State of Connecticut

Sexual Violence Prevention Plan

2009-2017

Keeping Connecticut Healthy

DPH

Connecticut Department of Public Health

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ACKNOWLEDGEMENTS

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STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

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The Connecticut Department of Public Health is pleased to present Connecticut's Sexual Violence Prevention Plan. This plan is the culmination of extensive work of key stakeholders within a Sexual Violence Prevention Planning Committee (SVPPC) over the last year and a half who focused on determining needs and priorities related to sexual violence in Connecticut. It contains goals and action strategies that will guide our efforts to reduce and eliminate sexual violence, ensure safe and healthy communities and improve people's lives.

This project was funded through a CDC Rape Prevention and Education Cooperative Agreement. The purpose of the Cooperative Agreement was two fold. The first part is to build and enhance the state's capacity to effectively prevent sexual violence from initially occurring by preventing first time perpetration and victimization through using a public health approach; supporting comprehensive primary prevention program planning at multiple social ecological levels; and building individual organizational and community capacity for prevention. The second part of the agreement is to create an eight-year comprehensive primary prevention plan in collaboration and coordination with the sexual violence prevention planning committee that includes a program component that assesses rape prevention and education current programming and enhances or develops primary prevention focused strategies and activities.

Sexual violence is a major public health problem within our state, our nation, and our world. Its impact is not only to physical and emotional health, but also creates severe economic burdens. One in every eight women, or 13.2% in Connecticut, has been raped at some time in their lifetime (Rape in Connecticut: A Report to the State, Kenneth J. Ruggiero, Ph.D., Dean G. Kilpatrick, Ph.D., May 15, 2003). Due to its prevalence and far reaching effect on society, sexual violence is a critical public health issue and as such it is important to have a comprehensive approach to prevention, services and justice that goes beyond the current system. A strength of public health is its ability to bring together diverse communities and professionals to address complex health and social conditions.

We wish to thank the Sexual Violence Prevention Planning Committee members and leadership for their time and commitment to this project. We look forward to our continued partnership and collaborations and encourage others to join with us in this effort. Only by working together can we make the changes necessary to prevent sexual violence and create a society that is free of sexual violence.

Sincerely,

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Executive Summary

The Connecticut Sexual Violence Prevention Planning Committee (SVPPC or Planning Committee) was created in 2007 by the Connecticut Department of Public Health (DPH) through a Centers for Disease Control and Prevention (CDC) Rape Prevention and Education Cooperative Agreement. The purpose of the Cooperative Agreement is to strengthen and expand the state's capacity to effectively prevent sexual violence from initially occurring by preventing first time perpetration and victimization. The SVPPC adopted the CDC's uniform definition of sexual violence for the state plan, which defines sexual violence as any sexual activity where consent is not obtained or freely given.[i]

DPH is the lead coordinator/authority for overseeing the implementation of the state plan. DPH contracts with Connecticut Sexual Assault Crisis Services (CONNSACS), who in turn contracts with four rape crisis centers in the state, known as Rape Prevention and Education (RPE) funded centers. There are five other rape crisis centers in the state that do not receive Rape Prevention and Education funds and are known as Non-RPE funded centers. Non-RPE funded centers do, however, receive other funding from the Department of Public Health. The DPH reviews the RPE Guidance Document and shares necessary information with the planning committee, and participates in ongoing CDC conferences and webinars to inform and guide the group process**.**

The Cooperative Agreement requires Connecticut to develop a long-term strategic plan for the primary prevention of sexual assault. DPH invited state and community agencies to participate in the process to coordinate efforts, expand capacity, and truly reflect the extent of the work that is being done in the area. As a result, the Planning Committee consisted of representatives from all the rape crisis centers and other state and community agencies that work in the areas of sexual health and sexual abuse prevention.

The Planning Committee utilized a public health approach, supporting comprehensive primary prevention program planning at every socio-ecological level: individual, relationship, community, and societal. The goal was to develop a comprehensive eight-year strategic plan to increase *individual* pro-social knowledge and attitudes, communication skills for respectful intimate and peer *relationships*, organizational and *community* capacity for prevention, and *societal* norms that do not tolerate gender-based sexual violence or other forms of inequalities.

The strategic plan developed by the Planning Committee includes four main components:

1. A program component that assesses sexual violence and rape prevention education and training curricula to ensure utilization of the most current programming that reflects best practices as they emerge over the years.
2. A technical assistance and training component that increases state and local level capacity for primary prevention of sexual violence.

3. A developmental component that implements, assesses, and refines the comprehensive primary prevention program plan and evaluative efforts throughout the eight-year project period.
4. An evaluation component that includes process and formative evaluation tools measured against the logic model adopted by the Planning Committee.

It should be noted that the strategic plan is a work in progress to guide the committee over the next eight years. The plan can, and will be, modified as needed.

Because sexual violence occurs within every age and demographic group, the *universal* population, defined by the Planning Committee, includes all residents in the state. Within the universal population, curricula is developed and implemented to target groups defined by age, such as school-aged children and college students. Teachers, youth leaders, and parents are also provided with primary prevention training and education. However, there are increased risks for particular groups of people, which lead to the definition of the *selected* population. Within the selected population, curricula are specific to vulnerable populations, such as youth in detention facilities and the professionals who work with them, as well as their families.

The plan that follows includes an analysis of the literature to define and describe the incidence of sexual violence and to understand the contexts within which it occurs. The prevalence of sexual violence in the state and across the nation is explored. Modifiable risk factors based on personal and social characteristics are described for young people that increase their likelihood of sexual violence and the identification of prevention strategies are incorporated into the strategic plan. It is known that most victims of sexual assault know their perpetrators. Thus, it is increasingly important for vulnerable populations, their families, and social support systems to know how to not only provide protection, but also to promote the intolerance of sexual exploitation and sexual harassment at the community level.

The plan also includes an overview of state and local primary prevention resources, along with an inventory of the available training and education programs. The result is a comprehensive set of goals and objectives, a work plan to guide the implementation process, a logic model for both RPE funded and Non-RPE funded programs, and a plan to develop evaluation criteria to measure social change.
The most reliable data sources available (e.g., the *gold standard*) were used in this report.

Forward

A group of people dedicated to the prevention of sexual assault in Connecticut, formed the Sexual Violence Prevention Planning Committee (SVPPC) in 2007. The Department of Public Health was given the task of creating the Sexual Violence Prevention Plan. As a result, a broad spectrum of representatives from state agencies and community-based organizations were invited to participate in the process. Thus the SVPPC was formed to create an eight-year strategic plan.

Connecticut's Sexual Violence Prevention Plan recognizes the importance of reinforcing sexual violence primary prevention information, education and training, and social messaging. There is a national shift in focus from intervening after sexual assault has occurred towards the direction of preventing sexual assault from occurring in the first place (i.e. primary prevention). Primary prevention initiatives are directed toward the public at large, particularly young people, in developing pro-social attitudes and behavior, believing in gender equity, and learning how to develop and maintain healthy personal and social relationships. Primary prevention also supports young women and men who may have an increased risk of victimization. In line with the national focus, primary prevention efforts are shifting away from "stranger danger," towards providing information based on the fact that most people are victimized by someone known to them or their families.

The strategic plan guides organizational members of the SVPPC as they programmatically move towards the national focus on primary prevention, based on best known practices at this time. The strategic plan also guides committee members to increasingly incorporate the preferred method of delivering prevention education through multiple sessions with smaller groups versus single sessions with larger audiences. In addition, individual-focused educational activities are reinforced through strategies that promote organizational, community, and systems changes that support healthy, safe environments.

Table of Contents:

State of Connecticut
Sexual Violence Prevention Plan

I. INTRODUCTION

The Connecticut Sexual Violence Prevention Planning Committee (SVPPC or Planning Committee) was created in 2007 by the Connecticut State Department of Public Health (DPH) through a Centers for Disease Control and Prevention (CDC) Rape Prevention and Education Cooperative Agreement. The purpose of the Cooperative Agreement is to strengthen and expand the state's capacity to effectively prevent sexual violence from initially occurring by preventing first time perpetration and victimization.

Sexual violence is largely perceived as a subgroup within domestic violence or violence in general in the state. It is also viewed as a public health issue by the state health department. The DPH views sexual violence as a health priority and has demonstrated leadership support for the statewide plan. For example, the Commissioner of DPH has endorsed the statewide sexual violence prevention plan; the DPH provides leadership and coordinates the SVPPC process; the DPH has included a copy of the state plan in a directory of health plans created for the state; and lastly, the DPH has a strong partnership with the Connecticut Sexual Assault Crisis Services Inc. (CONNSACS), to provide prevention and intervention programs in the state.

