant that many different definitions of VAW have been used in localities, at the state level, and nationally, making collecting and comparing data across time and place very difficult. This has resulted in great variation about estimates of the scope and severity of the VAW problem.

A second major problem is that much of the existing surveillance data is about the demand for and use of social, health and criminal justice services relating to VAW. These are data such as the amount and type of victim advocacy and support services provided, VAW crimes reported, and outpatient and inpatient health care services provided to victims. Although these types of data are essential for planning and monitoring the response to violence against women, they do not provide accurate information on the true scope of VAW (incidence and prevalence data) nor on the circumstances and conditions that surround acts of violence against women. And it is these types of data that are critical for the prevention of violence against women.

Accurate incidence and prevalence data describe the true scope of the problem of violence against women, both new cases and the lifetime experience of cases among the population. This data is necessary to ascertain, over time, whether or not prevention and early intervention efforts are reducing the problem. Data on the circumstances and conditions that surround acts of violence are needed to help determine who may be most at risk of violence and provide clues as to which strategies would be most useful for prevention. Specific examples of types of useful data are discussed in the recommendations section below.

The data problems identified nationally are also issues for Virginia's VAW surveillance and data systems. In addition to an overview of VAW surveillance and data systems in Virginia and a discussion of findings and their implications, described below are initiatives being undertaken to address some of these weaknesses.

Status of VAW Surveillance and Data Systems in Virginia

The Center for Injury and Violence Prevention produces annual reports on all injury-related deaths and hospitalizations and on intentional injury-related deaths and hospitalizations, each including information aggregated by age, gender, race, hospital charges and length of stay. Analysis of the leading causes of injury deaths and hospitalizations is also included.

This report shows that in 2001, homicide was the 18th leading cause of death for all women in Virginia, accounting for 144 deaths. Of these deaths, 60 (41.6%) were through firearms. In 2001, assault resulted in 300 hospitalizations of women in Virginia. It is important to note that only the most severe assaults will result in hospitalization, therefore it would be useful to have data from emergency rooms, outpatient clinics and doctors' offices about assaults requiring medical treatment but not hospitalization. It is also not possible to tell from these data which assaults and homicides resulted from domestic or sexual violence.

Virginia has an integrated statewide domestic violence and sexual assault data collection system, known as **VAdata**. **VAdata** was developed in the mid-90s by the two state VAW coalitions (Virginias Against Domestic Violence and Virginians Aligned Against Sexual Assault), and the Virginia Departments of Health, Social Services and Criminal Justice Services. The program is managed by VADV, and produces combined annual reports from the domestic violence programs and sexual assault centers across Virginia. Data have been collected since 1999, with 2000 being the first complete year of data. In addition to data about the number and type of services provided by domestic violence and sexual assault programs, **VAdata** includes some information on risk factors when the perpetrator is the victim's partner, experiences with the legal system, violence perpetrated against children, client needs and descriptions of perpetrators of violence against adults and children.

VAdata results from 2002 as compared to 2001 show some interesting trends with prevention and intervention implications. The number of children served in domestic violence programs and sexual assault centers increased by 20% overall. The number of children served who were victims of sexual violence almost doubled, from 534 in 2001 to 980 in 2002. Another change was seen in the gender of sexual violence victims receiving services. In 2001, 5% of the adult victims served were male, and 22% of the child victims were male. In 2002, these percentages increased substantially: 9% of adult victims of sexual violence receiving services were male and 32% of child sexual violence victims receiving services were male⁸.

The Office of the Chief Medical Examiner (OCME) publishes an annual report on family and intimate partner homicide in Virginia, providing descriptive information about homicide victims (e.g. age, sex, race, geographic region, weapon used) and their relationships with the alleged offenders. The data in the report are used for prevention, planning, policy development and systems change promotion. Reports are available beginning with 1999 data. The latest report provides 2002 data and shows that the number of men killed in homicides in Virginia was over

three times that of women (324 men to 101 women). However, women accounted for 74.6% of all intimate partner homicide victims (47 of 63). Of the women intimate partner homicide victims, 29.8% were killed in combined homicide-suicide events (defined as a homicide followed within one week by the perpetrator's suicide). Nineteen percent (19%) of women intimate partner homicide victims had obtained protective orders against the alleged offender; and 25% of the alleged offenders of intimate partner homicide had been arrested previously for crimes against the victims⁹.

In 2003, The Office of the Chief Medical Examiner (OCME) is beginning to implement the National Violent Death Reporting System (NVDRS). Funded by the Centers for Disease Control and Prevention, NVDRS will help to establish a national violent death surveillance system. This data system links information about violent deaths – homicides, suicides, unintentional firearm injuries, legal interventions and acts of terrorism – from sources such as forensic pathology, law enforcement, forensic science and vital records. NVDRS will support government and other policy makers as they attempt to understand the extent of the violence problem, develop public health interventions, and evaluate violence prevention program efforts. There were six states initially selected to pilot the project and it is hoped that data will be forthcoming from the NVDRS in 2004.

The OCME provides training and technical assistance to communities interested in forming domestic violence fatality review teams as well as to established teams. Fatality reviews provide a means for communities to examine the circumstances leading to a fatality, with the goal of improving system responses to those at risk of or experiencing domestic violence. Currently, there are six established domestic violence fatality review teams in Virginia.

In addition to the routinely collected data described above, there have also been several special sets of data collected relating to VAW that address information needs regarding prevalence and incidence of VAW. In 2002 and 2003, the Center for Injury and Violence Prevention added special questions to the annual Behavioral Risk Factor Surveillance Survey (BRFSS). The BRFSS is a national telephone survey coordinated by the National Center for Chronic Disease Prevention and Health Promotion of the CDC that is administered annually in and by each state. The BRFSS asks questions about the contributing risk factors for the leading causes of death, disease and injury and is given to a random sample of each state's population.

There are no questions about violence against women in the standard survey of the BRFSS; however, states may add any questions that they choose on health topics. In 2002, CIVP added a question to the Virginia BRFSS asking the respondent if his or her health care provider "voluntarily asks you questions pertaining to physical or emotional abuse?" Almost eighty percent (78.7%) of the respondents said "no".

This information from Virginia respondents answering as health care patients corresponds closely to data received from the "other side" of health care encounters – Virginia physicians. In a survey of Virginia family practice and obstetric-gynecologic physicians conducted by CIVP in 2000, only 16.1% of physicians reported that they screened every patient for violence¹⁰. That is, a large majority of both patients and physicians report that screening for violence is not routine.

For 2003, Virginia's BRFSS will include six questions about domestic violence and sexual assault. Respondents will be asked if they have ever been forced to have sex by a stranger, by an acquaintance or by a partner and if they have been pushed, hit, slapped kicked or physically hurt by a stranger, by an acquaintance or by a partner. This data will be available in 2004 and will provide basic information about the lifetime prevalence of experiences of sexual assault and domestic violence among Virginia residents.

In 2002, the Center for Injury & Violence Prevention commissioned a special telephone survey on the prevalence of sexual assault in Virginia, based on the National Women's Study and the National Violence Against Women Survey. *The Prevalence of Sexual Assault in Virginia*¹¹ was published in April, 2003 and includes data on sexual assault prevalence, age of first assault, number of events and perpetrators, characteristics of perpetrators, injury, use of threats and weapons, consequences of sexual assault and help seeking behaviors.

Some key findings of this survey with particular relevance for prevention are as follows:

- The lifetime prevalence of sexual assault in Virginia was 27.6% for women and 12.9% for men – this is more than one in four women and more than one in eight men.
- The majority of incidents occurred when victims were under 18 years of age: 86.6 percent among female victims and 96.2 among male victims.
- Multiple assaults by the same person were reported by 20.4% of female and 25.3% of male victims.
- The majority of perpetrators victimizing women were family members (28.4%) followed by friends (22.3%) and acquaintances (18.2%).
- The majority of women victims of sexual assault did not seek professional health care or criminal justice assistance – 10.8% went to a doctor; 3.1% called a sexual assault crisis line and 12.1% contacted police.

These findings confirm that sexual assault is a pervasive problem in Virginia, directly affecting many men as well as women. The information that the majority of the lifetime experiences of sexual assault took place during childhood, that multiple assaults by the same person were experienced by one-fifth of women and that one-half of all assaults of women were by family members and friends has great implications for the prevention of sexual assault of women and men. For example, personal safety and awareness programs designed for late adolescent and adult women to protect themselves from stranger assault may be too late and not relevant for many women who are sexual assault victims. And, prevention efforts that consider men only as perpetrators and not as victims will be undermining efforts to keep the population safe from sexual assault. When new strategies for prevention efforts are considered, it will be critical to keep this information in the forefront so that resources can be used in ways that will have the greatest impact.

Virginia has good data collection and reporting systems for service provision to victims of violence against women. Systems for the surveillance of injury and death from violence against women and the prevalence and incidence of violence against women are improving. Implementation of the National Violent Death Reporting System, in particular, will provide a wealth of information on the circumstances of violence in Virginia that will be very useful in planning prevention strategies.

