

**FURTHER RECOMMENDATIONS FOR THE
DEVELOPMENT AND COORDINATION OF SERVICES FOR
VICTIMS OF DOMESTIC AND SEXUAL VIOLENCE
IN THE STATE OF HAWAI`I**

**PREPARED FOR:
THE 1998 HAWAI`I STATE LEGISLATURE**

**PREPARED BY:
THE HAWAI`I STATE COMMISSION ON THE
STATUS OF WOMEN**

**IN COLLABORATION WITH:
THE AD-HOC COMMITTEE ON DOMESTIC AND SEXUAL VIOLENCE**

DECEMBER 1997/FINAL

RECEIVED
CITY CLERK
C & C OF HONOLULU
2015 APR -9 PM 3:56

1997 EXECUTIVE SUMMARY

Background

- This report is a follow-up to an initial report made to the 1996 Hawai'i State Legislature by the Ad-hoc Committee on Domestic and Sexual Violence.
- Some of the recommendations listed here are reiterations from last year's report (Attachment C). New ones have also been developed and presented here by members who have continued to meet.
- The Ad-hoc Committee was convened and chaired by the Hawai'i State Commission on the Status of Women and facilitated by the Center for Alternative Dispute Resolution.
- The Committee includes diverse representation from public and private agencies and community groups with experience and knowledge of domestic and sexual violence issues and services.

Report Development

- This report addresses the Direct Service and Prevention components of the Continuum of Care model that was developed in 1996 by the Committee.
- In order to conduct its work, the Committee utilized subcommittees, large group meetings, conference calling, and individual information gathering.
- Issues related to Criminal Justice elements will be addressed through subsequent Committee work.

Key Issues

- A Standing Committee on Domestic and Sexual Violence would provide an ongoing mechanism to ensure coordination, communication and collaboration regarding the development, implementation and evaluation of these services.
- Both legislative and public/private agency policy changes must be addressed in order to develop and implement an effective Continuum of Care.
- Public and private agency funding and program performance must be prioritized and monitored effectively to ensure that quality services are available to meet victim needs.
- The Committee presents the following recommendations for strong consideration (please refer to the content of the report for more detail):

Direct Service Recommendations

- The 1998 Legislature should pass a resolution to maintain the Ad-hoc Committee as a standing Committee on Domestic and Sexual Violence, recognizing its important work and ensuring an ongoing mechanism for effective planning, implementation, evaluation, and coordination of these services;
- All state agencies and publicly funded private agencies engaged in the provision of these services should be required to participate as members of the Committee on Domestic and Sexual Violence to promote communication, coordination, effective implementation, and ongoing evaluation of service needs;
- The Legislature should, as appropriate, provide for neutral evaluation and monitoring of all publicly funded domestic and sexual violence purchase of service contracts;
- Policy makers must make a strong commitment to fund or cut service dollars based upon the impact on victim safety and perpetrator accountability, and utilizing the continuum of care model;
- Short-term funding priority should be given to the provision of sexual assault services, particularly to maintain a 24-hour crisis hotline and crisis worker response statewide;
- Additional funding priority should be given to the arena of case management and the resources necessary to ensure this function;
- Every effort should be made to fund at least two Domestic Abuse Response Team pilot projects (one on Oahu and one on a neighbor island) for a minimum of two to three years;
- Before additional public funds are dedicated toward other service areas, a detailed assessment should be conducted to determine if services could be

Direct Service Recommendations - Cont'd.

improved by shifting existing dollars, what new program efforts are planned or underway, and how additional monies would be utilized to enhance the quality of existing programs;

- Public agencies should make technical assistance available to private service providers in order to increase their ability to adopt third party billing systems that would allow for the recovery of some victim/perpetrator service costs;
- Public agencies must ensure that administrators have a thorough understanding of domestic and sexual violence issues and service needs in order to effectively write, implement, and monitor purchase of service contracts so that services meet victim needs;
- Funding entities should require more collaboration between service provider agencies to foster a multi-disciplinary approach to the provision of services for victims of domestic and sexual violence, promoting efforts such as staff exchanges, inter-agency training, and utilizing comprehensive client assessment tools;
- In order to assure consistent and effective public advocacy statewide for victims of domestic and sexual violence, the Legislature should consider mandating basic service standards for victim/witness advocacy programs;
- Policy makers should encourage and support a comprehensive basic benefit package review, development and monitoring process to ensure mental health care coverage that meets the needs of victims of domestic and sexual violence;
- There should be no increases in the funding for perpetrator related services;
- Perpetrators should be required to pay for the costs of their services in order to increase funding for victims services and to increase perpetrator accountability -- this must be accompanied by quick and certain consequences for non-compliance; and

Direct Service Recommendations - Cont'd.

- In funding perpetrator services, efforts developed to primarily conduct intensive, long-term monitoring (at least two to three years) should take precedence over the provision of shorter-term intervention services, such as individual counselling and/or psycho-educational groups.