In order to highlight the importance of sexual violence prevention, the Planning Committee referenced Healthy People 2020 objectives that focus both on reducing sexual violence and increasing healthy sexual development and relationships. The SVPPC is working to increase community and political awareness of the issue by collaborating with both prevention-oriented and intervention-oriented agencies and coalitions. Therefore, the plan reflects prevention of sexual violence more broadly than primary prevention to be inclusive of RPE and Non-RPE funded programs.

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It should be noted that the strategic plan is a work in progress to guide the committee over the next eight years. The plan can, and will be, modified as needed.

NOTE: Definitions of commonly used terms in this document as defined by the Centers for Disease Control and Prevention are listed in Appendix A.[ii]

The Planning Process

An integral part of the comprehensive primary prevention program planning process was the creation and maintenance of a Sexual Violence Prevention Planning Committee (SVPPC) per the Center for Disease Control and Prevention's (CDC) recommendations. Members were recruited by sending invitation letters and follow-up telephone calls. For a complete list of membership, see page ii. The committee is comprised of key state and community partners who have provided input and guidance in the planning process and development of the plan. They have provided technical assistance and support for the sustainability of the comprehensive primary prevention plan. Committee members also participated on subcommittees that identified and defined universal and selected populations for the focus of the strategic plan, assessed community level needs, and conducted a literature review on primary prevention best practices and models.

A steering committee was also formed and met regularly to plan SVPPC meetings, monitor subcommittee activity and progress, and guide the development and writing of the strategic plan. Committee members met with many key stakeholders from diverse backgrounds and perspectives who share a commitment toward the prevention of sexual violence at local and state levels. Members of the committee participated in the shaping of public policy toward the prevention of sexual violence and sexual violence prevention education.

The Department of Public Health (DPH) receives funding from the CDC for the Rape Prevention and Education cooperative agreement. In turn, DPH contracts with Connecticut Sexual Assault Crisis Services, Inc (CONNSACS). There are four rape crisis centers in Connecticut that receive Rape Prevention and Education (RPE) funding and five rape crisis centers that do not receive RPE funding, referred to as non-RPE funded agencies. As the RPE contractee, CONNSACS held a significant leadership role during the planning process. In addition, numerous other agencies, which provide some

level of education and service regarding gender equality, sexual health, victim services and punishment/intervention for offenders, also participated in the planning process.

SVPPC Meeting Timelines and Activities

1. First Meeting: December 6, 2007. The DPH gave an overview of the project and expectations of the committee. A PowerPoint presentation was discussed including the purpose of the SVPPC, sexual violence as a public health issue, CDC's definition of sexual violence, public health approach to prevention, and the levels of prevention. The assigned epidemiologist from the Department of Public Health provided state and local demographic data, crime data, and school data that would be relevant for the needs assessment. There were 25 members in attendance.

2. Second Meeting: January 24, 2008. The DPH presented the results of a CDC survey, which committee members completed at an earlier time. CONNSACS gave a presentation on their efforts in *Ending Rape and Sexual Assault Through Primary Prevention*. A group exercise showed that of the agencies and organizations present, five were involved in primary prevention, seven were involved in secondary prevention, and eight were involved in tertiary prevention efforts. There were 19 members in attendance.

3. Third Meeting: March 6, 2008. The committee engaged in an exercise to create a vision statement and to reach consensus upon the definitions (through a PowerPoint presentation) that were going to be used for planning purposes, including the adoption of the CDC definition of sexual violence (Appendix A). Planned Parenthood of Connecticut gave a social marketing presentation entitled, *Real Life, Real Talk*. There were 19 members in attendance.

4. Fourth Meeting: April 17, 2008. The committee developed the mission statement and proceeded to identify statewide goals and objectives using the Getting to Outcomes Tool, the Socio-Ecological Model, and an article by Larry Cohen on the Spectrum of Prevention. The Department of Corrections gave a presentation on the *Offender Rehabilitation Program.* There were 17 members in attendance.

5. Fifth Meeting: May 22, 2008. An orientation was given for new members. The committee reviewed and revised the statewide goals. The Department of Children and Families gave a presentation on sexual assault crisis services, including an overview of primary, secondary, and tertiary prevention efforts. There were 12 members in attendance.

6. Sixth Meeting: June 18, 2008. Committee members had a brainstorming session to develop objectives and outcome statements based on the agreed-upon goals. There were 14 members in attendance.

7. Seventh Meeting: September 11, 2008. Committee members discussed and gave feedback on the draft plan. Three sub-committees were created: needs assessment, universal population, and selected population. CONNSACS and three of the RPE funded centers gave presentations about the services each center offers. There were 28 members in attendance.

8. Eighth Meeting: November 18, 2008. Sub-committee members provided the committee with updates of their progress. CDC Project Officer, Renee Wright, gave the committee feedback on the plan. Sub-committees worked on creating group goals and objectives. There were 27 members in attendance.

9. Ninth Meeting: January 13, 2009. The committee discussed and revised goals, objectives, and strategies for the plan. There were 19 members in attendance.

10. Tenth Meeting: March 10, 2009. Sub-committee members provided the committee with updates of their progress. There were 17 members in attendance.

11. Eleventh Meeting: April 28, 2009. Catherine Russell from the Eastern Connecticut Area Health Education Center was introduced as the new consultant to facilitate writing the plan. A draft of the RPE Logic Model was presented. The draft of the plan was discussed. There were 15 members in attendance.

12. Twelfth Meeting: June 2, 2009. The committee reviewed and discussed the Strategic Plan. A plan dissemination and kickoff event was briefly discussed. There were 19 members in attendance.

Strategic Planning Resources

Several CDC tools helped the committee determine the breadth and scope of the Rape Prevention and Education (RPE) strategic plan for the primary prevention of sexual violence.[iii]

- The CEO7-701 RFA and Program Announcement Guidance Document—identified the activities that are expected for RPE program implementation.

- The draft RPE Practice Guidelines—provided principles of effective practices and strategies when working with youth, families, and communities in sexual violence prevention.

- Getting to Outcomes (GTO)—provided guidance for developing program objectives and outcomes.

- Creating Safer Communities: RPE Theory Model of Community Change and Activities Models—provided an overarching framework that identified intended outcomes of prevention activities and guided the planning process.

- Socio-Ecological Model— provided a framework that identified levels for intervention.

- Spectrum of Prevention— provided another classification or scheme for the committee to use as guidance in writing goal statements.

Public Health Approach to Sexual Violence Prevention

The SVPPC used the public health approach to address the prevention of sexual violence, focusing on the health of an entire population rather than one individual.[iv] Tenets of the public health approach include benefiting the largest number of people possible, using data, and implementing evidence-based approaches. The public health approach contains four steps:

1) Define the problem
2) Identify risk and protective factors
3) Develop and test prevention strategies
4) Ensure widespread adoption

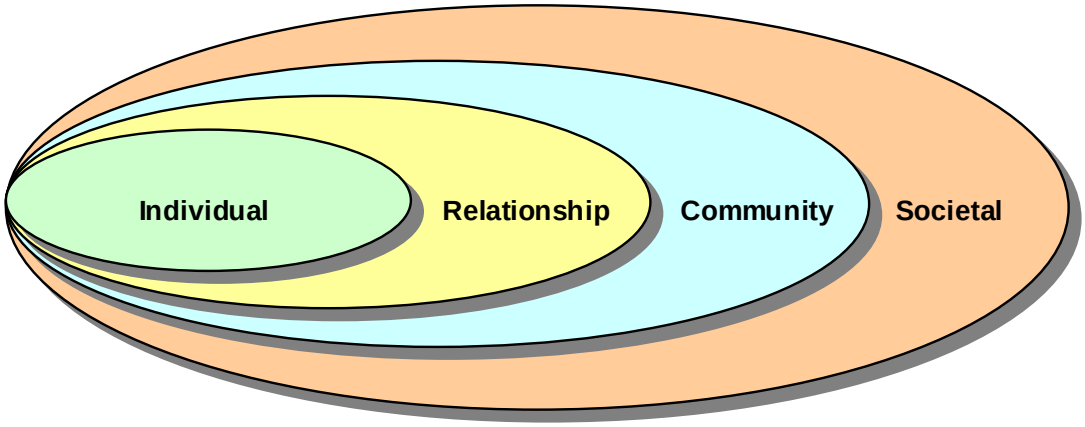
Within the SVPPC's public health approach, two complementary models helped identify risk and protective factors and guided the development of prevention strategies. The Socio-Ecological Model addresses cultural components, such as norms and beliefs, as they relate to sexual violence, across four different levels of societal interaction. The Spectrum of Prevention attempts to change elements of the social structure, through organizations and policies, in order to implement prevention strategies. These models are complementary as they seek to challenge existing cultural norms and beliefs that may support sexual violence and to change the existing structure in order to reduce sexual violence through primary prevention. Simply changing norms and beliefs without structural support is ineffective, as is changing the existing structure without altering people's ways of thinking.