Regarding needed additional efforts, those agencies, institutions and systems involved in the prevention of violence against women would benefit from the development of a research agenda regarding the prevention of domestic and sexual violence in Virginia. Such an agenda should be based on identified prevention needs in Virginia, and could include the collection of data in any of the areas mentioned in national research agendas on violence against women, for example:

- Information on risk and protective factors of victims and perpetrators and of youth and adults generally;
- Community attitudes and values regarding violence against women;
- Factors that influence behaviors by victims and perpetrators such as help-seeking;
- The outcomes and effects of policies and laws related to violence against women; and
- Measures of health and other providers' knowledge and behaviors related to violence against women

Some specific recommendations can also be made. Given that the majority of sexual assault victims in Virginia were assaulted as children, and by family members, it is critical that public health take a greater role in the prevention of child sexual assault in Virginia. There is also a need for a greater public health role in the prevention of sexual violence against men. An assessment of and specific recommendations in these areas were specifically excluded from this effort by the terms of the grant award from the Centers for Disease Control, which required a focus on women who are victims of domestic and sexual violence. However, the data on the increased demand for services from male victims of sexual assault, both adult and child, and the lifetime prevalence of sexual assault in men require a greater focus in the area of prevention of sexual violence against male and female children and against men. This issue will be addressed further in the logic model section below.

Given the young age of many victims of sexual assault, it is also recommended that Virginia implement the collection of prevalence, incidence and risk factors for violence among adolescents, through an assessment such as the Youth Risk Behavior Surveillance System (YRBSS). The YRBSS was developed in 1990 by the Centers for Disease Control and Prevention to monitor primary health risk behaviors that contribute significantly to the leading causes of death, disability and social problems among youth and adults. It includes a section on behaviors that contribute to violence, as well as information on the prevalence of sexual and other violent assaults among youth. Given that the experience of violence in childhood increases the risks of both perpetration and victimization later in life, it is critical to understand what risk factors for violence and what types of violent events have been experienced by Virginia's youth. Implementing a youth violence surveillance system such as the YRBSS would produce immediate results to improve planning, implementation and assessment regarding the prevention of violence against children and adults.

It is also recommended that the Virginia Department of Health, through the BRFSS or other means, implement an annual domestic and sexual violence incidence and prevalence survey among a random sample of Virginia's general population. This information is critical for understanding the scope of the domestic and sexual violence problem, guiding the development of prevention efforts as well as gauging the success of both prevention and intervention efforts regarding violence against women and men.

Given the needs for additional types of data to help focus prevention strategies and resource allocation, it is recommended that those institutions, agencies and systems with a stake in the prevention of violence against women develop and promote a violence prevention-focused research agenda for Virginia. It is also recommended that the agenda be promoted strongly with the many academic and other agencies doing research in Virginia, particularly those with a health focus.

Recommendation 1: That key stakeholders in Virginia develop a research agenda regarding the prevention of domestic and sexual violence and promote this agenda with institutions and agencies conducting research in Virginia.

Recommendation 2: That the Virginia Department of Health implement regular surveillance of the prevalence, incidence and risk and protective factors of all forms of violence among youth.

Recommendation 3: That the Virginia Department of Health implement regular surveillance of the prevalence, incidence and risk and protective factors of domestic and sexual violence among adults.

Recommendation 4: That the Virginia Department of Health expand the collection of injury surveillance data to include emergency rooms, outpatient clinics and physicians' offices.

III. Current Efforts within the Virginia Department of Health to Prevent Violence Against Women

Background

In the spring of 2003, 21 interviews were held with central office and field program staff in the Department of Health (VDH) to identify current prevention efforts within the Department regarding the prevention of violence against women and to explore what would be needed to increase the capacity of VDH to engage effectively in the prevention of violence against women. Additionally, on February 27, a work session was held, attended by 19 central office and field staff. The purposes of this work session were to identify specific existing opportunities for and interest in increasing VDH's efforts to prevent violence against women and to identify what types and level of resources would be needed to take advantage of those opportunities. As well, participants were asked specifically to identify any prevention efforts that were developed for special populations.

In July of 2003, a survey of Nurse Managers in local health departments was conducted to identify similar information at the local level: what activities regarding the prevention of violence against women are currently engaged in, what opportunities exist for increasing activities in the prevention of violence against women and what resources would be needed to take advantage of these opportunities. Out of approximately 51 Nurse Managers, 14 responded.

Current Efforts

Through the interviews, work session and survey, a variety of current efforts were identified at both the central office and local health department level. In the central office, there are a number of programs directly involved in the primary and secondary prevention of violence against women, as follows. Below are described key efforts, including those addressing special populations. Where identified through interviews, the workshop or the survey, opportunities for increasing the capacity of VDH programs to prevent domestic and sexual violence are also listed.

Current initiatives and activities of the Center for Injury and Violence Prevention to prevent domestic and sexual violence are detailed in section IV, which addresses statewide efforts. Until the initiation of this project for assessment and recommendations regarding prevention, the CIVP has not had a staff position specifically to address domestic violence prevention. However, over the last several years, staff with responsibilities in other areas of intentional injury prevention contracted to provide training to VDH and other health care providers on domestic violence screening, intervention and referral; conducted research and surveillance in the area of domestic violence and developed and promoted a website and other educational resources.

Partners in Prevention (PIP) coordinates community coalition in several areas of Virginia to promote the reduction of non-marital births in men and women ages 20-29 through education and awareness. Training on developing healthy relationships, recognizing the signs of potentially violent relationships and on what local resources are available to for those in violent relationships or who have been sexually assaulted has been provided to all PIP coalitions. The

Partners in Prevention coalition in northern Virginia provides basic domestic violence training in Spanish to people in housing projects. Another PIP coalition provides healthy relationship education, including information on domestic and sexual violence, to male prisoners awaiting release.

The Division of Women's and Infants' Health is promoting Bright Futures, a set of nationally developed expert clinical and practice guidelines for providing health supervision for children of all ages, from birth through adolescence. It includes guidelines for screening, assessment and referral for violence against women and those, such as children, affected by it. Thus, Bright Futures is one of a number of tools available to improve VDH's clinical response to domestic and sexual violence.

The Division of Dental Health has implemented the PANDA program in VDH dental clinics, which trains dental staff to identify symptoms and signs of violence in patients and make appropriate referrals. PANDA is aimed at child abuse and neglect, not victims of adult domestic and sexual violence. The Dental Health Division would like to provide more resources to dental clinics on screening and referral of adult victims of domestic and sexual violence.

The HIV/STD Program has a hotline that will make referrals for intimate partner and sexual violence, though its primary function is to respond to concerns about HIV/AIDS. Through its contracted community-based organizations, public education is provided on a number of topics, including domestic and sexual violence. The Street Outreach unit within the HIV/AIDS Program interacts mostly with sex workers, active drug users and others about HIV/AIDS, but also refers to shelters and other intervention services for domestic and sexual violence. Finally, health counselors doing HIV/AIDS counseling and testing sometimes include assessment for domestic or sexual violence with people who are getting tested for HIV. The HIV/AIDS Program provides education on domestic and sexual violence prevention to prisoners and to migrant laborers in their camps in conjunction with HIV prevention education. The Program also provides assessment and referral of sex workers for domestic and sexual violence.

The HIV/AIDS Program would like to provide more training on domestic and sexual violence to its community education contractors at their quarterly meetings. The Program is also willing to add language to their community education RFP that would require the inclusion of information on domestic and sexual violence in the HIV curriculum. As well, the HIV/AIDS Program would like to assess HIV testing and counseling staff on their ability to identify and refer cases of domestic and sexual violence.

The Breast and Cervical Cancer Early Detection Program (BCCEDP) uses an intake/history form that can capture sexual and intimate partner violence if the patient discloses it voluntarily. The intake form is also available in Spanish. The BCCEDP would like to include education on domestic and sexual violence at its annual conference, is willing to survey its coordinators as to whether or not they routinely screen patients for domestic and sexual violence and has interest in receiving additional materials to distribute to patients, such as brochures and posters.

The Fatherhood Program provides training to men, through local coalitions, aimed at helping men to be more involved in the lives of their children and to be more effective fathers. Coalition

members and staff have received training on recognizing and preventing domestic and sexual violence. The Fatherhood Program would like to engage men in talking about violence prevention, particularly adolescents and young men, and would like materials developed specifically for these populations. There is also an opportunity here to work with men in assisting them to raise children who are less likely to be victims or perpetrators of violence.

As noted in the section on surveillance and data above, the Office of the Chief Medical Examiner (OCME) conducts surveillance and publishes reports on homicide and suicide related to intimate partner violence for use by state and local agencies, planners, grant writers, legislators and policymakers. The OCME also has developed information and guidance on how to create local domestic violence fatality review teams and provides technical assistance in developing and supporting such teams.

Local health departments offer a variety of services, related to the prevention of domestic and sexual violence. These services, which vary from district to district depending on resources and other responsibilities, include:

- Requiring domestic and sexual violence screening, identification and referral of all women patients seeking services in clinics and on home visits
- Presentation of written educational and referral materials to patients
- Crisis response to women who are in immediate danger and seeking help
- Having staff who are members of local domestic violence death review teams, local domestic and sexual violence coalitions and/or local crisis response teams
- Community prevention activities, such as providing presentations on domestic and sexual violence to local schools and other organizations.