Prevention Recommendations

- Adopt a prevention policy approach that includes the definitions, criteria and elements detailed in this report;
- Make no additional cuts to funding already provided for the prevention of domestic and sexual violence;
- By the year 2000, increase the level of spending for domestic and sexual violence prevention by at least 10-fold;
- Ensure a focus on prevention spending in the areas of Research, Education, and Evaluation;
- Provide legislative support for the Violence Prevention Curriculum Initiative;
- Put public agency prevention dollars into separate contracts and encourage non-direct services providers with a prevention orientation to compete for these monies;
- Re-examine and write public agency contracts to ensure that they incorporate effective and appropriate primary prevention criteria and elements into the scope of services;
- Ensure that public and private agencies seek out opportunities to pool available prevention dollars, enhancing collaboration and effectiveness;
- Encourage all departments, agencies and organizations to examine how prevention concepts and approaches can be integrated into their current projects, programs and training efforts;

Prevention Recommendations - Cont'd.

- Promote the use of funding for accessible, easily understood research data and analyses; and
- In funding direct services, give legislative priority to better networked, effective, comprehensive and integrated service programs that would complement primary prevention efforts and help build healthier, safer communities.

TABLE OF CONTENTS

Introduction.....	1
Section I: Background	
General Information.....	2
Ad-hoc Committee Mission.....	3
Section II: Direct Services	
Identifying Direct Service Issues.....	5
Defining Direct Services.....	8
Direct Service Recommendations.....	13
Section III: Prevention	
Identifying Prevention Issues.....	15
Defining Prevention.....	17
Prevention Recommendations.....	20
Attachment A (Subcommittee List).....	22
Attachment B (Fax List).....	23

Attachment C (1996 Ad-hoc Committee Report)

**FURTHER RECOMMENDATIONS FOR THE
DEVELOPMENT AND COORDINATION OF SERVICES FOR VICTIMS OF
DOMESTIC AND SEXUAL VIOLENCE
IN THE STATE OF HAWAII**

Report Prepared By:

The Hawai'i State Commission on the Status of Women

In Collaboration With:

The Ad-hoc Committee on Domestic and Sexual Violence

December 1997

This report was mandated by Act 167, which 1) directed the Departments of Health and Human Services to establish and administer programs for prevention, protection and treatment related to domestic and sexual violence; 2) created the Ad-hoc Committee on Domestic and Sexual Violence to be convened and chaired by the Hawai'i State Commission on the Status of Women; and 3) required a plan for the continuation of related Judiciary programs under the auspices of the Executive Branch, and; 4) prohibited a reduction in funding, termination, or transfer of any these Judiciary programs.

This report was made possible through the support and assistance of The Center for Alternative Dispute Resolution, which provided valuable assistance in the facilitation process that created this report, and by the participation and commitment of the following public and private agencies and organizations in the work of the Ad-hoc Committee on Domestic and Sexual Violence:

The Hawai'i State Departments of Health, Human Services, and the Attorney General; Parents and Children Together; Catholic Charities/Family Services;

The Family Crisis Shelter, Inc.; Hale Ola Windward Abuse Shelter; Hope Domestic Violence Consultants; Americorps/Hawai'i Lawyers Care; YWCA of Kauai Sex Assault Treatment Program; Sex Abuse Treatment Center; Sex Abuse Interventions, Inc.; Office of the Prosecuting Attorney/Hilo; the Hawai'i State Coalition Against Sexual Assault; Hawai'i YWCA Sexual Assault Support Services; Women's Resource Center/YWCA of Oahu; League of Women Voters of Honolulu; Honolulu Police Department; UH School of Nursing; and the Hawai'i State Commission on the Status of Women.

Section I: Background

General Information

Over the last several years, state budget cuts dramatically impacted the level of funding available for services to victims of violence. In response to this situation, the Hawai'i Women's Coalition included a measure in its 1996 legislative package that sought to incorporate the provision of such services as one of the responsibilities of the Hawai'i State Departments of Health (DOH) and Human Services (DHS). The goals were to ensure that such services are an acknowledged social and health priority in Hawai'i, to make such services part of the mission of these departments, and thereby offer better protection of existing funding and service levels.

This proposal evolved into Act 167, which requires DOH and DHS to establish and administer programs that provide both prevention and direct services for the protection and treatment of victims of domestic and sexual violence. The Act also called for the creation of an Ad-hoc Committee on Domestic and Sexual Violence to develop a transition plan for the continuation of victim services that have been funded by the State Judiciary. The Hawai'i State Commission on the Status of Women (HCSW) was named as the convener and chair of this committee.

The Ad-hoc Committee on Domestic and Sexual Violence was convened in April of 1996 by HCSW. The Committee includes diverse representation from both public and private entities across the state who have direct experience and knowledge relating to the public funding of services for both victims and perpetrators of violence against women. The group has been meeting on a regular basis through December of 1997. It submitted an initial report to the 1997 Hawai'i State Legislature, promising subsequent reports to provide the greater detail needed to achieve the recommendations that were outlined. This is the first of those promised reports.