The Socio-Ecological Model

The Socio-Ecological Model supports a comprehensive public health approach that not only addresses an individual's risk factors, but also the norms, beliefs, and social and economic systems that create the conditions for the occurrence of sexual violence.[v] The Socio-Ecological model recognizes that the individual is strongly influenced by domains, systems and norms, and that influencing each of these will most effectively reduce violence. The model is based on the recognition that no one group or institution can end sexual violence alone and that change needs to take place on the individual, relationship, community, and societal levels to truly impact the problem.[vi]

The Socio-Ecological Model (see Figure 1) considers the complex interplay between individual, relationship, community, and societal factors. It allows us to address the factors that put people at risk for experiencing or perpetrating violence. Prevention strategies should include a continuum of activities that addresses each level of the model. This approach is more likely to sustain prevention efforts over time than any single intervention.[vii]

Figure 1: Socio- Ecological Model



First, at the *individual* level we begin by identifying biological and personal history factors that may increase the likelihood of becoming a victim or perpetrator of sexual violence. Second, at the *relationship* level we consider how a person's closest social circle of peers, partners, and family members influence behavior and life experiences. Third, at the *community* level we seek to identify characteristics of particular settings, such as schools, workplaces, and neighborhoods that are associated with individuals becoming victims or perpetrators of violence. Finally, at the *societal* level we assess broad social factors, including social and cultural norms, which help to create a climate where violence is encouraged or inhibited. Other large societal factors include the health, economic, educational, and social policies that help maintain economic or social inequalities between groups in society.

Risk and protective factors reside in each layer of the socio-ecological model. These factors influence socio-emotional wellness and behavior. *Risk factors* include characteristics, variables, or hazards that if present for a given individual make it more likely that the individual (rather than someone selected at random from the general population) will develop a disorder, problem, or some disruption in functioning. Conversely, *protective factors* include characteristics or variables that if present, enhance adaptive capacities and outcomes and/or reduce vulnerability to some hazard or adversity that will result in a positive outcome.

Just as interventions at each level in the model are more likely to sustain prevention efforts than any single intervention, increasing multiple protective factors or decreasing risk factors at each level of the model increases the likelihood and effectiveness of prevention efforts over time. In this regard, risk and protective factors can be seen as

the two ends of the continuum, with the goal of tipping the balance to enhance protective factors, and/or decrease risk factors.

The see-saw represents the mediating and counter-balancing of risk and protective factors that occurs throughout human development

Figure 2 broadly outlines some of the most common risk and protective factors within each level of the Socio-Ecological Model. It is important to note that all members of the general population do not experience risk and protective factors equally. Within each level of the model there are wide ranges both within and across demographic groups (e.g., gender, race, social class, etc.) in terms of access to protective factors and susceptibility to risk. For a more detailed discussion of specific risk factors as they relate to sexual violence perpetration, see *Factors that Increase an Individuals Risk for Sexual Violence Perpetration*, in Section II, Literature Review.

Figure 2: Risk and Protective Factors within the Socio-Ecological Model

INDIVIDUAL	**RELATIONSHIP**
Risk Factors o Medical difficulties o Cognitive/learning developmental delays o Limited adjustment skills o Low self-esteem	Risk Factors o Violence o Family conflict/disruptions o Unsafe, unpredictable home environment o Neglectful, abusive caregiver o Extreme definition of gender roles, hypermasculinity
Protective Factors o Physical health o Strong cognitive/academic functioning o Adaptive adjustment o Positive self-image	Protective Factors o Stable, nurturing, supportive relationships o Safe, consistent home environment o Nurturing/attentive caregiver o Adequate financial resources

Figure 2, continued: Risk and Protective Factors within the Socio-Ecological Model

COMMUNITY	SOCIETAL
Risk Factors o Alienation from peers o Friends engaged in negative behaviors, negative modeling o Peer pressure/bullying	Risk Factors o Poverty, low economic opportunity o Crime and violence o Inadequate housing o Neighborhood disintegration o Chaotic, low-resourced schools
Protective Factors o Close friendship o Supportive workplaces/schools o Community intolerance for violence o Friends engaged in pro-social activities, positive modeling o Age-appropriate cooperation/support	Protective Factors o Strong or emerging economic opportunities o Safe neighborhoods o Safe, affordable housing o Connected neighbors o Active communities o Stable, well-supported schools

The identified risk factors are germane to the field of sexual violence and perpetrator characteristics. Risk factors are additive in that the more risk factors present, the greater the risk of offending. This model supports the professional experiences of the SVPPC members and reinforces the need to address antisocial behavior and influence social norms.

The Spectrum of Prevention

The Spectrum of Prevention (see Figure 3) reflects a framework that is complementary to the Socio-Ecological Model in that one strategy or approach will not eliminate complex social problems such as sexual violence. Prevention efforts need to take place simultaneously on all levels of the spectrum which range from influencing policy, changing organizational practices, fostering coalitions and networks, educating providers, promoting community education, and strengthening individual knowledge and skills.[viii]

Factors which might predict men's propensity to sexually assault include: alcohol or drug use, fantasies and attitudes supporting sexual violence, impulsive and antisocial tendencies, a preference for impersonal sex, hostility toward women, a history of sexual abuse or family violence as a child, poverty, lack of employment, lack of institutional support, community tolerance of sexual assault, societal norms supportive of male superiority and sexual entitlement, social norms supportive of sexual violence, weak laws and policies on gender equality and sexual assault, high levels of violence in his

surroundings, a strong patriarchal relationship between the perpetrator and victim, family honor and associating with sexually aggressive peers. It is the goal of the SVPPC to address these factors through identified goals and strategies for the universal and selected populations.

Preventing sexual violence requires the recognition that conditions within our society and communities perpetuate this type of violence. The beliefs we share, the traditional gender roles we reinforce, and the myths we validate all contribute to a climate in which sexual violence is permitted and condoned. Challenging norms and beliefs that enable people to wield power and control over others, in addition to changing the social structure within which these norms and beliefs exist, presents the most complete and promising approach to preventing sexual violence before it occurs.

Figure 3: The Spectrum of Prevention

Levels of the Spectrum	Description
Strengthening individual knowledge and skills	Enhancing an individual's capability of preventing injury or crime
Promoting community education	Reaching groups of people with information and resources in order to promote health and safety
Educating providers	Informing providers who will transmit skills and knowledge to others
Fostering coalitions and networks	Bringing together groups and individuals for broader goals and greater impact
Changing organizational practices	Adopting regulations and norms to improve health and safety; creating new models
Influencing policy and legislation	Developing strategies to change laws and polices in order to influence outcomes in health, education, and justice

II. LITERATURE REVIEW

The SVPPC adopted the CDC's definition of sexual violence. According to the CDC, sexual violence is any sexual act (i.e., physical, verbal, or psychological) that is forced against someone's will.

There are four types of sexual violence, as described below:

1. Completed sex act- contact between the penis and the vulva or the penis and the anus involving penetration, however slight; contact between the mouth and penis, vulva, or anus; or penetration of the anal or genital opening of another person by a hand, finger, or other object

2. Attempted, but not completed, sex act

3. Abusive sexual contact - intentional touching, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or buttocks of any person

4. Non-contact sexual abuse - abuse that does not involve physical contact, such as: voyeurism; intentional exposure of an individual to exhibitionism; pornography; verbal or behavioral sexual harassment; threats of sexual violence; and taking nude photographs of a sexual nature of another person.

All four types of sexual violence involve victims who do not consent, or who are unable to consent, or refuse to allow the act.

The definition of sexual violence can also be found in Appendix A.

The Scope of Sexual Violence in the United States

Sexual Violence is a significant problem in the United States. Sexual violence is not only a threat to public health but also a fundamental violation of human rights. The United States Department of Justice's *2001 National Crime Victimization Survey* calculates that approximately every two minutes, somewhere in America, someone is sexually assaulted.[ix] Sexual assault is a broad category that the Department of Justice uses to classify rape, attempted rape, and other violent felonies that fall short of rape. The Department of Justice defines rape as "forced vaginal, anal, or oral penetration." Looking at completed rapes only, the same data show that every six minutes someone is raped.