Clinical staff members in local health departments were most interested in having ongoing training on the basics of screening, response and referral for those patients experiencing domestic and/or sexual violence. Although several Nurse Managers mentioned that screening, response and referral for domestic and sexual violence are part of the standards of practice required for all female patients, other Nurse Manager respondents commented that these activities *should* be part of the standards of practice, implying that they are not currently perceived as such. Several central office staff were interested in having a chart audit performed on patient records to assess whether or not screening for domestic and sexual violence is performed routinely. Such an audit would also provide data on the prevalence of domestic and sexual violence among local health department clients, thus supporting Recommendation 4 above in section II on surveillance and data.

In interviews and at the February planning session, several program staff mentioned a desire to work more with children who have been affected by witnessing domestic and sexual violence. A number of programs also mentioned an interest in collaborating more with local and state-level domestic and sexual violence agencies.

In sum, although VDH programs are engaged in a number of activities related to the prevention of domestic and sexual violence, these activities are not consistent, comprehensive or coordinated across programs. There is no VDH set of goals, objectives and standards regarding

the prevention of domestic and sexual violence, nor has the Department identified the prevention of domestic and sexual violence as a priority. One capacity improvement already made is that the CIVP has established a permanent Domestic Violence Prevention Coordinator position that will be fully integrated with sexual violence prevention functions and activities.

Recommendation 5: That the Virginia Department of Health perform a quality assurance review of clinical patient records in local health department clinics to assess the prevalence of domestic and sexual violence among clinic patients and also the quality of screening, identification and referral provided regarding domestic and sexual violence.

Recommendation 6: That policies and plans be developed and implemented to address any shortcomings identified in Recommendation 5.

Recommendation 7: That the CIVP's Domestic Violence Prevention Coordinator assist VDH programs with resources and technical assistance to respond to the opportunities identified above for improving capacity to prevent domestic and sexual violence, including:

- Screening and referral information developed specifically for dentists' offices
- Training for HIV/AIDS contractors
- Patient information materials for BCCEDP patients

Recommendation 8: That a task force be established within the Virginia Department of Health to develop and implement goals, objectives, priorities and standards regarding domestic and sexual violence prevention within VDH central and local health department programs to ensure the consistency, comprehensiveness and coordination of such efforts.

IV. Current Efforts Regarding the Prevention of Violence Against Women in Virginia

Background

An initial review of the status of VAW prevention efforts showed that efforts in this area are not guided by approaches that are coordinated, comprehensive and consistent. As will be described below, this situation is exacerbated regarding prevention of violence against women who are in special or underserved populations. What would approaches for the prevention of VAW be like if they were coordinated, comprehensive and consistent? They would be based on a set of prevention goals and objectives; on a model, such as the Spectrum of Prevention, for guiding prevention efforts; on a perspective of the scope and fundamental nature of the VAW problem in Virginia and on clear principles and values regarding the prevention of VAW. These elements would be *shared* across all agencies, institutions and systems with a significant interest in the prevention of violence against women.

That such an approach to preventing violence against women has not been developed is understandable. In Virginia, as in the United States generally, the first services developed to address domestic and sexual violence were intervention and support services for victims. This area is where most of the national, state and local resources for violence against women remain focused. As well, in 2002 as in previous years, the demand in Virginia for services in response to violence against women has increased and in the case of shelter services for domestic violence, the demand has continued to exceed capacity.

The lack of dedicated resources and infrastructure for the prevention of VAW as well as the growing and sometimes unmet need for response to VAW do not create a favorable climate for prevention. In spite of these difficulties, there have been ongoing efforts in Virginia for prevention of violence against women, and now there are several new initiatives that hold much promise for improving the state's capacity and effectiveness in preventing VAW.

Current Efforts

All Domestic Violence Programs and Sexual Assault Crisis Centers in Virginia provide some type of education and public awareness programs. Unfortunately, the *VAdata* system does not capture the amount or types of educational services provided by these agencies. However, in its 2002 Annual Summary of Services, Virginians Aligned Against Sexual Assault (VAASA) reported that the Sexual Assault Crisis centers and VAASA provided 4,000 hours of educational, public awareness and prevention programs to over 200,000 people, including members of the general public, providers, college students and K-12 students.

The CIVP contracts with 18 local Sexual Assault Crisis Centers to provide sexual violence prevention programming, mostly at the school and community level. The CIVP also has funded the development of curricula and training on sexual violence prevention through competitive grant funding to local non-profit agencies. Many of these curricula focus on training students to

educate their peers on preventing sexual violence, dating violence, and sexual harassment and on developing healthy relationships. In fiscal year 2002, the Sexual Assault Crisis Centers provided 260 educational programs to 5,382 professionals and 3,990 educational programs to 584,480 children, adolescents and young adults.

The CIVP Sexual Violence Prevention Program also supports several statewide initiatives addressing prevention of child sexual abuse. The Child Assault Prevention Program is a national program to prevent child sexual abuse in the local community. The CIVP currently funds this effort in several communities. Additionally, the CIVP, in partnership with the Department of Social Services, provides financial support for the “Hugs and Kisses” theatre program, which tours to local elementary schools.

The CIVP has also begun a statewide project, Men Ending Violence, to provide targeted outreach to men, to invite and engage them in efforts to prevent sexual violence. Men Ending Violence has developed a Community Speakers Bureau, a group of men and women trained to provide sexual violence prevention education within their own communities. Men Ending Violence is also promoting the White Ribbon Campaign, an international public awareness and education initiative focused on engaging men in ending sexual violence.

Virginia stakeholders, including CIVP, completed a comprehensive, statewide strategic plan for the prevention of sexual violence in the spring of 2003. Representatives from VAASA, VADV, the Virginia Departments of Health, Education and Criminal Justice Services and local Sexual Assault Centers developed the plan through a series of facilitated sessions. The purposes of the Virginia Statewide Sexual Violence Prevention Plan are:

- To have a vision to respond to sexual violence in Virginia
- To help clarify the vision of those committed to ending sexual violence and providing services to victims of sexual violence so that other agencies know where they fit
- To guide and/or generate grants and funding activities
- To identify stakeholders
- To provide a unified continuity of purpose that guides others working to end sexual violence in the state

There are five goals in the Plan that address: increasing funding and other resources for sexual violence prevention; improving sexual violence data to guide and monitor sexual violence prevention; ensuring that comprehensive sexual violence services are accessible in every Virginia community; ensuring that comprehensive and effective sexual violence prevention strategies are implemented across the state; and reforming public policy to respond effectively to sexual violence through prevention and intervention. A Sexual Violence Statewide Planning Advisory Board is guiding the implementation of the plan in Virginia. The entire plan is attached here as Appendix A.

A major new effort regarding the prevention of domestic violence also is under way, but has only recently started. In late 2002, Virginians Against Domestic Violence (VADV), the statewide domestic violence coalition, received a DELTA (Domestic Violence Prevention Enhancement

and Leadership Through Alliances) grant from the Centers for Disease Control and Prevention. The DELTA program hopes to increase significantly the capacity of local communities to engage effectively in domestic violence prevention, using a coalition-based approach. The three-year grant focuses on providing technical assistance and training to selected community coalitions on prevention planning, strategies and techniques, as well as on developing community-level leadership for and commitment to the prevention of domestic violence.

Thus far, VADV has selected coalitions in 15 communities to participate in DELTA and also selected five priority populations and settings for DELTA's prevention efforts. The priority populations are: men, general public, clergy, teens, children and the priority settings are: media, health care providers, neighborhoods, workplaces, churches and schools.

A final initiative to be discussed is the transformation process being undertaken by the two state coalitions on sexual violence and domestic violence, VAASA and VADV. Although not focused on prevention alone, this process should have a significant impact on improving systems for the prevention of VAW. Several years ago, the two coalitions began an extended process of discussion and analysis to explore the possibility of becoming one coalition to address both sexual and domestic violence. A Coalition Transformation Committee was formed, which developed a vision of what a combined coalition would do:

- Serve the diverse constituencies of sexual assault and domestic violence focusing on enacting social change to end gender-based violence
- Create a common vision and bring together knowledge, expertise and tangible assets to actively support and nurture community agencies
- Provide a strong collective voice, expand resources, increase diversity, develop new partnership and provide greater visibility to promote social change

The transformation process included retreats and work by six task groups charged with collecting information and making recommendations on the development of a new coalition. In the spring of 2003, the Boards of Directors of both VAASA and VADV voted to become a single coalition to address both domestic and sexual violence. The transformation process is expected to be complete in an additional one year to eighteen months. Because domestic and sexual violence often occur together and share significant underlying causes, such as society's bias against and oppression of women, a combined coalition will provide greater opportunities for a more comprehensive approach to the prevention of VAW.