The Ad-hoc Committee Mission

As the Committee initially began its work, it became obvious that continuation of any specific programs or funding levels could only be effectively discussed while considering the entire system that supports all publicly funded services for victims of domestic and sexual violence. In addition, the Committee recognized that no clear picture was available regarding the types of services available, their funding levels, or who was providing the funding and/or services. Furthermore, members acknowledged that funding is not the only issue impacting victims services. They acknowledged the need for a long-term and ongoing mechanism that will solve problems related to gaps in services, the availability of appropriate and necessary services, monitoring effectiveness, the ability to adapt to the changing needs of victims of domestic and sexual violence, as well as inadequate funding levels.

Therefore, the Ad-hoc Committee adopted and continues to endorse the following mission statement:

The Ad-hoc Committee on Domestic and Sexual Violence will work to design and implement a comprehensive and coordinated service system for the protection of women and their children from domestic and sexual violence.

The Committee's 1996 recommendations and mission statement represented a unanimously supported approach that was reached after many hours of

thoughtful discussion and reflection. Each of the members who participated in 1996 committed to providing the long-term time and effort to ensure that this mission is achieved. However, some domestic violence service providers and the Judiciary elected not to continue their participation for a variety of reasons. In their place, new members have emerged to join ongoing Ad-hoc Committee domestic violence service provider representatives. Any previous members who signed on in support of the 1996 Ad-hoc Report, and who have not participated over the last year, are continually invited to join us through regular faxes and meeting notices (Attachment B). Other interested parties are also listed on the fax roster.

It is important to emphasize that the work of the Ad-hoc Committee and its sub-committees (see Attachment A) has been enhanced by even broader community networking attained throughout the last year that includes grassroots community and victim input. Therefore, our first strong recommendation -- as it was last year -- is that the Legislature pass the House/Senate Concurrent Resolution endorsing the work of the Ad-hoc Committee. This would serve to recognize the important contributions being made to this effort, provide the legislature with an informed systems approach to policy making, and further encourage broad participation and collaboration on behalf of this crucial work.

While this report seeks to acknowledge and address the gaps in our current system of care in Hawai'i, we want to emphasize that many dedicated professionals, para-professionals, victims and others are working with a variety of agencies, both public and private, to ensure the provision of quality and appropriate services related to domestic and sexual violence. Some cutting-edge program development and data collection, unique collaborations, and new funding approaches are unfolding in our state that can greatly improve work in this arena.

However, the extent to which we can quickly and effectively address the system's problematic areas will be the extent to which we can promote, enhance and replicate these efforts. We hope this report will be an important step in that direction.

Section II: Direct Services

Identifying Direct Service Issues

As discussed in the 1996 Ad-hoc Committee report, public funds that support both victim and perpetrator services are administered variously by the Departments of Health, Human Services, and the Attorney General, and by the Judiciary. Although, these agencies and branches of government have different contract requirements and goals for similar services they have recognized their need for continued coordination to ensure resources are focused on the most needed service areas. While coordination is not perfect, strides have been made over the past couple of years. The lack of coordination, although improved, makes it hard to track funding and the types of services available. This also makes it difficult to achieve policy development and implementation, or to ensure consistency and effectiveness of victim or perpetrator programs. In addition, multiple and varying public agency requirements and timelines cause the unnecessary expenditure of resources by private service providers who are trying to navigate through this maze.

Based upon the funding matrix developed in 1996, about 42% of the approximately \$7.3 million expended by the above agencies on behalf of domestic and sexual violence services is spent on perpetrator programs. *However, this amount does not include enormous perpetrator costs associated with police intervention, incarceration, or court procedures.* It must also be emphasized that while 58% of the above total is spent on victim services, the victim population greatly exceeds the number of perpetrators, victims needs continue to go unmet, and victim service costs typically represent a much lower per individual amount. Additionally, the true incidents of domestic violence and sexual assault is considerably higher than the reported amounts.

The Committee's work has also acknowledged that funding decisions may not be based upon their impact on victim safety or perpetrator accountability. And

yet, victim safety and perpetrator accountability should be fundamental pieces to any comprehensive, coordinated and effective system to address domestic and sexual violence in our communities. Therefore, any funding decision should include an assessment of these two issues. Additional funding should increase victim safety (save more lives, reduce the severity and amount of injury) and increase perpetrator accountability (ensuring quick and certain consequences for any violations of the law, sentencing or program requirements), while funding must not be cut where it would undermine or decrease victim safety and/or perpetrator accountability.

It must be pointed out that some domestic violence service cuts were restored over the last fiscal year and new spending was also provided for specific programs. However, no sexual assault service funding has been restored. In fact, DOH sexual assault purchase of service contracts currently face additional funding reductions. At this time, not all sexual assault service providers are able to guarantee the provision of 24-hotlines and/or the availability of crisis advocates. Tight dollars are forcing more reductions in the number and types of services available for these victims and/or the inability to serve all sex assault victims requesting services.