While men are the primary perpetrators of sexual assault and women are the primary victims, men too, can be sexually assaulted. [x] Current estimates show that 1 in 6 women and 1 in 33 men reported experiencing an attempted or completed rape at some time in their lives according the *National Violence Against Women Survey,* which is

based on United States Census estimates of the number of women and men age 18 and older in the United States in 1995, the year the sample was generated.[xi] Almost 18 million women and 2.8 million men in the United States have been raped at some time in their lives. A more recent survey of 9,684 adults showed that 10.6% reported experiencing forced sex at some time in their lives, with 2.0% being men. In the same survey, 2.5% of women and 0.9% of men surveyed said they experienced unwanted sexual activity in the previous 12 months.[xii]

These statistics may only present us with a partial understanding of the number of women and men who have and will experience sexual violence in their lifetime. Statistics on incidents of rape and other forms of sexual violence are among the most unreliable for serious crime. [xiii] This is partly due to inconsistencies in the definition of rape in both legislation and academic studies. In the United States for example, rape is often defined differently by separate states. In addition, underreporting of rape and sexual violence is also common. According to the United States *National Crime Victimization Survey*, only 39% of rapes and sexual assaults are reported to law enforcement officials.[xiv] For male rape, less than 10% of the cases are believed to be reported. Most often victims do not report rape because they believe that it is a personal or private matter, they fear reprisal from the assailant, they are unaware of their rights, or unsure of how to seek assistance. For men, fear of being stigmatized as weak or unmanly further adds to the likelihood of underreporting. In addition, many vulnerable populations, such as people of color and those from lower socioeconomic classes, often mistrust law enforcement officials and other people of authority.[xv] This mistrust further increases the likelihood of underreporting sexual violence.

Moreover, within the United States, society typically constructs rape as a violent act carried out by a stranger, when in reality, sexual violence often occurs between intimate partners or casual acquaintances. Not only does this construction of rape as violent and stranger based aid in underreporting, but it also often leads to the dichotomization of rapes. Thus, rapes become labeled as “real rapes” and those in the “grey area.” There are many factors that people use to define a grey area rape such as being drunk, flirting, being in a relationship with the perpetrator, not fighting enough or not fighting at all. However, we must remember that rape is not defined by the behavior of the victim but by the behavior of the perpetrator. There are no grey areas when it comes to rape and consent.

The literature overwhelmingly focuses on perpetrator risk factors and glosses over sexual violence perpetrator protective factors.[xvi] The protective factors that are most commonly addressed in RPE-funded member center training include promoting: empathy and caring for others; problem solving; conflict resolution skills; critical thinking skills; parent-child communication; and non-kin adult support for youth.

According to the World Health Organization, early childhood and family-based approaches “that aim to develop physically, emotionally, and socially healthy children and reduce exposure to violence and other adverse events have the potential to significantly reduce the prevalence of all forms of violence, including intimate-partner

violence and sexual violence."[xvii] Early childhood interventions are important for promoting health and well-being throughout the lifespan. Key elements of this approach include teaching parents to model healthy relationships, to manage their children's behavior positively and without harsh physical punishment, and fostering children's anger management, impulse control, problem-solving, conflict resolution and social skills.

Populations with Increased Risk for Sexual Violence Victimization

Sexual violence occurs within every age and demographic group. However, there are increased risks for particular populations. The following section briefly discusses some of the issues faced by populations with an increased risk for being raped and sexually assaulted. In addition, recommendations for reducing risk among these populations are also presented. Some of the recommendations presented are secondary and tertiary prevention in nature, as opposed to all of them being primary prevention. As throughout the narrative and development of the plan, the State of Connecticut has included both RPE and Non-RPE funded activities as a comprehensive approach to preventing sexual violence.

Children and Adolescents

Children are at increased risk for being sexually assaulted. About 70% of sexual assault cases reported to law enforcement involve victims under the age of 18.[xviii] Approximately 25% of people in the United States have been victimized by child sexual abuse.[xix] The most reliable estimates of child sexual abuse currently available suggest that 30% to 40% of female children and 13% or more of male children are sexually abused during childhood.[xx] Child sexual abuse may include fondling a child's genitals, masturbation, oral-genital contact, digital penetration, and vaginal and anal intercourse. Child sexual abuse is not restricted to physical contact; other forms of abuse include exposure, voyeurism, and child pornography. [xxi] Child sexual abuse is often perpetrated by adults or family members entrusted with the care of a child. Families, institutions, and social mores may inadvertently collude with the perpetrator leaving the burden to recognize and stop the abuse to the minor victim. Children who are abused may experience anxiety, guilt, fear, and often display regressive behaviors, such as a return to thumb sucking or bed wetting, and academic or other general behavioral problems.

The problem of child abuse is large and increasing. However, research shows that only 12% of childhood rape is reported to authorities.[xxii] Often children do not report sexual abuse because they are afraid no one will believe them, they may get in trouble, they do not want the abuser to get into trouble, or they do not have the words to talk about their abuse. If no one has ever talked to a child about his/her body, a child may not understand that abuse has occurred.

Reducing the risk of victimization for children is the responsibility of adults. Recommendations include:

- Talking openly with children about their bodies.
- Understanding risks for victimization, especially the high risk of the offender being a family member or friend.
- Understanding why children are afraid to "tell."
- Supporting mutual learning among adult friends and family members about sexual abuse.
- Learning the signs of sexual abuse.
- Knowing how to offer support without overreacting.

Young children are not the only victims of child sexual abuse. Among high school students surveyed nationwide, about 8% reported having been forced to have sex. The CDC's Youth Risk Behavior Surveillance System (YRBSS) reports that 9.9% of students surveyed had been hit, slapped, or physically hurt by their boyfriend or girlfriend. In Connecticut, approximately 10% of high school students reported having been forced to have sex. Across the board, females (11%) were more likely to report having been forced to have sex than males (4%).[xxiii] For a more detailed breakdown of the YRBSS data see Appendix B. Peer abuse situations are common but likely to be dismissed in various ways by adolescent offenders, authorities, and society at large.[xxiv] Although adolescent victims are most frequently abused by dates or friends, family members and older acquaintances also can be perpetrators.

Similar to young children, adolescents may not report abuse for fear of getting in trouble or because they feel that no one will believe them. According to the Texas Association Against Sexual Assault, an overwhelming 78% of adolescent victims never tell their parents or caregivers about the assault and only 5-6% ever call the police or rape crisis center.[xxv]

Measures to reducing the risk of victimization for adolescents should be implemented before dating begins (i.e., 8th grade). Recommendations include:

- Learning effective ways to communicate with a partner and for dealing with anger towards a partner.
- Learning how unfair gender-based expectations of partners can potentially lead to abuse.
- Identifying and analyzing verbal and nonverbal cues that a partner is not ready to have sex.

- Establishing personal sexual boundaries and respecting partner's boundaries.

- Discussing dating tips to protect one's self from sexual dating violence.

College Students

An estimated 20% of college women in the United State experience attempted or completed rape during their college career.[xxvi] Between 2005 and 2006, CONNSACS member programs reported providing services to nearly 500 college students in Connecticut alone.[xxvii] Students who survive incidents of violence are left with difficult questions, such as: "Why did this happen to me?", "Who should I tell?", "Should I report this to the police, and if I do, will I be blamed?", and "How will my friends and family react?"[xxviii] Although the victim is never responsible for the violent incidents, many people find ways to fault the victim for the abuse or assault and as a result, victims will often blame themselves.

Violence against women on college campuses may significantly impact the ability of students to participate and perform well academically. The first six weeks of college for freshmen pose an even greater risk for sexual assault. During this period, sometimes referred to as "the red zone," students are adjusting to a new environment with new acquaintances. Students may not be familiar with campus relationship norms, such as the "hook up culture," or they may find themselves in a situation for the first time where alcohol and drugs are being used. As a result, new students are at an elevated risk for experiencing a sexual assault. An assault occurring this early in a college student's academic experience could seriously affect the entire course of his or her educational career.[xxix]

Sorority women are also at an elevated risk for experiencing sexual assault, given their close relationships to fraternity men. Research suggests that fraternities represent a social context that tolerates, if not actually encourages, sexual coercion of women.[xxx] Fraternity men are more likely to engage in non-physical coercion and use drugs and alcohol as a sexual strategy compared to non-fraternity men. According to the Justice Department's *Sexual Victimization of College Women* report, approximately 10% of completed rapes occur in fraternity houses.[xxxi]

While a large number of sexual assaults occur on college campuses, underreporting of sexual violence remains a serious problem. Many victims do not file police reports because they are afraid to tell the police, friends, or family about the rape or sexual assault. They may be ashamed or embarrassed and there may be social and/or cultural repercussions for losing their virginity or being considered promiscuous. Further, many studies show that the majority of perpetrators of sexual assault on college campuses are members of the campus community, often students known to the victims. Students who survive assaults may find it difficult to disclose the abuse for fear of encountering the offender.

Recommendations to reduce the risk of victimization for college students include:

- Clearly defining definitions of sexual assault, including policies that define consent, especially as it relates to alcohol consumption.

- Creating and implementing formal, easily accessible, policies that address sexual assault on campus, including a statement of the school's commitment to recognizing and dealing with the problem.