Special Populations

A critical area of assessment regarding current efforts in the prevention of violence against women is that of violence prevention for women who are members of underserved or special populations. For the purpose of this report, special populations of women are defined to include: lesbian/bisexual/transgender women, sex workers, elderly and adolescent women, immigrant and refugee women, women with disabilities, women with low incomes, women with substance abuse and other mental health problems, women who are homeless, women who are prisoners, and women who are members of ethnic and cultural minority groups. This assessment area

addressed whether there are consistent and widespread programs or activities in Virginia for the prevention of violence against women who are members of the identified populations. The assessment looked at the issue of special populations from two directions: from the perspective of domestic violence and sexual assault agencies and from the perspective of agencies whose main purpose is serving these special populations (who most likely would not have a primary focus on domestic and sexual violence).

Nationally and in Virginia, there is increasing interest in special populations among those working to end violence against women for a number of reasons, including:

- Changing demography, with increasing diversity of population
- An increased recognition that women in special populations may face increased risk of domestic and sexual violence
- An increased recognition that women in special populations face extra barriers to accessing prevention and intervention services
- An increased understanding that effective prevention and intervention strategies must be tailored to meet the unique needs of and be acceptable to special populations throughout the life cycle

Demographic trends important for those working to end VAW include that in Virginia as in the U.S., the population is becoming increasingly more diverse culturally and ethnically, because of changing rates of reproduction among different groups, increasing mobility within the U.S. and a significant increase in immigration to the U.S. since 1965. The latter also means there has been an increase in the proportion of the population that is immigrant or refugee. As well, the age distribution of the population is changing – an increasing proportion of our state and national populations is above the age of 65. The number and proportion of women in prisons is increasing as part of the overall increase in the proportion of the population that is incarcerated. Finally, as a result of our society’s growing recognition of diversity in sexual and gender orientation, the number of women who openly identify themselves as lesbian, bisexual and/or transgender is increasing.

There is also growing recognition, from research and experience, that women in some special populations may face increased risks of domestic and sexual violence. These may include women who are homeless, women who are immigrants or refugees, women with disabilities, sex workers, older women, and women with substance abuse or mental health problems.

Women in special populations also face unique barriers in accessing all types of services related to domestic and sexual violence. These include the lack of knowledge of service availability because of language and other barriers and a more limited ability to access services because of financial and language barriers.

It is also understood that ending VAW requires prevention strategies and intervention services to be acceptable to and meet the specific needs of special populations. An aspect of this recognition is an acknowledgement that some violence prevention and intervention services have been influenced by negative judgments and beliefs about special groups of women, thus rendering them even less effective and less likely to be used.

Nationally, most of the efforts to make services more responsive to the unique needs of special populations of women have focused on intervention and response services, not prevention. The same is true in Virginia, though as noted below in the logic model section, there certainly is recognition among key stakeholders that developing improved strategies for prevention of violence against women in special populations is a priority area.

Many of the local Domestic Violence Programs and Sexual Assault Crisis Centers have taken steps to inform women in special populations about their services and to make their services more accessible and acceptable in several ways. These approaches include having interpretation or translation services at the agencies, providing education and outreach materials in languages other than English and networking for referrals from other types of agencies serving the population of interest. For example, the Chesterfield County Domestic Violence Resource Center saw the demand for services among Latino/a people increase by 20%-30% in one year after an intensive outreach effort.

There are also several broader initiatives in the state to address the needs of women in special populations – again with a main focus on intervention and response to victims. VADV has several projects in this area related to women of color, women with mental health concerns and women with disabilities. Through a grant from the Ms. Foundation, VADV sponsored the creation of a group to develop leadership in response to domestic and sexual violence among young women; women of diverse races and ethnicities; immigrant and refugee women; lesbian, bisexual and/or transgendered women; and survivors of domestic and sexual violence. The group chose the name of *SAVOR! – Sisters Against Violence and Oppression Resist!* and is providing leadership to VADV in ensuring that domestic violence services are acceptable and accessible to all women, children and men.

VADV is also partnering with VAASA and an international group, the Global Organization for Feminists with Disabilities (GO FWD) to work to improve access to services for victims of domestic and sexual violence who may be deaf, hard of hearing, have mobility limitations or a mental health disability. The project is studying existing services to make recommendations for improvement and also developing training for Domestic Violence Programs, Sexual Assault Crisis Centers, court personnel and health care providers to improve their ability to provide services to women with these disabilities.

The Central Virginia Task Force on Older Battered Women (the CVa Task Force) is a regional collaboration of domestic violence, sexual assault, aging, law enforcement and legal services agencies working since 1998 to improve the community response to older women who experience domestic violence or sexual assault in the City of Richmond and the Counties of Chesterfield, Hanover and Henrico. The CVa Task Force received funding from the Department of Criminal Justice Services in the spring of 2003 to assess the needs, barriers and availability of domestic violence and sexual assault services for older women and make recommendations for system improvements.

There is also a statewide Teen Dating Violence Prevention Alliance (TDVPA), comprising members from Domestic Violence Programs, Sexual Assault Crisis Centers and CIVP. The TDVPA has developed resources such as a public awareness campaign for adolescents, a

facilitator's guide for educators called, "Virginia Responds: Teens Building Violence Free Relationships" and conferences held for teens and adult educators on this topic.

Another effort focused on adolescents is the Statutory Rape Awareness Project. The CIVP first received a grant from the Virginia Department of Social services through the Temporary Assistance to Needy Families Project in 2001. The project has three components: data collection, public awareness and training. Regarding data, in February of 2002, the CIVP produced a report, "Estimating the Incidence of Statutory Rape in Virginia"¹². The CIVP contracted with the American Institutes of Research to develop and implement a public awareness campaign targeting adult men ages 18-30. As of the fall of 2003, the campaign, *Isn't She A Little Young?*, has been piloted in the region of the state showing the highest incidence of statutory rape. Additionally, the CIVP contracted with local Sexual Assault Crisis Centers to provide presentations to adolescents to help them recognize and avoid sexual coercion. CIVP has also produced an 11-minute video on sexual coercion, along with a curriculum on sexual coercion for youth service providers.

As noted above, the other direction taken to assess the prevention of domestic violence and sexual assault in special populations was to look at agencies that serve those special populations, but do not have a primary mission regarding domestic and sexual violence. The agencies reviewed served youth; lesbian/bisexual/transgendered people; immigrants or refugees, sex workers; women who are prisoners, people with disabilities, people with substance abuse and other mental health problems; and people who are homeless. These agencies are only a few of those serving the special populations of interest; as such they are a convenience sample and may not be representative. Of the agencies reviewed, few provided prevention services regarding sexual or domestic violence to their clients. Many of the agencies did report having referral relationships with their local Domestic Violence Program and/or Sexual Assault Crisis Centers.

One agency reviewed that has a sexual and dating violence prevention component for its clients is the Richmond Organization for Sexual Minority Youth (ROSMY), which provides support and development services to gay/lesbian/bisexual/transgendered/questioning youth ages 14 to 21. ROSMY is developing and implementing a series of educational and skill-building workshops on a number of key issues, including the prevention of sexual and dating violence. Another agency making efforts in the prevention of sexual and domestic violence is the Fan Free Clinic in Richmond, which provides primary medical care and preventive services to people who do not have access to other health care settings. Currently the Fan Free Clinic conducts specialized outreach to sex workers, including those who are transgendered, to provide referrals and education on a number of medical and health issues, specifically including sexual and domestic violence.

It is not surprising that agencies whose primary mission is in areas other than sexual assault or domestic violence would not have projects on the prevention of these problems – this would be outside their main scope of work. However, such agencies would make excellent partners for those key stakeholders committed to the ending of domestic and sexual violence among women in special populations.

In educational settings from kindergarten through high school, there are programs addressing the prevention of violence in general, such as peer conflict resolution and healthy relationship promotion. The Board of Education Guidelines and Standards of Learning for Virginia Public Schools, implemented by the Department of Education, provide outcome statements relating to healthy relationships, but do not specify standards or curricula for how the outcomes are to be achieved. The Safe and Drug-Free Schools Program of the Virginia Department of Education is a funding and support resource for violence prevention efforts in schools. The Program requires that all such efforts must meet a set of Principles of Effectiveness, including being based on community needs data; using established performance measures; being developed based on “scientifically based research” about effectiveness; being routinely evaluated; being based on a risk and protective factors analysis and requiring parental consultation.

At the level of higher education, there are many sexual and domestic violence projects on individual campuses. The Virginia Task Force on Campus Sexual Assault is a coalition of such providers “who work together to improve both education and victim services on campuses, and seek to foster an improved collaborative relationship with community services”. The Task Force’s activities include sponsorship of statewide and regional trainings and conferences; collaboration with other statewide agencies such as VAASA, VADV and State government agencies; and the provision of technical assistance to develop campus programs and improve the campus response to sexual violence, stalking and dating violence.

Though there is increased understanding among key stakeholders that the prevention of domestic and sexual violence among women in special populations is a priority, development and implementation of strategies has been limited, due largely to a lack of resources and an emphasis on providing response and advocacy services rather than prevention. Among providers of services to the identified special populations, there are often referral relationships for response to sexual and domestic violence, but few programs or partnerships for prevention of these problems.