In conducting their work on behalf of the Ad-hoc Committee, members engaged in many detailed discussions with both providers and recipients of victim and perpetrator services across our state. From these discussions, it became clear that the quality, availability, and appropriateness of services throughout Hawai'i are inconsistent and may not be meeting victim needs. A few examples include the following: 1) some perpetrator programs do not conduct victim safety checks; 2) domestic violence victims complain of unhealthy environments, inconsistent availability of food, and little access to information about transitional services or safety planning in some shelters; 3) funding for domestic violence related legal services focuses on the provision of temporary restraining orders (TROs) when what victims want and need is civil legal help on divorce, custody, child support enforcement, workplace harassment, tenant rights and immigration

issues; 4) finding civil legal assistance for sex assault victims, particularly on the neighbor islands, can be very difficult and cost prohibitive; 5) there aren't enough resources available for transitional or long-term affordable housing, for child care, job training/placement, or for relocation to another island or out-of-state; 6) some agencies have cut program services without cutting their relatively high administrative overhead; 7) standards and availability of services often vary from island to island, from agency to agency; and 8) service providers have little flexibility to utilize their public funding for basic and immediate needs such as clothing and transportation, or the replacement of such critical items as eyeglasses and dentures;

To be sure, there are many agencies dedicated to providing the best possible services that will assist victims of domestic and sexual violence. Many of their staff are overworked and underpaid, and these agencies often operate on the most bare bones budget because adequate funding is just not available. Additionally, there are victims who can attest to the excellent services they have received, this often being the key component to saving their lives.

However, the real problems and inconsistencies that do exist must be acknowledged and addressed, if we as a community are to save more lives and provide a truly coordinated, comprehensive and quality service system. The scope of services that these contracts entail must be based upon more consistently informed and ongoing discussions between public agencies and among a wider range of service providers and victim advocates. To be fully informed and responsive to victim needs, these discussions must include direct victim input.

It should be noted that through their continued participation on this Ad-hoc Committee, public and private agency members have begun to address these issues and demonstrate a commitment to improving the design, implementation, and quality of domestic and sexual violence services.

Defining Direct Services

The 1996 Ad-hoc report included a continuum of care, the Committee's first attempt at detailing the service areas that must be addressed for both perpetrators and victims of domestic and sexual violence. In its work on the 1997 report, the Committee has more fully defined and prioritized the elements of this continuum. The following elements apply to the provision of victim services:

24-hour Crisis Intervention. This refers to the constant availability of an immediate response to victims in crisis. At a minimum, adequate and effective crisis intervention requires a person, as opposed to an answering machine, who can provide referral information, advocacy assistance, and safety planning for those who are in imminent danger and/or who have just been involved in a domestic or sexual violence incident.

The first 24-48 hour time period following a violent incident is a high risk period for any victim, who may be vulnerable to additional violence, may need immediate police intervention, medical attention, HIV/AIDS and/or STD testing, and safe shelter. This time period also represents an important opportunity to conduct victim safety planning, provide service referral information, and conduct forensic exams and evidence gathering to enhance perpetrator prosecution, relieving victims from some of the burdens of testifying in court. It may also be the only time of access to victims; the only opportunity to provide them with critical information that could later save their lives -- and sometimes the lives of their children.

For these reasons, it is critical to have effective, sufficient and quality crisis services available on a 24-hour basis statewide. Having a victim advocate on the scene allows for the critical interventions mentioned above, and helps to prevent re-victimization during police interaction, evidence gathering and medical examination/treatment. This, in turn, makes it much more likely that victims can and will be able to participate as witnesses in the prosecution of domestic and sexual violence cases.

However, there are currently no Domestic Abuse Response Teams (DART) available in Hawai'i. The original DART project was not funded for a long enough time period to be effectively evaluated or replicated. Pu'uhonua provides collaborative, cross-disciplinary assistance to domestic violence victims on O'ahu. But this program hasn't the resources to be available 24-hours or on weekends. It also relies upon victims, who are aware of the program, to transport themselves to the center. It cannot currently support outreach workers who can respond at the scene. Primarily because of funding disparities, sexual assault service providers are now finding it increasingly difficult to maintain a 24-hour crisis response statewide. And few, if any programs, currently provide much in the way of services for bilingual, deaf, blind or disabled victims.

Medical Services. This includes the development and implementation of common domestic and sexual violence protocols in all hospitals and medical clinics; the availability of emergency medical treatment; and the statewide establishment and/or implementation of medical evidence gathering protocols, with appropriately trained personnel consistently available. It also includes access to immediate STD testing; to long-term medical and psychological services; and to HIV/AIDS testing, including mandatory perpetrator testing with victim notification procedures.

In the arena of medical services, the development and implementation of hospital and medical protocols for victims of domestic violence are inconsistent at best. For both domestic and sexual violence, there is often a lack of appropriately trained personnel available to properly interact with victims in need of medical care and to conduct forensic exams. This can be particularly true for the neighbor islands. Public funding for even short-term counseling is inadequate, while health plans typically will not cover the longer term psychological services that victims may require. Additionally, most service provider agencies are not equipped to engage in third-party billing as a way to supplement the sometimes meager public funding available for victim counseling services.

Legal Advocacy. Comprehensive legal advocacy provides a range of legal services for victims of domestic and sexual violence including assistance to victims during the reporting process; court accompaniment; legal representation in divorce, custody, child support, alimony, and other proceedings; ensuring victim/witness assistance as a priority for prosecution; and consistent notification regarding perpetrator related hearings and release dates.