- Annually disclosing information about crimes, including specific sexual crime categories in and around campus, as per the Student Right to Know and Campus Security Act of 1990 (also known as, the Clery Act).

- Training students and staff in what to do if someone discloses that she or he has been sexually assaulted, as they are often the "first responders."

- Considering offering anonymous reporting in addition to confidential reporting.

- Providing service after business hours to file criminal charges and campus reports.

- Promoting healthy relationships among students, including a movement to change societal and campus attitudes that perpetuate violence against women.

People with Disabilities and the Elderly

People with disabilities are four to ten times more likely than others to become victims of violence, abuse, or neglect.[xxxii] Children with disabilities are more than twice as likely as other children to be physically or sexually abused. Similar proportions of women with and without disabilities report having experienced physical violence, sexual violence, or emotional abuse. Women with disabilities, however, report a greater number of perpetrators and longer time periods of individual episodes than women without disabilities.[xxxiii]

Eighty-three percent of women and 32% of men with developmental disabilities will be sexually abused in their lifetime. Among people with disabilities, 84% of sexual assault victims are females. Data from the *2005 Behavioral Risk Factor Surveillance System* (BRFSS), demonstrated that those with disabilities experienced almost twice the rate of all forms of abuse compared to other non-disabled populations.[xxxiv] Variables increasing the likelihood of abuse included being female, disabled, not employed, single, and young. Several studies have found that in 95% to 99% of sexual assault cases involving a victim with a disability, the perpetrator was a family member, a friend, a service providers (e.g., institutional and home based care takers), or otherwise known to the victim.[xxxv]

Factors that may contribute to this elevated risk of victimization include: unemployment or underemployment of persons with disabilities, which restricts their income and limits their choices for caregivers; lack of money often causes persons with disabilities to live in areas where crime rates are high and the potential for physical and sexual violence is greater than in wealthier neighborhoods. Frequently, health care and law enforcement professionals are uninformed about victimization of persons with disabilities and may not have the specialized knowledge or skills to identify and assist these individuals when victimized.

Similar to people with disabilities, the elderly, particularly those in institutional settings, have an increased risk of victimization. In both populations, many individuals need assistance to complete everyday tasks, such as bathing, dressing, and toileting. Because of this increased dependence on others, the lines between personal space and privacy for people with disabilities and the elderly are often blurred. Over time, these populations are often taught to be compliant and not question authority in their lives. Moreover, people with disabilities and the elderly are often not seen as sexual beings and are often deprived information about their bodies and sexual health, making it difficult to identify and communicate abuse. Many times when individuals with disabilities or the elderly do report abuse, officials may not perceive them as credible due to their disability or age.[xxxvi]

Recommendations to reduce the risk of victimization for people with disabilities and the elderly include:

- Educating people with disabilities and the elderly about their rights to their body, especially regarding privacy.
- Implementing a national database of abusers to supersede individual state databases.
- Ensuring abusers, who are service providers, permanently lose professional licenses and/or certifications.
- Increasing access (including transportation) to protective services, like shelters, for individuals with limited mobility.
- Providing training for law enforcement, first responders, emergency room staff and court personnel about the characteristics and needs of persons with disabilities and the elderly whom they may encounter.

Lesbian, Gay, Bisexual, Transgendered, Queer, Questioning, and Intersex (LGBTQI) Youth

LGBTQI youth are subject to the same spectrum of sexual violence as the general public. However, homophobia in our culture puts LGBTQI youth at greater risk for sexual assault by strangers. It is common for perpetrators to use sexual violence as a

way to punish and/or humiliate someone for being LGBTQI. A common example of this is when individuals think they can "change" a women's sexual orientation and specifically target lesbian and bisexual women for sexual assault. It is estimated that approximately 10% of all hate crimes against LGBTQI youth include some form of sexual assault.[xxxvii] Reports on the number of rapes experienced by LGBTQI youth vary. Studies suggest that anywhere between 12%-52% of LGBTQI people have been raped.[xxxviii]

Homeless LGBTQI youth face additional challenges. Studies estimate that 25%-40% of the homeless youth population in large cities are LGBTQI.[xxxix] LGBTQI youth report being abused in shelters by other youth and service providers, leading many LGBTQI youth to avoid shelters altogether.[xl] As a result, some homeless LGBTQI youth may turn to "survival sex" for food and shelter when living on the streets. Sexual abuse during survival sex is especially hard to identify, as youth may have initiated some form of sexual activity presently or in a past encounter.

For the LGBTQI community, being sexually assaulted as a teenager can be particularly challenging. LGBTQI youth may not yet have a system of friends/community from which to get support. Often, LGBTQI youth are just beginning to explore their sexuality and may be confused over where to go for help and how to express and talk about their abuse. Even more, some LGBTQI youth may not have accepted their own sexual orientation, complicating the situation even further. Many LGBTQI youth have difficultly naming an experience as assault, especially if there was no overt physical violence involved, they wanted or initiated some sexual activity, or if there was no penetration.

LGBTQI youth commonly feel that they have nowhere to turn for help and often fear hostile responses from police, courts, service providers, and therapists because of homophobia and anti-LGBTQI bias.[xli] Others choose not to report their sexual assault for fear of being forced to "come out" to family, friends, and others; fear of isolation from the community; and a fear of reinforcing negative stereotypes (e.g., gay men are promiscuous).

Recommendations to reduce the risk of victimization for LGBTQI youth include:

- Undermining and confronting prejudice at a younger age (i.e., elementary and middle school) through education.
- Creating an environment where everyone is respected and free to have different perspectives, which are never used against, or in opposition to, one another.
- Teaching respect through interaction with peers.
- Training law enforcement, first responders, emergency room staff and court personnel about the specific risks and challenges LGBTQI youth face.

Inmates

According to the *National Inmate Survey* (NIS) conducted in 282 jails (with approximately 40,500 inmates) between April and December 2007, 1.6% of inmates reported an incident of sexual assault involving another inmate and 2.0% reported an incident involving staff within the 6 months prior to the interview or since admission to the facility, if shorter.[xlii] Inmate-on-inmate victimization occurred most often in the victim's cell (56% of the time), while staff-on-inmate victimization typically occurred in a closet, office, or other locked room (47% of the time). The report also found that an estimated 5.1% of female inmates, compared to 2.9% of male inmates, said they had experienced one or more acts of sexual assault.

While no inmate is immune from sexual victimization, certain groups appear to be more vulnerable, including those who are: young and inexperienced, physically small or weak, suffering from a mental illness, middle class or not "streetwise," not gang affiliated, homosexual, convicted of sexual crimes, disliked by staff or other inmates, and previously sexually assaulted.[xliii]

While sexual assault is common in prison, collecting data on the number of incidents is difficult, as many assaults are unreported. Similar to sexual assault outside of prison, many survivors in prison are ashamed and embarrassed, fear that their claim will be hard to prove or not taken seriously, or fear that the attacker will retaliate. Inmates who report sexual assault are frequently segregated in isolation, to protect them from retaliation, but this isolation can be emotionally and physically draining. [xliv]

Recommendations to reduce the risk of victimization for inmates include:

- Training both high-level corrections officials and line staff about prisoner-on-prisoner and staff-on-prisoner sexual abuse, including additional training for males staff working with female inmates.

- Sensitizing corrections officials as to the importance of taking effective steps to prevent sexual abuse in prisons.

- Strictly enforcing state criminal laws prohibiting rape by investigating and prosecuting instances of prison rape in addition to handling the situation via internal disciplinary procedures.

- Providing an inmate orientation on the Prison Rape Elimination Act (PREA), which includes an in facility zero tolerance policy.

- Granting victims access to the same resources that they would receive in the community.

Factors that Increase an Individual's Risk for Sexual Violence Perpetration

When it comes to sexual violence, there is no typical perpetrator. Sexual violence perpetrators come from every age and demographic group (i.e., gender, race, social class, sexual orientation, etc). However, there are multiple risk factors associated with a greater likelihood of sexual violence perpetration. It is important to note that not everyone identified as at-risk becomes a perpetrator of sexual violence. Further, while risk factors are contributing factors to perpetration, they may or may not be direct causes.

Individuals who have a history of alcohol and drug use, impulsive and antisocial tendencies, and childhood sexual abuse have a greater risk of becoming sexual violence perpetrators. Further, those associated with sexually aggressive and delinquent peers or who come from a physically violent and/or unsupportive familial environment also have an increased risk.[xlv] At the community level, a lack of institutional support from police and the judicial system and weak sanctions against sexual violence perpetration can also lead to increased levels of risk for perpetration.