In sum, while there are many existing and emerging efforts regarding the prevention of violence against women, these efforts are not directed by a vision, goals, objectives, models, values or principles that are shared among key stakeholder agencies and institutions. Efforts to address the prevention of domestic and sexual violence among women in special populations are especially undeveloped. The result is that approaches to the prevention of violence against women remain fragmented, largely unevaluated and subject to an inconsistent and insufficient resource commitment at the local and state level. Recommendations in this area are included following the next section on the development of a logic model.

V. Development of a Logic Model for the Prevention of Violence Against Women in Virginia

Background

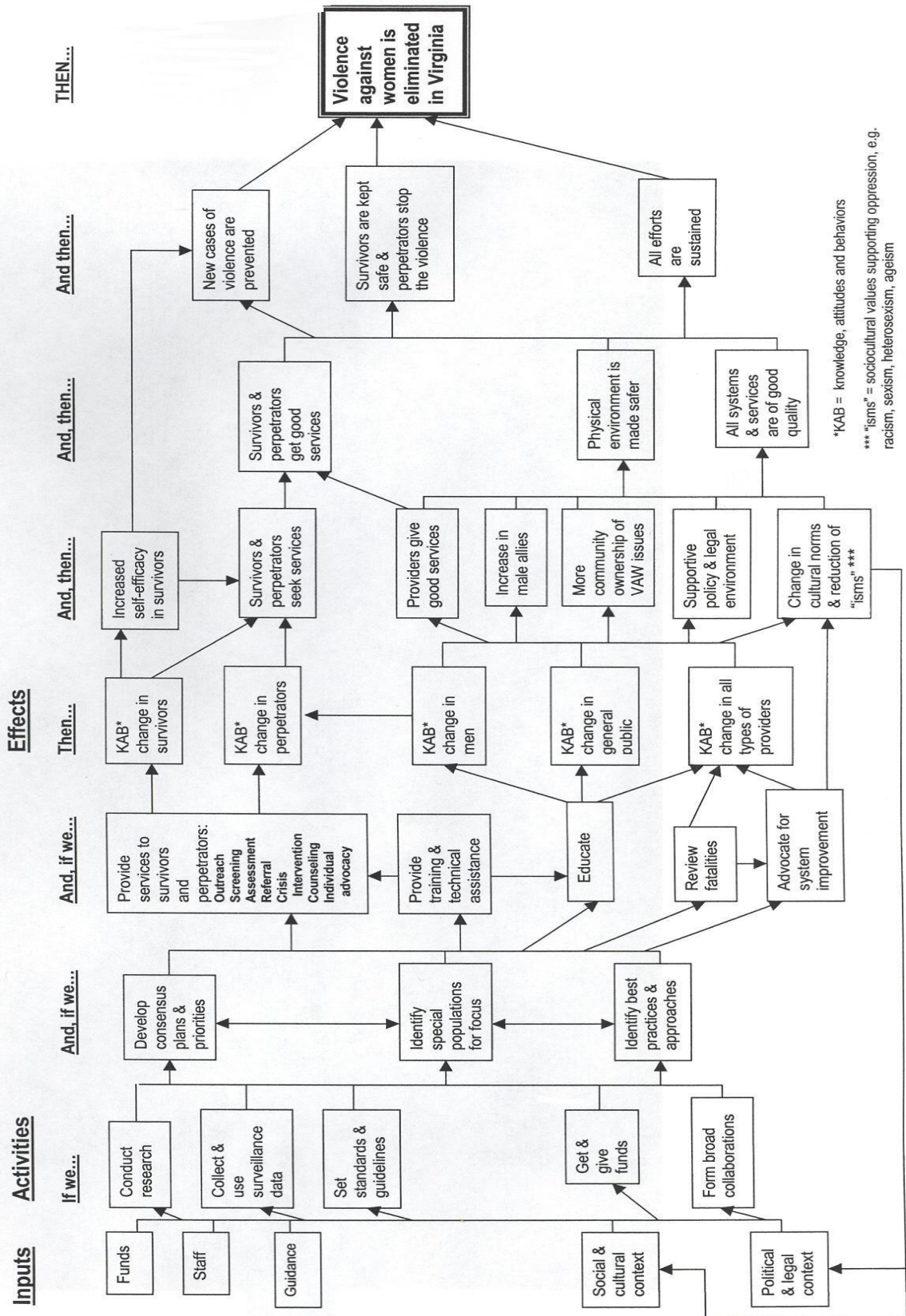
In April, 2003, the Center for Injury and Violence Prevention convened a workgroup of over 30 key stakeholders in the area of violence against women, including representatives from health care, public health, education, law enforcement, social services, domestic violence programs, sexual assault centers and the criminal justice system, to develop a logic model as a basic plan for the prevention of violence against women in Virginia. Tom Chapel, MBA, Senior Scientist with the Centers for Disease Control, led the workshop. The logic model is presented as Figure 1.

The development of a logic model as a basic plan is a critical step that can assist key stakeholders in clarifying outcomes for the prevention of violence against women and in understanding the relationships (or lack thereof) between program activities and the desired outcomes. The benefits of creating logic models at any level are as follows:

- Logic models provide clarity for agencies and institutions about their specific role in addressing a problem
- Logic models allow for groups of key stakeholders to reach consensus on what are the essential activities; the desired effects; the proper order of activities and outcomes; and the causal relationship between activities and outcomes needed to eliminate a problem
- Logic models link research agendas with actual program needs
- Logic models become a framework for further planning by creating a roadmap from activities to intended effects, including identifying missing activities as well as discarding activities that don't lead to desired effects
- Logic models clarify the proper evaluation focus on measuring effects and outcomes, rather than counting how much of any service or program is provided.

Other immediate benefits of logic models are that they can be useful to support grant writing and other resource development by presenting a clear picture to funders of what is desired and how it will be reached. As well, logic models help stakeholders see critical and necessary effects other than those for clients alone, such as effects for programs, organizations, systems and communities. It is hoped that this logic model can serve as a basic plan for the prevention of domestic violence and sexual assault in Virginia.

Figure 1: A Logic Model for the Prevention of Violence Against Women in Virginia



Logic Model Development

The workgroup began by brainstorming the intended effects or results of activities to prevent violence against women. These effects were not limited to primary prevention of violence against women (new cases of violence are prevented), but also included prevention effects that are secondary (survivors are kept safe and perpetrators stop committing violence) and tertiary (all services and efforts regarding VAW are sustained).

Through consensus development, agreement was reached that the ultimate outcome is the “elimination” of violence against women in Virginia, not a “reduction”. Participants saw this as critical because aiming for elimination rather than reduction would affect the development of activities and the definition of desired effects from the very beginning all the way through the process. As one participant said, “We do not want to let ourselves off the hook on this problem. If we only want to *reduce* violence, than we might be satisfied with a small reduction and say that we had done our jobs. That’s not acceptable.”

Effects were identified at the short-term, medium-term and longer-term level. Participants were then asked to brainstorm all the activities seen as necessary to achieve these effects. Then, with assistance from the facilitator, activities and effects were grouped in the proper sequence to show the causal and necessary sequential relationships among them.

Another important consensus item was that the elimination of oppression (referred to as the “isms”, including racism, sexism, heterosexism, ageism, and classism) is a critical and necessary medium-range effect for the elimination of violence. As the discussion continued, participants frequently expressed a sense that the oppression issue needed to be moved further to the left side of the logic model, as oppression is part of the current environment, not only a desired effect.

The facilitator, at the group’s request, addressed this issue and sent a recommendation after the workshop. In the work session, the participants did not list the basic platform of resources affecting the necessary activities, effects and outcomes. This basic platform is termed the “inputs” to the logic model and includes elements such as staff and funding. By adding inputs, including sociocultural context, the facilitator was able to represent that sociocultural values are both part of the existing situation and also something that is amenable to change and improvement so that violence against women can be eliminated.

After the initial logic model was developed, the facilitator led a discussion to identify the strongest existing paths within the logic model, that is, where Virginia has progressed furthest towards the elimination of violence against women, and also where the connections are weakest and most in need of development. The group agreed that progress has been greatest in the area of secondary prevention, which is about ensuring that victims are not re-victimized by providing effective response and advocacy services and that perpetrators cease committing violence. This is the arena of domestic and sexual violence crisis response – the shelters, hotlines and all related support services. An area of growing strength is the response to children who are victims of sexual assault and to children who are witnesses to and/or victims of domestic violence.

Even in this area of strength, though, the group agreed that the success varied by population and location. Response services have been most successful for women who are middle-class, white, adult (young to middle-aged) and residents of metropolitan areas. The response to women in rural areas and women in the special populations defined above has not been well developed.

Regarding the weakest paths, there was general agreement that efforts addressing men as victims, allies and perpetrators are essential, but relatively undeveloped at all levels – primary, secondary and tertiary – and this needs to be a focus in the coming years. The other major path that was seen as weak is primary prevention, the efforts that are made to keep new cases of violence from happening. This weakness is reflected in the logic model, where all types of social change efforts are captured in the boxes labeled “Educate”, “Advocate for system improvement” and “Provide training and technical assistance”. These are areas where it will be important for stakeholders to provide more specific strategies about what is needed to gain the desired effects of knowledge, attitude and behavior change among providers, the general public and men, and of changing the cultural norms and values that promote all forms of oppression. The group agreed that the latter is central to the success of primary prevention efforts.