As victims have pointed out, most of the resources for legal advocacy are allocated by both public and private agencies to provide assistance in obtaining TROs. Yet, victims often identify TROs as a system/agency focus, not a victim need. They identify a much broader range of important legal issues, as noted above.

Safe Shelter. This includes twenty-four hour availability of staffed emergency shelter for short-term stays of up to three months for victims of domestic and sexual violence that includes basic services such as food, safety planning, and resource and transition referral.

Like crisis intervention, providing emergency shelter offers a critical solution to an immediate need for victims at risk. It is also an invaluable opportunity to conduct or review safety planning, to identify appropriate resources, to plan for transition from the shelter, to offer psycho-educational group counseling that develops understanding about the cycle of violence and helps build self-esteem, and to conduct in-depth, cross-disciplinary assessment and referral. These most basic services must be available in all shelters to all victims. But most state purchase of service contracts do not consider these issues, regarding shelters or any other service programs. Instead, they typically require reporting such as numbers of clients served, demographic information about these clients, with very basic quarterly financial information.

Shelters should be evaluated based upon their provision of these services, as well as available child care, personal care items, food, cost to the victim, adequate 24-hour staffing, cleanliness and safety. As a state, we cannot hope to claim an effective safety net for victims of domestic and sexual violence if we

cannot ensure the availability of safe, emergency shelter for them and their children. Therefore, adequate funding must be available to ensure this component, and public agencies must conduct more effective, detailed program monitoring to ensure consistent quality of services.

Case Management/Victim Advocacy. This refers to the availability of staff trained from a multi-disciplinary perspective. Such staff should be able to assist and advocate for victims in order to address their needs and help them to navigate through the myriad of agencies, services and procedures that comprise our current system. This includes short and long-term housing, transportation, medical care, economic and legal assistance, child care, vocational/educational opportunities, and counseling programs.

Case management is the most underfunded area related to domestic and sexual violence, both in terms of staffing and the actual resources necessary to address victim needs. It is through the function of case management that victim advocacy takes on one of its most important roles as a long-term effort to ensure victim safety and transition into a greatly improved quality of life. Like the term prevention, the term advocacy is utilized quite liberally in the arenas of domestic and sexual violence, but means different things to different people. Victim advocacy is often confused with agency advocacy.

Agency advocacy occurs on behalf of a public or private provider of resources or services in order to increase or maintain its level of funding and way of doing business. On the other hand, victim advocacy occurs on behalf of individuals to: 1) ensure that they are aware of and receive all of the appropriate, quality services they need; 2) that they have input as to how those services function; and 3) that they have access to information and a voice related to perpetrator prosecution, sentencing and release. Victim advocacy requires case managers who are well trained with a multi-disciplinary focus, are dedicated to collaboration, are willing and supported when they speak out -- when they advocate -- on behalf their clients, and are able to work with clients on a long-term basis. Some victims and service provider staff consistently express

frustration at their inability to conduct these kinds of services for victims on anything but a sporadic basis. This occurs because of insufficient staffing resources, the possibility of conflicting goals/messages when advocacy resources are housed in a public agency, and because well trained staff are not always available in this area. Sometimes there is simply a lack of public or private commitment to this issue.

Finally, our system has barely begun to allocate funding for all of the services that case managers would like to help clients access. These range from the relatively simple to the complicated and include items such as health insurance, free or subsidized child care, and affordable housing. Furthermore, provider agencies often do not have the flexibility to utilize funding to adequately address client's real needs. A simple example would be providing a suit of clothes, a decent haircut, and a bus pass to a client so that she is properly prepared to go on job interviews.

While there are not enough of these services to meet an ever growing demand, there is a large pool of funds currently available through public prosecutor's offices for victim/witness advocacy. However, there are inconsistencies in the kinds of services provided to victims, the level of victim/witness advocate training, and sometimes disagreement over the appropriate role of these publicly funded victim/witness assistance programs.

Treatment and Counseling. These services include crisis and post-trauma individual counseling and psycho-educational groups for adults victims, as well as for child witnesses of violence; residential treatment facilities; long-term treatment opportunities; and aftercare for independent living assistance.

In the arena of treatment and counseling, there are few public dollars dedicated to victim counseling services when compared to perpetrator counseling services. At the same time, barriers are created by the limits of coverage for long-term counseling and psychological services in health care insurance plans. Yet, we have begun to understand that untreated psychological trauma, just as untreated disease, has both long-term mental and

physical health implications. High rates of post-traumatic stress disorder (PTSD), alcohol/substance abuse, suicide attempts, as well as increased risk for high blood pressure, diabetes, and cancers have all been associated with victims of domestic and sexual violence. We also know that children who witness violence are more likely to become adult victims or perpetrators themselves. All of this results in a diminished quality of life, further draining our social service, law enforcement, legal and medical resource dollars.