In addition, empirical evidence supports the link between a culture of hypermasculinity and an increased risk of sexual assault perpetration.[xlvi] Hypermasculinity, often exhibited through adherence to strict gender roles, may lead to the development of hostility towards women and coercive or violent sexual fantasies. At the societal level hypermasculinity is embedded within societal norms that support male superiority and sexual entitlement, while reinforcing female inferiority and sexual submissiveness. These norms may be used to justify or tolerate sexual violence in our society.

III. THE STATE OF CONNECTICUT

Connecticut is the southernmost New England state, bordered by Massachusetts to the north, Long Island Sound to the south, Rhode Island to the east, and New York to the west. The state is divided into eight counties and 169 towns. Much of Connecticut's population lives in larger towns along the coast and in the Connecticut River valley, which bisects the state from north to south. It is the third smallest state in the United States in terms of area, but it has the 29th highest population and is the fourth most densely populated.

Connecticut is characterized by high social and economic contrast and racial and ethnic diversity. Whether in terms of health status, income, poverty, racial composition, or almost any other factor, statewide averages for Connecticut often are misleading. Striking disparities exist across town lines, among racial and ethnic groups, and between urban and rural populations. These differences have engendered the concept of "two Connecticuts."[xlvii] One Connecticut comprises people who live in the wealthiest state in the nation and the other consists of those who live in some of the most severe and concentrated pockets of poverty in the nation.

Population Demographics

In order to implement a comprehensive and wide-reaching primary prevention plan, it is necessary to have a demographic understanding of the various groups that make up Connecticut's total population. The following section briefly discusses some of the demographic trends across the state both generally and for specific populations.

In many cases, data was not available to address each of the populations with increased risk, as discussed in the previous section. It should be noted that Census data is not available for the number of LGBTQI residents living in a particular area. Further, inmate population data is limited. As of June 2009, there are 18,760 inmates in Connecticut. Of those inmates, only 6.4% (1,209) are female.

School Aged Children, Adolescents, and College Students

In 2006, approximately 27% of Connecticut's population was enrolled in some level of schooling (i.e., preschool through college). Table 1 illustrates school enrollment by specific level of schooling for both the total population and for the specific age group. For example, we see that 2.0% of Connecticut's population is enrolled in preschool. However, this figure accounts for 61.3% of the 3 and 4 year old population. Looking at school enrollment levels provides a broader idea of the size of these particular populations at risk for sexual victimization. In addition, school enrollment information can be used to assess the needed scale and magnitude of prevention efforts.

Table 1: School Enrollment, 2006

Level of School	Population	% Total Population	% of Age Group
Preschool (ages 3-4)	63,597	2.0%	61.3%
Kindergarten	43,414	1.3%	96.3%
Elementary (grades 1-4)	181,440	5.6%	96.3%
Middle (grades 5-8)	190,482	5.9%	98.4%
High school	207,569	6.4%	97.2%
College (undergraduate)	201,268	6.2%	46.2%

Source: US Census Bureau, 2006 American Community Survey

People with Disabilities

Approximately 13% of Connecticut's residents have developmental disabilities (both physical and mental). Table 2 presents the percentages of individuals living with disabilities by gender and age group. On average, the percentages are similar for males and females. There is a slightly higher percentage of females over the age of 65 living with a developmental disability. Disability population data can, in part, be used to assess the needed scale and magnitude of prevention efforts for people living with developmental disabilities.

Table 2: Percentage of Individuals Living with Disabilities, 2006

Population	% Total Population	% of Age Group
Male		
5 to 15 years old	1.1%	6.7%
16 to 64 years old	7.1%	9.9%
65 and older	4.0%	34.0%
Female		
5 to 15 years old	.60%	4.0%
16 to 64 years old	7.1%	10.2%
65 and older	5.8%	38.0%

Source: US Census Bureau, 2006 American Community Survey; *Includes physical and mental disabilities.

The Elderly

Connecticut's population on average is older compared to the average age group nationwide. Older adults are the fastest growing segment of the Connecticut population. Between 1990 and 2000, the median age of Connecticut residents increased from 34.4 years to 37.4 years or 2.1 years greater than the national median age.[xlviii] During the same period, the number of people 65 years of age and older grew by more than 24,000. In 2006, Connecticut had a total population of 3.5 million - 1.8 million (51 percent) females and 1.7 million (49 percent) males. The median age was 39.1 years. Twenty-three percent of the population was under 18 years and 13 percent was 65 years and older. As the Connecticut population continues to age, it is likely that the number of elderly individuals at risk for sexual abuse will increase.

Race, Ethnicity, and Social Class

Groups from different racial and ethnic backgrounds and those from varying social classes often have different cultural norms regarding the roles and expectations for men and women. Further, groups may have different definitions for sexual abuse. In general, racial and ethnic, as well as income based, groups may also have different norms regarding seeking support and services outside of the family. All of these factors are likely to impact the way individuals respond to and understand sexual violence prevention efforts.

From 1990 to 2000, the number and proportion of whites in Connecticut decreased, whereas minority populations increased, in some cases by 50% or more (see Table 3). Although Connecticut's population still remains predominately white (81.6%) and non-Hispanic (90.6%), the racial and ethnic composition is dramatically different in the state's largest cities and towns. Non-whites account for 72% of the population in Hartford, 57% in New Haven, and 55% in Bridgeport, and Hispanics (of any race) represent 41%, 21%, and 32%, respectively, of the population in these three cities.[xlix] Hispanics are the largest minority group in Connecticut.

Table 3: Selected Racial/Ethnic Group Populations, 1990 and 2000

	1990		2000		Change from 1990 to 2000	
Population Group	**Number**	**%**	**Number**	**%**	**Number**	**%**
Total Population	*3,287,116*	*100*	*3,405,565*	*100*	*118,449*	*3.6*
White	2,859,353	87.0	2,780,355	81.6	-78,988	-2.8
African American*	274,269	8.3	309,843	9.1	35,574	13.0
Asian American/Pacific Islander	50,698	1.5	83,679	2.5	32,981	65.1
American Indian/Alaskan Native	6,654	0.2	9,639	0.3	2,985	44.9
Hispanic/Latino (any race)	213,116	6.5	320,323	9.4	107,207	50.3

Source: US Census Bureau, 2000; *African American includes individuals who consider themselves Black

Connecticut is the wealthiest state in the nation, but a great and growing gap exists between its rich and its poor. Between 1990 and 2000 the *per capita* income of Connecticut residents rose by 42.5% to $28,766. This figure was more than double the income defined by the federal government as "poverty level" for a family of three ($13,740).[l] During the same period, the poverty rate declined nationally, while the number of people living below the poverty level in Connecticut rose from 217,347 to 259,514, an increase of nearly 20%, representing 7.6% of the state's population (see Table 4).

White Connecticut residents had the highest *per capita* income of any racial or ethnic group ($31,505). *Per capita* income was 58% lower for Hispanics and 47% lower for African Americans.[li] Connecticut poverty rates were 7% for whites, 28% for African Americans, and 32% for Hispanics in 2002-2003.[lii]

It is important to note that the Census Bureau may be undercounting actual poverty in Connecticut. The cost of living in Connecticut is higher than the national average. Accordingly, although an individual's or family's income may be above the national threshold for poverty, they might still be living in stressed financial conditions by Connecticut standards.[liii]

Table 4: Percentage of Families and People Below the Poverty Level, 2006

Population	Percent
All families	5.9%
With related children under 18 years	9.3%
With related children under 5 years only	10.0%
Married couple families	2.2%
With related children under 18 years	2.7%
With related children under 5 years only	2.8%
Female headed householder (single parent)	20.8%
With related children under 18 years	28.4%
With related children under 5 years only	35.9%
All people	8.3%
Under 18 years	11.0%
18 years and over	7.4%
18 to 64 years	7.7%
65 years and over	6.1%

Source: US Census Bureau, 2006 American Community Survey

Educational Attainment

Education attainment plays a large role in determining social class standing. In addition, educational attainment impacts an individual's ability to comprehend and understand prevention materials and the ways in which an individual seeks services or support for sexual violence. Individuals with higher levels of educational attainment are more likely to comprehend prevention materials. Further, those with higher levels of education are more likely to know where/how to seek support for sexual violence (or have an increased capacity to find the necessary information) than those with lower levels of education.

The educational attainment of Connecticut residents has been increasing compared to the United States' population as a whole, and Connecticut residents have a higher level of educational attainment (see Table 5). In 2006, 84% of Connecticut residents 25 years of age and older were high school graduates or higher and 31% had completed a bachelor's degree or more, whereas less than 6% had less than a 9th grade education. In contrast to statewide figures, however, in Hartford and Bridgeport only 61% and 65% of residents, respectively, were high school graduates, only about 12% had a bachelor's degree or higher. At the same time 17% (Hartford) and 15% (Bridgeport) respectively had less than a 9th grade education.