As this logic model is large-scale – it includes activities and outcomes at the state level – it is hoped that key stakeholders will “zoom in” on specific paths or sections of the logic model where their specific responsibilities are. Then they can elaborate on those paths or sections to assess and develop critical activities, appropriate for their agencies, connected to desired effects. In this way, the logic model can serve as a planning and implementation guide at the agency level, as well.

Several key implications of this logic model and the discussions of it are:

- Special populations are a priority for prevention at all levels and they must be identified early so that they are included in prevention efforts throughout the process.
- In order to be effective for the prevention of violence against women, all efforts *must be based on consensus plans and priorities and best practices and approaches*.

As one workshop participant noted, “Right now, we provide educational presentations to anyone who asks for them. If we *really* agree that developing plans and priorities and identifying best practices are necessary before we educate and communicate, we’d be doing things very differently”.

- Primary prevention efforts remain undeveloped among all stakeholders and a central element for primary prevention efforts is *social change* – changing the social norms and values that promote and support all forms of oppression.
- Working with men as victims, allies and perpetrators is critical at all levels of prevention.

Based on the above assessment of the overall status of prevention efforts in the state and on the logic model as a basic plan for the prevention of violence against women, the following recommendations can be made.

Recommendation 9: That key stakeholders identify the priority special populations of women critical for inclusion in domestic and sexual violence prevention efforts in the geographic areas they serve.

Recommendation 10: That key stakeholders identify agencies and organizations already serving the identified priority populations of women and seek partnerships with them for domestic and sexual violence prevention.

Recommendation 11: That the CIVP, in partnership with key stakeholders, identify and disseminate best practices, tools and strategies for the primary prevention of domestic and sexual violence among special populations of women, children and men.

Recommendation 12: That key stakeholders recommend a public health approach to the prevention of first-time perpetration of sexual and domestic violence.

Recommendation 13: That the CIVP and key stakeholders identify and disseminate best practices, tools and strategies for the *implementation and evaluation* of prevention efforts.

Recommendation 14: That the CIVP and other key stakeholders develop and implement agency- and state-level education, training and advocacy strategies that are needed to bring about the desired changes in knowledge, attitudes and behavior among providers, the general public and men, with special attention to those strategies focused on changing cultural norms and values regarding oppression.

Recommendation 15: That the CIVP and key stakeholders identify and develop sustainable funding and other support for the prevention of domestic and sexual violence in Virginia.

Specific strategies for these recommendations need to be developed, especially regarding Recommendation 13. However, reasonable next steps would be for key stakeholders to:

- Set as a priority the promotion of training on primary prevention for those professionals of all types committed to ending domestic and sexual violence.
- Identify the cultural norms and values most central to the oppression of women to develop the most appropriate prevention strategies.
- Work to identify and include the needs of special populations in all aspects of prevention from the very beginning.
- Promote the inclusion of education on responding to domestic and sexual violence into the training curricula for health care professionals, at the student and continuing education levels.
- Continue and broaden efforts to work with men as allies in the prevention of and response to domestic and sexual violence.

- Identify and implement best practices regarding the prevention of domestic and sexual violence among children including school and community based programs for parents, caregivers and youth, such as:
 - Recognizing domestic and sexual violence
 - Healthy relationships
 - Anger management
 - Conflict resolution
 - Bullying prevention
 - Assertiveness training
 - Impact of media
 - Available resources and services

- Implement public awareness campaigns on domestic and sexual violence.

- Publicize and support treatment services for victims and intervention services for perpetrators.

This assessment of the status of efforts to prevent domestic and sexual violence in Virginia shows much commitment and concern on the part of many individuals, communities and agencies. However, primary prevention efforts, particularly those focused on special populations of women, on children and on men, remain fragmented and undeveloped, though there are promising capacity-building efforts under way. As domestic and sexual violence affect *all* Virginians, it is important that primary prevention efforts be united through shared priorities, strategies and outcomes.

VI. Summary of Recommendations

Recommendation 1: That key stakeholders in Virginia develop a research agenda regarding the prevention of domestic and sexual violence and promote this agenda with institutions and agencies conducting research in Virginia.

Recommendation 2: That the Virginia Department of Health implement regular surveillance of the prevalence, incidence and risk factors of all forms of violence among youth.

Recommendation 3: That the Virginia Department of Health implement regular surveillance of the prevalence and incidence of domestic and sexual violence among adults.

Recommendation 4: That the Virginia Department of Health expand the collection of injury surveillance data to include emergency rooms, outpatient clinics and physicians' offices.

Recommendation 5: That the Virginia Department of Health perform a quality assurance review of clinical patient records in local health department clinics to assess the prevalence of domestic and sexual violence among clinic patients and also the quality of screening, identification and referral provided regarding domestic and sexual violence.

Recommendation 6: That policies and plans be developed and implemented to address any shortcomings identified in Recommendation 5.

Recommendation 7: That the CIVP's Domestic Violence Prevention Coordinator assist VDH programs with resources and technical assistance to respond to the opportunities identified above for improving capacity to prevent domestic and sexual violence, including:

- Screening and referral information developed specifically for dentists' offices
- Training for HIV/AIDS contractors
- Patient information materials for BCCEDP patients

Recommendation 8: That a task force be established within the Virginia Department of Health to develop and implement goals, objectives, priorities and standards regarding domestic and sexual violence prevention within VDH central and local health department programs to ensure the consistency, comprehensiveness and coordination of such efforts.

Recommendation 9: That key stakeholders identify the priority special populations of women critical for inclusion in domestic and sexual violence prevention efforts in the geographic areas they serve.

Recommendation 10: That key stakeholders identify agencies and organizations already serving the identified priority populations of women and seek partnerships with them for domestic and sexual violence prevention.

Recommendation 11: That the CIVP, in partnership with key stakeholders, identify and disseminate best practices, tools and strategies for the prevention of domestic and sexual violence among special populations of women, children and men.

Recommendation 12: That key stakeholders recommend a public health approach to the prevention of first-time perpetration of sexual and domestic violence.

Recommendation 13: That the CIVP and key stakeholders identify and disseminate best practices, tools and strategies for the *implementation and evaluation* of prevention efforts.

Recommendation 14: That the CIVP and other key stakeholders develop and implement agency- and state-level education, training and advocacy strategies that are needed to bring about the desired changes in knowledge, attitudes and behavior among providers, the general public and men, with special attention to those strategies focused on changing cultural norms and values regarding oppression.

Recommendation 15: That the CIVP and key stakeholders identify and develop sustainable funding and other support for the prevention of domestic and sexual violence in Virginia.

VII. End Notes

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VIII. Resources for the Prevention of Domestic and Sexual Violence in Virginia

General Resources

Centers for Disease Control and Prevention

US Department of Health and Human Services
1600 Clifton Road
Atlanta GA 30333
(404) 639-3311
(404) 639-3312 (TTY)

<http://www.cdc.gov/ncipc/default.htm>

- Although national in scope, the CDC has many educational and other resources for professionals and the general public related to the prevention of domestic and sexual violence.
- The CDC provides surveillance and other data on many injury topics that are available at the state level.

Family Violence Prevention Fund

383 Rhode Island Street, Suite #304
San Francisco CA 94103-5133
(415) 252-8900
(800) 595-4889 (TTY)

<http://endabuse.org/>

- The Family Violence Prevention Fund is national in scope and provides a wide range of prevention and educational resources, many designed for special populations such as immigrant and refugee women, children, African-American women and men.
- The Fund provides many materials designed to improve the ability of health care providers to identify, treat and refer victims of domestic and sexual violence.

Virginia Department of Education

Safe and Drug-Free Schools Program
P.O. Box 2120
Richmond VA 23218-2120
(804) 225-2871

<http://www.safeanddrugfreeva.org/>

- The SDFSP is a primary vehicle for preventing violence in and around schools and preventing the illegal use of drugs (alcohol, tobacco and other drugs) by students.
- The SDFSP awards grants to schools and public and private entities to provide programming, technical assistance, training and evaluation services related to the prevention of violence and drug use among students.

Virginia Department of Health

Center for Injury and Violence Prevention (CIVP)

1500 East Main Street, Room 105

Richmond VA 23219

(804) 692-0104

<http://www.vahealth.org/civp>

- The CIVP has print, electronic, video, and other resources for the prevention of domestic and sexual violence, including a number of curricula developed and tested in Virginia.
- The CIVP has developed several reports on domestic and sexual violence prevention that are available online as well as in print.

Office of the Chief Medical Examiner

400 East Jackson Street

Richmond VA 23219

(804) 786-3174

<http://www.vdh.state.va.us/medexam/>

- The OCME provides annual reports on domestic violence homicide
- The OCME provides technical assistance in the creation of local domestic violence fatality review teams.