Direct Service Recommendations

Again, it should be emphasized that the best victim service programs are collaborative and cross-disciplinary in nature, ensure availability and accessibility, are affordable, maintain a consistent level of quality, include ongoing evaluation, and are able to adapt and respond to the needs of their clientele. Based upon its discussions and research of direct services related to domestic and sexual violence, and considering the State's current funding difficulties, the Ad-hoc Committee makes the following recommendations:

- The 1998 Legislature should pass a resolution to maintain the Ad-hoc Committee as a standing Committee on Domestic and Sexual Violence, recognizing its important work and ensuring an ongoing mechanism for effective planning, implementation, evaluation, and coordination of these services;
- All state agencies and publicly funded private agencies engaged in the provision of these services should be required to participate as members of the Committee on Domestic and Sexual Violence to promote communication, coordination, effective implementation, and ongoing evaluation of service needs;
- The Legislature should, as appropriate, provide for neutral evaluation and monitoring of all publicly funded domestic and sexual violence purchase of service contracts;

- Policy makers must make a strong commitment to fund or cut service dollars based upon the impact on victim safety and perpetrator accountability, and utilizing the continuum of care model;
- Short-term funding priority should be given to the provision of sexual assault services, particularly to maintain a 24-hour crisis hotline and crisis worker response statewide;
- Additional funding priority should be given to the arena of case management and the resources necessary to ensure this function;
- Every effort should be made to fund at least two Domestic Abuse Response Team pilot projects (one on Oahu and one on a neighbor island) for a minimum of two to three years;
- Before additional public funds are dedicated toward other service areas, a detailed assessment should be conducted to determine if services could be improved by shifting existing dollars, what new program efforts are planned or underway, and how additional monies would be utilized to enhance the quality of existing programs;
- Public agencies should make technical assistance available to private service providers in order to increase their ability to adopt third party billing systems that would allow for the recovery of some victim/perpetrator service costs;
- Public agencies must ensure that administrators have a thorough understanding of domestic and sexual violence issues and service needs in order to effectively write, implement, and monitor purchase of service contracts so that services meet victim needs;
- Funding entities should require more collaboration between service provider agencies to foster a multi-disciplinary approach to the provision of services for victims of domestic and sexual violence, promoting efforts such as staff exchanges, inter-agency training, and utilizing comprehensive client assessment tools;

- In order to assure consistent and effective public advocacy statewide, the Legislature should consider requiring the development of basic service standards for victim/witness advocacy programs;
- Policy makers should encourage and support a comprehensive basic benefit package review, development and monitoring process to ensure mental health care coverage that meets the needs of victims of domestic and sexual violence;
- There should be no increases in the funding for perpetrator related services;
- Perpetrators should be required to pay for the costs of their services in order to increase funding for victim services and to increase perpetrator accountability -- this must be accompanied by quick and certain consequences for non-compliance; and
- In funding perpetrator services, efforts developed to primarily conduct intensive, long-term monitoring (at least two to three years) should take precedence over the provision of shorter-term intervention services, such as individual counseling and/or psycho-educational groups.

Section III: Prevention

Identifying Prevention Issues

One of the major challenges involved in any discussion about prevention is the lack of a common understanding about what prevention means, what it is and what it is not. In our media, in policy discussions, and often in programmatic planning, projects and programs that would be appropriately labeled intervention are typically described as prevention. For example, a newspaper headline may tout a new government 'prevention' program that invests substantial funds into drug/alcohol rehabilitation treatment for revolving door

criminals. But that program is *not* prevention. It is a direct service intervention seeking to solve a problem long after it already exists among a specific population.

Direct service interventions are typically oriented toward at-risk individuals, families, or neighborhoods. The underlying notion can often be that certain people or areas will inherently have problems that others either will not have at all, or will not have with any great significance. The direct service approach tends to be heavily agency centered, fostering dependence with its focus on problems. It is usually reactive and crisis oriented. And unfortunately, the direct service approach also tends to be disconnected and categorical, failing to make important connections and linkages between issues and resources within or across programs, agencies or communities.

By contrast, prevention programs seek to keep a problem or negative outcome from occurring in the first place. Primary prevention efforts are population-based, meaning they are focused on everyone in every community, recognizing that all people, organizations and entities have something to gain from and contribute to the effort. In fact, prevention strategies amount to investments that focus on building healthy and safe communities. True prevention programs promote resiliency in communities, as opposed to dependence. They are broad-based, fostering ongoing community dialogue and mobilization, identifying what people want their community to be and how they can get there. A prevention approach acknowledges that all communities have strengths and resources which can be tapped. It promotes linkages between issues, programs, projects and resources to achieve informed, coordinated, and comprehensive efforts. As with any investment portfolio, prevention programs also demand a long-term view, while maintaining the flexibility to shift appropriately as pertinent information is gathered and incorporated, to ensure a strong, long-term payoff.

For decades, most of our resources have been appropriated for direct service interventions that typically focus on the short-term. But the need only continues to grow for more monetary and other resources to fulfill the demand

for these services. And this approach, although helpful in individual cases, has not demonstrated long-term effectiveness in decreasing the incidence of abusive behavior within our communities. Neither is there any reduction in sight of the related costs for social services, law enforcement, mental health and medical care, or business losses. Any hope in stemming this tide resides in our willingness to begin investing heavily and consistently in effective prevention programs and approaches.