Table 5: Educational Attainment, 2006
Population 25 Years and Older

Educational Attainment	Population	% Total Population
Less than 9th grade	114,000	4.8%
9th to 12th grade, no diploma	169,402	7.2%
High school graduate (and equivalent)	704,762	29.8%
Some college, no degree	409,332	17.3%
Associate's degree	172,604	7.3%
Bachelor's degree	456,201	19.3%
Graduate or professional degree	341,210	14.4%

Source: US Census Bureau, 2006 American Community Survey

Language Spoken at Home

Given the racial and ethnic variation across the state, a variety of languages are spoken in Connecticut. Like educational attainment, language not only directly impacts an individual's ability to comprehend and understand prevention materials, but also the ways in which an individual seeks services or support for sexual violence. Non-English speakers, or those who do not speak English "very well," are likely to have a difficult time reading prevention materials that are solely published in English. In addition, non-English speakers, or those who do not speak English "very well," may have difficultly

seeking sexual violence services and support due to limited communicative abilities. Table 6 presents data for language spoken at home in 2000.

Table 6: Language Spoken at Home, 2000

Language Spoken at Home	Population	% Total Population
English only	*2,639,307*	*79.9%*
Language other than English	663,431	20.1%
Speak English less than "very well"	262,324	7.9%
Spanish	308,863	9.4%
Speak English less than "very well"	130,191	3.9%
Other Indo-European languages	270,572	8.2%
Speak English less than "very well"	99,900	3.0%
Asian and Pacific Islander languages	64,075	1.9%
Speak English less than "very well"	26,558	.8%
Other languages	19,921	.6%
Speak English less than "very well"	5,675	.2%

Source: US Census Bureau, 2000

The percentages of Connecticut residents who speak a language other than English and who do not speak English *at least well* is steadily increasing. Spanish is the second most spoken language in the state after English. In 2000, nearly one in five Connecticut residents over 5 years of age spoke a language other than English and more than 7% did not speak English *very well.* However, in Hartford and Bridgeport more than 40% of the population spoke a language other than English and more than one in five spoke English less than *very well.*

The Scope of Sexual Violence in Connecticut

Like most other states and nations, Connecticut struggles to shake history's record of sexual violence as a powerful and successful weapon of oppression. Generations of societal tolerance, silence, and misplaced blame have permitted a wide spectrum of sexually violent acts to continue to be perpetrated against our citizens and communities.

According to Kilpatrick and Ruggiero's 2003 report, it is estimated that approximately 13.2% of women in Connecticut have been raped. [liv] In other words, over one out of every eight adult women, or about 178,000 women in Connecticut, has been the victim of one or more forcible rapes in her lifetime. It is important to note that these estimates are conservative because they do not include women who were not *forcibly* raped but who experienced alcohol- or drug-*facilitated* rape, *incapacitated* rape, *statutory* rape (i.e., perpetrator has sex with an underage child or adolescent without using force or threat of force) or *attempted* rape.

The physical and mental effects of rape extend beyond the time of the incident. If rape victims in Connecticut were similar to rape victims nationally, then of the estimated 178,000 adult women in Connecticut who have been forcibly raped, over 55,000 have developed Post-Traumatic Stress Disorder (PTSD) at some time in their lives, and nearly 20,000 currently meet full criteria for PTSD.[lv]

In addition to PTSD, several other mental health problems often affect rape victims. Major depression is experienced by 30% of rape victims (over 53,000 victims in Connecticut) compared to 10% of women never victimized by violent crime. Suicide attempts are reported by 13% of rape victims (over 23,000 victims in Connecticut) and only 1% of non-victims of crime. Cocaine use is reported by 15.5% of rape victims (nearly 28,000 victims in Connecticut) and 2.6% of non-victims. Use of hard drugs, other than cocaine, is reported by 12.1% of rape victims (nearly 22,000 victims in Connecticut) and only 1.2% of non-victims.

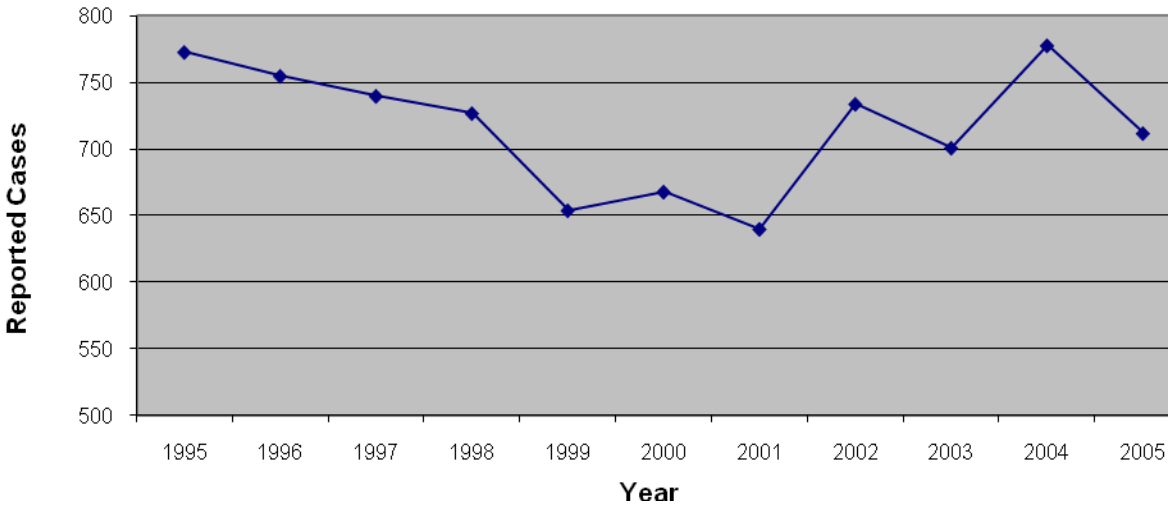
A *Sexual Assault Attitudes and Experiences Study* was conducted between September 1999 and February 2000 to determine attitudes toward sexual assault, possible lifetime or recent experiences with sexual assault, and access to and familiarity with available services among Connecticut residents.[lvi] Results indicated that the rates of sexual assault in Connecticut were similar to that of national studies. When considering the four types of sexual assault: forced oral sex, being forcibly fondled, attempted penetration, and completed penetration, the study found that 26% of Connecticut's female residents (372,376 women) experienced sexual assault. When penetration or rape was analyzed separately the results showed that one out of eleven women reported being a sexual assault survivor. The study also found that 10% of Connecticut's male residents (102,156 men) experienced sexual assault and were *more* likely than women to have experienced multiple assaults. Between 2007-2008, Connecticut Sexual Assault Crisis Services reported that 13.65% of victims seeking services were male.

According to the *State Police Crimes and Data Analysis Unit, Connecticut 2005* crime statistics show that 757 rapes were reported to the police in calendar year 2005, for a rate of 41.79 rapes/100,000 females.[lvii] Figure 4 illustrates the reported cases of rape and attempted rape in Connecticut between 1995 and 2005. While the graph shows a slight decline in reported cases between 1999 and 2001, the number remains relatively consistent over time. It is important to remember that only one in six rapes are reported to law enforcement. [lviii] Likewise, a significant percentage of sexual assault victims do not seek services from rape crisis or other agencies that specifically address sexual violence. Therefore, data from police reports or sexual violence agencies clearly cannot provide a comprehensive picture of sexual assault that occurs each year within a state.

The National Child Abuse and Neglect Data System (NCANDS) data shows that children, too, are victims of sexual violence in Connecticut. In the year 2000 alone, there were 844 reported cases of child sexual abuse. Of those cases, over half were among those between the ages of 9 and 15.[lix]

Based on arrest data from the CT Uniform Crime Reporting (UCR) 2005 report, it is clear that the age of sex offender starts young. There are persons as young as 10 to 12 that have committed rape, and 18% (50 of the 283 arrested) of the perpetrators are less than 18. The highest number of offenders is the 25-29 age group, which accounts for 16% of the total. Considering the young age of so many of the offenders and the probability that this is not their first offense, it would seem that any primary prevention for perpetration should have to start before the age of 10. This supports the decision to target youth as the selected population.

Figure 4: Reported Cases of Rape and Attempted Rape in Connecticut, 1995 - 2005



Source: CT UCR, 2005

Table 7 presents rape rates per 100,000 people for the Connecticut towns with the highest report rates from 2000-2004. Within and across towns, the rates fluctuate over time. There are no consistent increases or decreases in the rate of rape between 2000 and 2004. The average rates range from 27.30 rapes per 100,000 people in West Haven to 81.41 rapes per 100,000 people in Groton. Once again, it is important to note that these rates only include reported rapes. In reality, the actual rape rates may be higher for each town.