Partners in Prevention

1500 East Main Street, Room 135

Richmond VA 23219

(804) 786-5916

<http://www.vahealth.org/pip/>

- Through coalitions around the state and the provision of consultation and technical assistance, PIP provides education, mentoring and counseling to young adults to promote self-esteem, healthy relationships and male responsibility.
- PIP includes domestic and sexual violence prevention in its training and other programs.

Virginians Against Domestic Violence (VADV)

1010 N. Thompson Street, Suite 202

Richmond VA 23230

(804) /377-0335

(804) 377-7330 (TTY)

(800) 838-8238 (Family Violence and Sexual Assault Hotline)

<http://www.vadv.org/>

- VADV is the statewide coalition seeking to end domestic violence in Virginia. VADV has a variety of print and video resources for awareness and prevention and also a Training Institute that provides training on prevention.
- VADV is working to improve outreach, crisis response and prevention efforts for people in several special populations, including lesbians, women of color and women with disabilities
- VADV also manages the **VAdata** system, which provides data on domestic and sexual violence service provision. Reports may be found at: <http://www.vadv.org/vadata.html>

Virginians Aligned Against Sexual Assault (VAASA)

508 Dale Avenue, Suite B

Charlottesville VA 22903

(434) 979-9003

(800) 838-8238 (Family Violence and Sexual Assault Hotline)

<http://www.vaasa.org/>

- VAASA is the statewide coalition working to eliminate sexual violence in Virginia
- VAASA provides a variety of print, video and other resources on sexual violence awareness and prevention
- VAASA also provides many types of training related to awareness of and response to sexual violence, including efforts for people in special populations.

Resources for Special Populations

These resources are examples of domestic and sexual violence programs that have a special populations focus, **OR** examples of other types of programs that work with special populations who have included the prevention of domestic and sexual violence in their work.

Central Virginia Task Force on Older Battered Women

Virginia Center on Aging, MCV Campus

P.O. Box 980229

Richmond VA 23284

(804) 828-1525

- The Task Force is currently engaged in an assessment of and recommendations for the improvement of prevention and crisis response services to older women who are victims of domestic and sexual violence.

Fan Free Clinic

1010 North Thompson Street

Richmond VA 23230

(804) 358-6343

<http://www.fanfreeclinic.org/index.html>

- The Fan Free Clinic provides health care, including counseling and education, to those who would not otherwise have access to care.
- The FFC has special outreach programs to prisoners, high-risk women, sex workers and prisoners that include the prevention of domestic and sexual violence.

ROSMY (Richmond Organization for Sexual Minority Youth)

P.O. Box 5542

Richmond VA 23220

(804) 644-4800

<http://www.rosmy.org/>

- ROSMY provides support services for central Virginia area gay, lesbian, bisexual, transgender and questions youth.
- ROSMY provides life skills training that includes knowledge and skill-building for healthy relationships and the prevention of domestic and sexual violence

SAVOR! (Sisters Against Violence and Oppression Resist!)

Virginians Against Domestic Violence

1010 N. Thompson Street, Suite 202

Richmond VA 23230

(804) /377-0335

(804) 377-7330 (TTY)

- SAVOR! is a coalition organized through VADV to provide new voices for leadership in preventing and responding to domestic and sexual violence, including women of color, older women, l/b/t women and women who have survived domestic and/or sexual violence.

Appendix A

Sexual Violence Prevention Plan – 2003

Vision: A Virginia free from sexual violence

Values and Guiding Principles:

Sexual violence against women, children and men affects every person in Virginia.

Sexual violence is a violation of human rights.

Responses to sexual violence must be culturally appropriate, accessible, victim-centered, empathic and characterized by respect and dignity.

Sexual violence is a continuum of behaviors of a sexual nature that are non-consensual, and/or exploitative and may cause emotional, physical and/or psychological harm.

Condoning any form of oppression, intimidation or the use of force to gain power and control supports the same societal conventions that allow sexual violence to continue.

The scope of the work must include the elimination of the root causes of sexual violence and societal acceptance of sexual violence.

Education and training must address the pervasive lack of accurate information that enables our culture to deny, justify and perpetuate sexual violence.

Sexual violence is a public health and a public safety issue because of the harm to the individual victim and to the community as a whole. Individuals and institutions must hold perpetrators accountable to improve the quality of life for all Virginians.

Goal 1: Sexual violence prevention¹ and intervention services receive adequate funding and resources.

Lead agency	2 year objectives	5 year objectives	10year Objectives
Planning team	1. Create a collaborative agreement between the appropriate statewide groups to outline the roles and responsibilities relative to the implementation of objectives in the VA Sexual Violence Prevention Plan.		
	2. Collaboratively fund state and regional planning efforts referred to this planning document.		
State sexual violence coalition Legislature	3. Based upon a needs assessment, secure an increase in state funding support for sexual assault centers by at least 50% of the projected need.	a. Update needs assessment and secure an increase in state funding support for sexual assault centers to meet the current need.	
State sexual violence coalition	4. Initiate state funding support for sexual violence prevention.	a. Increase state funding support for sexual violence prevention by 100%.	i. Increase state funding support for sexual violence prevention by an additional 100%.
Planning team	5. Identify agencies other than sexual assault programs that could also be providing some sexual violence services.	a. Expand the scope of state supported sexual violence services.	i. Expand agencies providing sexual violence services.
Campus task force DOE	6. Secure a state coordinator for sexual violence and interpersonal violence services at the State Council of Higher Education (SCHEV).	a. Every higher education institution has a sexual violence coordinator. b. Secure and maintain a stable funding base for campus sexual assault programs.	

¹ Prevention includes primary, secondary and tertiary prevention.

Goal 1 continued

Lead agency	2 year objectives	5 year objectives	10year Objectives
VDH, DOE, DCJS, State sexual violence coalition	7. Create an infrastructure that enables the Commonwealth of Virginia ² will apply for and receive relevant grants for sexual violence.	a. The Commonwealth of Virginia will apply for and receive new relevant grants for sexual violence.	i. The Commonwealth of Virginia will apply for and receive new relevant grants for sexual violence.
State sexual violence coalition	8. Secure sources of funding for data collection efforts, including data entry and technology for local and state VAData efforts.	a. Secure sources of funding for data collection efforts, including data entry and technology for local and state surveillance efforts	i. Secure sources of funding for data collection efforts, including data entry and technology for local and state criminal justice efforts
State sexual violence coalition	9. Educate sexual violence stakeholders about grant and funding opportunities.	a. Establish a resource clearinghouse on funding opportunities and strategies for sexual intervention and prevention.	
State sexual violence coalition	10. Secure funding to the state sexual violence coalition to support making VAWA a permanent federal fund. ³	a. Secure funding to the state sexual violence coalition to support making VAWA a permanent federal fund.	i. Secure funding to the state sexual violence coalition to support making VAWA a permanent federal fund
State sexual violence	11. Expand federal VOCA guidelines to cover sexual violence victims charged with crimes (such as sex workers and victims in prison). ⁴	a. Expand federal VOCA guidelines to cover sexual violence victims	i. Expand federal VOCA guidelines to cover sexual

² This reference to the Commonwealth of Virginia is meant to include state, county and local government, private non-profit organizations, and other partners

³ The state sexual assault coalition will work with national groups to achieve this objective.

coalition		charged with crimes (such as sex workers and victims in prison).	violence victims charged with crimes (such as sex workers and victims in prison).
State sexual violence coalition	12. Raise or eliminate the cap on federal VOCA funds. ⁵	a. Raise or eliminate the cap on federal VOCA funds.	i. Raise or eliminate the cap on federal VOCA funds.

⁴ The state sexual assault coalition will work with national groups to achieve this objective.

⁵ The state sexual assault coalition will work with national groups to achieve this objective.

Goal 2: Data are used to improve sexual violence prevention⁶ and intervention.

Lead agency	2 year objectives	5 year objectives	10year Objectives
State sexual violence coalition; VDH	<ol style="list-style-type: none"> 1. Consolidate all sexual violence data in a report and distribute to all stakeholders.⁷ 2. Identify data gaps and develop a plan to close gaps. 	a. Create a standardized data set to be collected by all data sources closing the gap between needs and available data.	i. Publish a report incorporating data from all data sources, including standardized prevention and evaluation data elements and feedback to centers.
State sexual violence coalition	3. Develop a mechanism to gather data to identify Virginia’s “best practices.” ⁸	a. Showcase data driven “best practices” through a state conference and publication.	i. Support the state coalition to establish a Virginia sexual violence data driven “best practices” technical assistance information center

⁶ Prevention includes primary, secondary and tertiary prevention.

⁷ Data sources include surveillance data, SANE/SART, campuses, sexual violence coalition, etc.

⁸ Tasks: identify areas of best practices, such as fundraising, support groups, volunteers, etc.

Goal 3: Comprehensive sexual violence services are accessible in every Virginia community.