The 1996 Ad-hoc Committee report to the legislature demonstrated that an amount equal to just 6% of the total spent on perpetrator and victim services is being allocated for the prevention of domestic and sexual violence. (It should be noted that much of this funding is incorporated into contracts that include the provision of direct services for victims. Because these services are already underfunded, particularly in the arena of sexual assault, prevention dollars are the first to be cut. In addition, when monies run short for victim services because demand is underestimated, prevention dollars are often shifted over to victim services to address the shortfall. Therefore, including programmatic provisions for prevention efforts in contracts which primarily address direct service needs merely presents an illusion that primary prevention efforts are being funded and conducted. At the same time, the insufficient funding levels for victim services is minimized by this arrangement.) To overcome this disparity, we must begin by promoting and adopting a common language and approach regarding prevention policies and programs.

Defining Prevention

While the 1996 Ad-hoc report acknowledged prevention as a very important component of any coordinated and comprehensive system addressing domestic and sexual violence, detailed information related to this area was not provided. Therefore, the Committee has now identified the following elements as necessary to the prevention of domestic and sexual violence in Hawai'i:

Research. This includes the collection and review of data and other information related to domestic and sexual violence in Hawai'i to develop an accurate picture of what's happening in our communities, and to monitor changes and improvements. In conducting these assessments, community resources of all kinds must also be identified, including their accessibility and availability.

It is often difficult to obtain funding for research when competition is keen for dollars and legislators feel forced to "choose between serving people or supporting pencil pushing." Research results have not always been translated into an effective common language that is accessible by both policy makers and the public. Nor is this information widely distributed on a consistent basis so it can be incorporated into all appropriate planning and program efforts. But effective research is critical to ensure our understanding of the impact of domestic and sexual violence in our communities, for effective program planning, implementation and evaluation.

Public Awareness. This refers to the provision of general information about issues, attitudes, and behaviors to the broader population. Public awareness campaigns may define an issue, may focus on risk reduction (i.e., safety tips, how to identify warning signs, etc.), may disseminate resource information, and generally increase consciousness about domestic and sexual violence. However, they do not necessarily create behavior changes.

Currently, the vast majority of our prevention resources are spent on Public Awareness campaigns. These campaigns are fairly quick and easy to organize and are relatively inexpensive. Sometimes they create a false sense of sufficient action on behalf of the prevention of domestic and sexual violence. While public awareness campaigns are useful in highlighting certain issues for the public, further evaluation must be conducted to determine their effectiveness.

Education. In contrast to public awareness efforts, education is knowledge based. It ensures that myths about domestic and sexual violence are eroded, replaced by an understanding of the dynamics of this violence and the full scope

of its impact. It increases or enhances skills in communicating about this violence, in using alternatives to violence, in developing violence prevention policies and programs, and results in changes of behavior.

Educational efforts include professional training and continuing education, incorporating a cross-disciplinary focus. They should be available in the work place, particularly for human resource departments, in colleges and universities, in schools grades K -12, and for community groups.

The Ad-hoc Committee has identified education at all levels as the most fundamental primary prevention tool because it has the capacity to build knowledge, develop skills, and foster changes in attitudes, behaviors and systems. Prevention education can also ensure that we have the interested, mobilized community we must rely upon to create, not only effective primary prevention models, but better secondary direct service efforts for child and adult witnesses and victims of violence. While some education related efforts are underway, they tend to be offered inconsistently, in a disconnected manner. And education is often confused with public awareness. Essentially, relative to other areas, few of our resources are focused on this crucial mechanism to prevent domestic and sexual violence.

Community Mobilization. This includes encouraging broad participation, networking and communication between diverse public and private agencies and organizations, businesses, and community groups large and small. Mobilization occurs on behalf of policy/program development, implementation, and coordination. It includes promoting advocacy on behalf of these efforts.

Community Mobilization is an important area that is beginning to receive much attention and resources, primarily in terms of staff time and assistance. In relation to public awareness and community mobilization, efforts in research, education and evaluation receive much less focus and fewer resources relative to their importance and impact.

Evaluation. This refers to both short and long-term evaluation of program development and implementation, as well as assessing the achievement of

program goals as indicated by outcome measures. It must be integrated as a component of any program from its inception through a dialogue that identifies criteria for success, clearly delineating which of these are actually measurable and how they will be measured.

Like the word "prevention," the term "evaluation" has also begun to enter our discussions about public and private programs on a much more frequent basis. Yet, we often do not clarify differences between short and long-term evaluation, acknowledge the limits on our ability to conduct evaluation, or integrate it from the inception of our program development. Funding is certainly an issue here, as well. Fear about the requirements and resources to conduct effective evaluation often dissuade us from focusing on the subject and acknowledging limitations. We also often shy away from discussing quality of life issues -- something most people and communities value highly -- and how to incorporate these in tandem with more typical or formal evaluation efforts.

While some kinds of evaluation do demand considerable time, money and technical expertise, this is not always the case. By engaging in early and ongoing dialogue about evaluation -- and about what is important to us --, we could identify criteria and outcome measures that do not require the development of new systems, that we may already be capturing, and that require less technical expertise and expense to capture.