Lead agency	2 year objectives		5 year objectives	10year Objectives
State sexual violence coalition	1. Sexual assault centers provide comprehensive services.	1. A task force comprised of sexual violence service professionals and sexual violence survivors will determine an ideal set of comprehensive services for sexual assault centers ⁹ .	a. Task force will develop and distribute a plan to encourage centers to implement the comprehensive services.	i. 50% of sexual assault centers will be able to meet 100% of the comprehensive services ideal. ¹⁰
State sexual violence coalition	2. Allied professionals providing services provide to sexual violence victims provide quality services.	2. Identify standards of services for allied professionals. ¹¹	a. A plan will have been developed to meet the identified needs.	i. Allied Professionals will have implemented their plans.
Local centers State sexual violence coalition	3. All residents of Virginia have equal access to culturally appropriate services. ¹²	3. Stakeholder advisory groups of underserved populations convene to identify obstacles to accessible services.	a. Stakeholder groups develop plans to removed identified obstacles and increase accessibility.	i. All of Virginia implement plans.

⁹ The Standards Committee may be invited to participate in this taskforce.

¹⁰ Eligibility for funding will be based on minimum standards. Centers will not lose funding for not implementing comprehensive services recommended by the task force.

¹¹ For example, uniformity of regulations, rules, etc.

¹² Local sexual assault centers, VAASA and VDH will identify an appropriate response time for support to respond to victims in crisis.

Goal 4: Effective and comprehensive sexual violence prevention¹³ strategies are implemented across Virginia.

Lead agency	2 year objectives		5 year objectives	10year Objectives
State sexual violence coalition	1. Everyone recognizes, responds ¹⁴ to and/or refers victims of sexual violence.	1. Public awareness campaigns and public education on recognition of victimization, and responding to and referring victims are provided in 25% of Virginia communities	a. Public awareness campaigns and public education on recognition of victimization, and responding to and referring victims are provided in 50% of Virginia communities	i. Public awareness campaigns and public education on recognition of victimization, response to and referring victims are provided in 100% of Virginia communities
		2. Training on recognizing victimization and responding to and referring victims is provided to 25% of relevant providers (e.g., mental health centers, schools, workplaces, medical and legal community)	a. Training on recognizing victimization, and responding to and referring victims is provided to 50% of relevant providers (e.g., mental health centers, schools, workplaces, medical and legal community)	i. Training on recognizing victimization, and responding to and referring victims is provided to 100% of relevant providers (e.g., mental health centers, schools, workplaces, medical and legal community)
DOE SCHEV		3. Age appropriate curriculum (recognize, respond and refer ¹⁵) is implemented in 25% of schools (kindergarten through undergraduate school) across Virginia	a. Age appropriate curriculum (recognize, respond and refer) is implemented in 50% of schools (kindergarten through undergraduate school) across Virginia	i. Age appropriate curriculum (recognize, respond and refer) is implemented in 100% of schools (kindergarten through undergraduate school) across Virginia

¹³ Prevention includes primary, secondary and tertiary prevention. Therefore, prevention activities may include those designed to change culture so that sexual assault does not occur, activities designed to help people who encounter a potentially dangerous situation avoid sexual assault, and activities intended to reduce revictimization or re-offending.

¹⁴ Responds means more than a referral.

¹⁵ Recognizing victimization, responding to victims and making appropriate referrals for victims

Goal 4 continued: Effective and comprehensive sexual violence prevention strategies are implemented across Virginia.

Lead agency	2 year objectives		5 year objectives	10year Objectives
State sexual violence coalition; VDH; SOPAC	2. Everyone has access to information about recognizing and responding to perpetrator behavior.	4. Provide a Statewide Hotline to provide options for callers who suspect someone of being a perpetrator or for callers who are perpetrators. 5. Develop and implement a public awareness campaign to inform the public about this service of the Statewide hotline	a. Increase calls to the hotline by 25%	i. Increase calls to the hotline by 50%
Planning team	3. Allied professionals and other disciplines recognize and respond to behaviors and attitudes that contribute to sexual violence.	6. Identify and develop a training curriculum to recognize and respond to behaviors that contribute to sexual violence	a. Implement a training curriculum for 50 disciplines to recognize and respond to behaviors that contribute to sexual violence	i. 25% of each of the 50 disciplines will be trained.
State sexual violence coalition	4. Individuals will not engage in or support sexual violence.	7. Materials for a prevention media campaign will be developed and the campaign will begin.	a. Messages contained in a prevention media campaign are recognized, remembered, and repeated by 25% of people in Virginia.	i. Messages contained in a prevention media campaign are recognized, remembered, and repeated by 50% of people in Virginia.
DOE; VDH; State sexual violence coalition		8. Prevention strategies for kindergarten through undergraduate school will be researched and identified.	a. Prevention strategies for kindergarten through undergraduate school will be developed, authorized and begin to be implemented.	i. Prevention strategies will be implemented in every school in Virginia (kindergarten through undergraduate school))

Goal 4 continued: Effective and comprehensive sexual violence prevention strategies are implemented across Virginia.

Lead agency	Subgoal	2 year objectives	5 year objectives	10year Objectives
State sexual violence coalition		9. Prevention strategies for the workplace will be researched and identified.	a. Prevention strategies for the workplace will be developed, authorized and begin to be implemented.	i. Prevention strategies will be implemented in every workplace in Virginia. ¹⁶
State sexual violence coalition	5. Systems and organizations will not support sexual violence. ¹⁷	10. Identify those systems and organizations and the structures that support sexual violence within them.	a. Education programs will be implemented that make the connection that the use of sexual violence is not acceptable within the system or organization.	i. All systems and organizations will implement policies that do not support or tolerate, sexual violence and that support victims.
Planning team; SOPAC;	6. Sex offender treatment is effective and available.	11. A panel of treatment providers and victims' advocates audit the current state of sex offender treatment and identify best practices in Virginia.	a. According to this audit, panel will develop a plan to certify all sex offender treatment providers (highlighting effectiveness and availability).	i. Every region ¹⁸ has at least one certified sex offender treatment program.

¹⁶ Employers with more than 15 employees.

¹⁷ For example, enforce zero tolerance for sexual violence in prison. Social structures include schools, courts, military, churches.

¹⁸ Region is a problematic term in that it is not used consistently in Virginia. This needs to be further identified.

Goal 5: Public policies are reformed to respond effectively to sexual violence through prevention and intervention.

Lead agency	Subgoal	2 year objectives	5 year objectives	10year Objectives
State sexual violence coalition; General Assembly	1. Public policies support sexual violence prevention.			
DCJS; State sexual violence coalition	2. There is uniformity and accountability in sentencing for sex offenders.	1. The Virginia Crime Commission studies the criminal code and sentencing guidelines to identify gaps and inconsistencies.	a. Based on their recommendations, the General Assembly adopts legislation to standardize minimum sex offender consequences b. The General Assembly adopts legislation that requires judges, Commonwealth's Attorneys and probation/parole officers to receive training on legislative changes.	i. 100% of judges, Commonwealth Attorneys and probation and parole officers will receive mandatory training from appropriate agencies on the legislative changes
DCJS; State sexual violence coalition	3. Public policies promote sexual violence prevention strategies and support the needs and rights of sexual violence victims.	2. Legislative Commission on Sexual Violence Reduction convened.	a. All recommended legislative and policy changes are identified	i. Reform the Code. ii. Implement the legislative and policy revisions agenda recommended by the Commission.

Appendix B
Participants List - Logic Model Development Work Session
April 22, 2003

Kim Birdwell
Response - Sexual Assault Support
Services of the YWCA
Norfolk VA

Cathy Bodkin
Virginia Department of Health
Richmond Virginia

Tom Chapel
Centers for Disease Control & Prevention
Atlanta GA

Toby Cook
Cumberland Health District
Lebanon VA

Elizabeth Cramer
School of Social Work
Virginia Commonwealth University
Richmond VA

Janett Forté
Domestic Violence Resource Center
Chesterfield VA

Bob Franklin
Virginia Department of Health
Richmond VA

Sherrie Goggans
Virginians Against Domestic Violence
Richmond VA

Sarah Johnston
ROSMY (Richmond Organization for Sexual Minority
Youth)
Richmond VA

Helen Leonard
Virginia Department of Social Services
Richmond VA

Jay Malcan
Virginia Union University
Richmond VA

Ginny Mittereder
Arlington Department of Human
Services
Arlington VA

Karen Mock
Hanover Domestic Violence Task Force
Ashland VA

Cheryl Myrick
Juvenile Protection & Substance Abuse Committee
Virginia PTA
Richmond VA

Barbara Parker
Virginia Department of Health
Richmond VA

Brad Perry
Virginians Aligned Against Sexual Assault
Charlottesville VA

Carol Pollock
Virginia Department of Health
Richmond VA

Greer Saunders
Office of the Attorney General
Richmond

Myra Shook
Virginia Department of Education
Richmond VA

Tina Simms
Office of the Chief Medical Examiner
Virginia Department of Health
Richmond VA

Cyndi Simpson
Virginia Department of Health
Richmond VA

Jan Thomas PHD
Circle Safety & Health Consultants
Richmond VA

Stacie Vecchietti
Department of Criminal Justice Services
Richmond VA

Jeanine Woodruff
Virginians Aligned Against Sexual Assault
Charlottesville VA