Prevention Recommendations

Based upon its discussions and conclusions about prevention, the Ad-hoc Committee makes the following recommendations regarding prevention funding, planning, and focus in Hawai'i:

- Adopt a prevention policy approach that includes the definitions, criteria and elements detailed in this report;
- Make no additional cuts to funding already provided for the prevention of domestic and sexual violence;

- By the year 2000, increase the level of spending for domestic and sexual violence prevention by at least 10-fold;
- Ensure a focus on prevention spending in the areas of Research, Education, and Evaluation;
- Provide legislative support for the Violence Prevention Curriculum Initiative;
- Put public agency prevention dollars into separate contracts and encourage non-direct services providers with a prevention orientation to compete for these monies;
- Re-examine and write public agency contracts to ensure that they incorporate effective and appropriate primary prevention criteria and elements into the scope of services;
- Ensure that public and private agencies seek out opportunities to pool available prevention dollars, enhancing collaboration and effectiveness;
- Encourage all departments, agencies and organizations to examine how prevention concepts and approaches can be integrated into their current projects, programs and training efforts;
- Promote the use of funding for accessible, easily understood research data and analyses; and
- In funding direct services, give legislative priority to better networked, effective, comprehensive and integrated service programs that would complement primary prevention efforts and help build healthier, safer communities.

--END--

ATTACHMENT A

SUBCOMMITTEE MEMBER LIST

Direct Services Subcommittee

Co-chairs: Deborah Marks, Americorps/Hawai'i Lawyers Care
Rita Martin, Hale Ola Windward Abuse Shelter

Members: Annelle Amaral, Women's Coalition
Penny Hirakawa, Sex Abuse Treatment Center
Donna Hopkins, PACT/Family Peace Center
Julie Owens, Hope Transition House
Ina J. Percival, Hawai'i State Commission on the Status of Women
Anne Sloat, UH School of Nursing
Cindy Spencer, Victim Advocate

Prevention Subcommittee

Co-chairs: Sachi Taketa, Department of Health
Ina J. Percival, Hawai'i State Commission on the Status of Women

Members: Mary Arace, Women's Resource Center/YWCA of Oahu
Suzanne Meisenzahl, League of Women Voters
Eric Tash, Injury Prevention and Control Program/DOH
Brandon Stone, Honolulu Police Department
Ann Horiuchi, Department of Education
Renee Echavez, YWCA/Sexual Assault Support Services/Hilo

ATTACHMENT B

**AD-HOC COMMITTEE ON DOMESTIC AND
SEXUAL VIOLENCE**

FAX LIST

{For Meeting Notices, General Information}

Lorrie Alfonsi, PACT/Family Peace Center
Annelle Amaral, Women's Coalition
Mary Arace, Women's Resource Center/YWCA of Oahu
Representative Dennis A. Arakaki
Senator Rosalyn Baker
Dave Boerner, Dept. of Human Services
Margery Bronster, Attorney General
Representative Ed Case
Dr. Susan Chandler, Dept. of Human Services
William Christoffel, Department of Health
Senator Avery B. Chumbley
Senator Suzanne Chun Oakland
Karen Crocker, PACT/Pu'uhonua
Angle Doi, Child and Family Service
Jim Fulton, Honolulu Prosecutor's Office
Ann Horiuchi, Dept. of Education
Penny Hirakawa, Sex Abuse Treatment Center
Tom Jackson, Dept. of Labor and Industrial Relations (HCSW)
Senator Brian Kanno
Maureen Klehm, Judiciary/Family Court
Lari Koga, Dept. of the Attorney General
Nanci Kriedman, Domestic Violence Clearinghouse & Legal Hotline
Beth Kurren, Catholic Charities

ATTACHMENT B-2

Renee Echavez, YWCA/Sexual Assault Support Services
Representative Marilyn B. Lee
Dee Dee Letts, Center for Adult Dispute Resolution
Senator Andrew Levin
Kenneth Ling, Judiciary
Deborah Marks, Americorps/Hawai'i Lawyers Care
Rita Martin, Hale Ola Windward Abuse Shelter
Representative Barbara Marumoto
Senator Matt Matsunaga
Kendra McKenna, Women Helping Women
Suzanne Meisenzahl, League of Women Voters
Representative Hermina Morita
Wendy Mow-Taira, Family Crisis Shelter
Barbara Mullen, Catholic Charities Family Services
Dana Newberry, Safety Network
Julle Owens, Hospitality House
Ina J. Percival, Hawai'i State Commission on the Status of Women
Nancy Peterson, YWCA of Kauai Family Violence Shelter
LaVonne Pironi, YWCA Sexual Assault Treatment Program
Ruthann Qultlquit, PACT
Adriana Ramelli, Sex Abuse Treatment Center
Jeannie Reinhart, Dept. of Human Services
Nora Sanchez-Turner, Office of the Prosecuting Attorney/Hilo
Representative Alexander C. Santiago
Anne Sloat, UH School of Nursing
Sara-Lynn Smith, Sex Abuse Interventions, Inc.
Kate Stanley, Dept. of Human Services
Brandon Stone, Honolulu Police Department

ATTACHMENT B-3

Representative K. Mark Takai

Sachiko Taketa, Dept. of Health

Eric Tash, Dept. of Health

Representative Cynthia Henry Thielen

Tony Wong, Dept. of the Attorney General