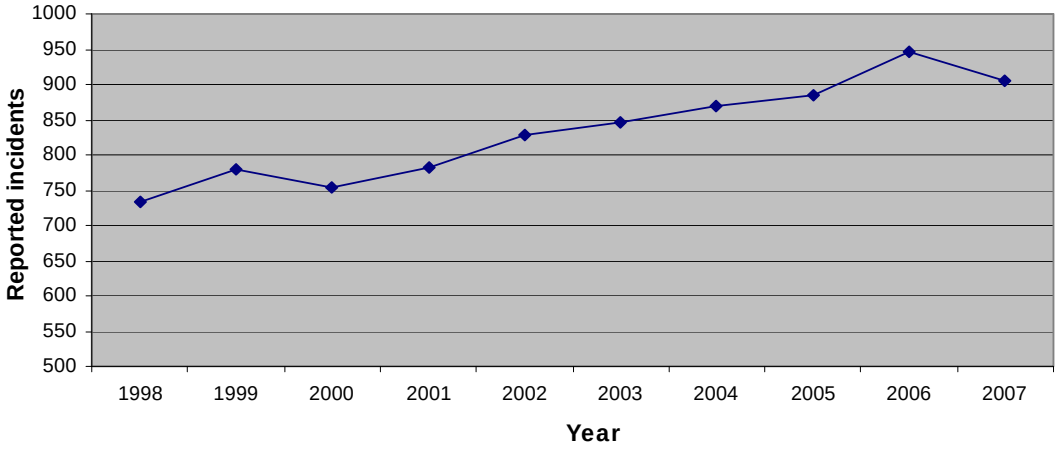
Table 7: Reported Rape Rates per 100,000 People
Connecticut Towns with Highest Report Rates, 2000-2004

Town	2000	2001	2002	2003	2004	Average
Bridgeport	60.92	49.36	46.56	35.02	42.28	46.83
East Hartford	44.38	38.20	24.17	48.39	67.11	44.45
Groton	85.20	68.84	111.75	49.98	91.31	81.41
Hartford	43.59	51.48	47.42	51.37	43.35	47.44
Manchester	34.71	31.09	32.68	48.75	26.99	34.84
New Haven	50.96	45.24	64.40	55.33	56.89	54.56
New London	70.12	38.21	57.06	79.73	83.83	65.79
Norwich	63.68	52.90	63.88	88.20	76.76	69.08
Waterbury	59.66	35.38	44.59	46.23	42.50	45.67
West Haven	21.01	32.40	34.13	24.51	24.48	27.30

Note: Although rates are calcuated per 100,000 people actual town populations vary and range from approximately 36,000 to 140,000 people.

Figure 5 illustrates the number of emergency room visits in Connecticut that were coded as sexual assault between 1998 and 2007. The graph shows that over time, there is a slight increase in the number of victims seeking emergency room care, with a slight decline in 2007. This data broken down by demographic group can be found in Appendix C.

Figure 5: Emergency Room Visits in Connecticut with ICD-9 Code of Sexual Assault, 1998 - 2007



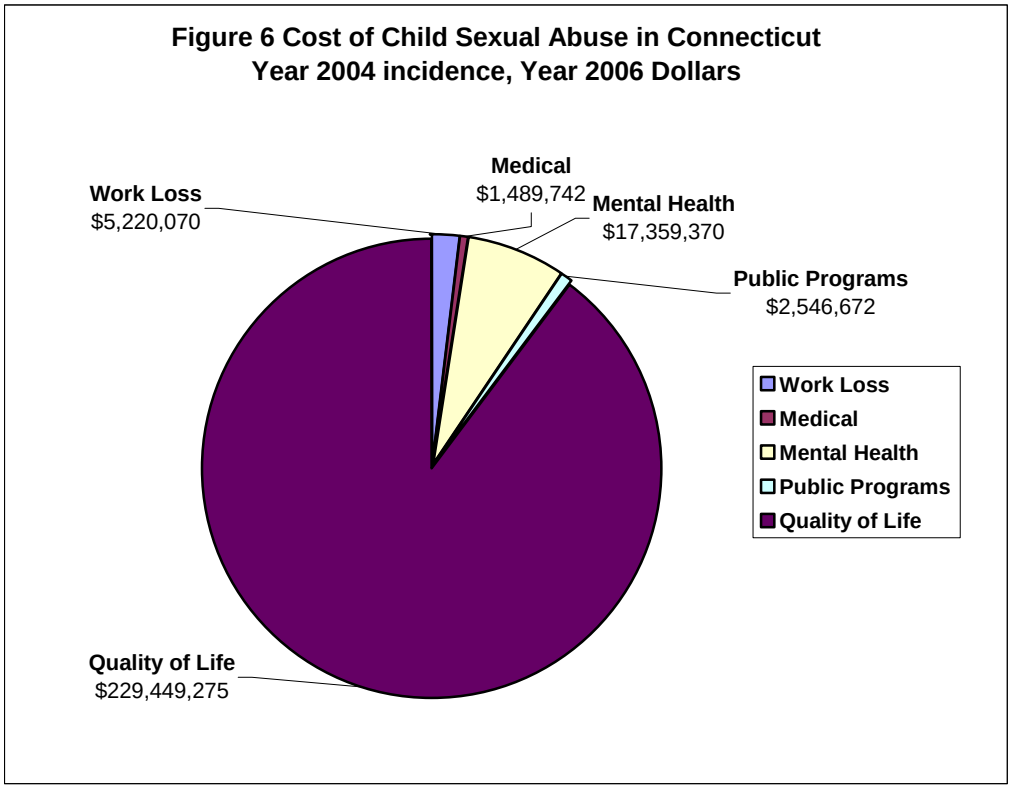
Source: CT CHIME data

There is a noticeable difference between the number of reported rapes in Figure 4 and the number of emergency room visits in Figure 5. For example, in 2004, Connecticut hospital data listed 894 Emergency Department (ED) visits coded as sexual assault (0.08% of the total visits), compared to the 778 reported rapes. Connecticut law does not require that hospitals report rape and sexual assault to authorities, unless a firearm was involved.[lx] This may, in part, account for the discrepancy between the number of individuals who sought emergency room care for sexual assault and the number of reported rapes.

Economic Impact

Rape is the most costly of all crimes to its victims. Total costs are estimated to be $127 billion a year in the United States alone (excluding costs of child sexual abuse, costs incurred by businesses, criminal justice systems or society at large) as compared to costs of physical assault at $93 billion, murder at $71 billion, drunk driving at $61 billion, and child abuse at $56 billion. Total cost per incidence of adult sexual assault is estimated to be $87,000 which includes medical care, mental health services, loss of productivity, and pain and suffering.

The total tangible costs of adult sexual assault are estimated to be $5,100 and include: $500 short term medical care, $2,200 lost productivity, and $2,200 mental health care. [lxi] At $5,100 per case the total cost of adult sexual assault in Connecticut was approximately $3,631,200 in 2005. While the economic impact of adult sexual assault is undeniably high, child sexual abuse is even more costly. In 2006 alone, child sexual abuse cost Connecticut $256,065,129. Figure 6 breaks down the cost of child sexual abuse by specific expenditure.



Source: Research and Evaluation, Calverton, MD, 2008. All costs were calculated using incidents reported in the Child Maltreatment 2004, National Center on Child Abuse and Neglect Data Set.

VI. NEEDS AND RESOURCE ASSESSMENT

System Capacity

Survey I

A survey was developed by CDC as part of the statewide Rape Prevention and Education planning process to learn about local efforts to prevent sexual violence. Of the 25 surveys that were handed out at the first meeting, 19 responses were returned. Fifteen were from non-RPE funded organizations and agencies and four were from RPE funded agencies and organizations.

One of the biggest strengths identified in the survey is the extensive network among the SVPPC member agencies. The SVPPC members currently partner with 44 other agencies. The personal commitment of SVPPC members is also noteworthy in light of the time, effort and thoughtfulness that it took to develop this strategic plan.

The non-RPE funded members surveyed represented agencies and organizations including public health, education, medical, and mental health, among others. Most of the organizations represented focused their programmatic services on survivors of sexual abuse and reported moving in the direction of primary prevention.

There were 14 questions directed to non-RPE funded organizations about their agency's commitment to the prevention of sexual violence. The three statements they agreed with most strongly were as follows:

- *My organization is committed to and supportive of activities for the primary prevention of sexual violence.*
- *My organization commits personnel to activities for the primary prevention of sexual violence.*
- *Most staff members see program planning as an essential part of my organization.*

Two other statements the non-RPE funded agencies agreed with were as follows:

- *My organization is knowledgeable about the primary prevention of sexual violence.*
- *Most staff members see using evidence-based approaches as an essential part of our organization's work.*

There was less support for the following statements:

- *My organization has a mission statement which includes ending, preventing or eliminating sexual violence.*

- *Primary prevention of sexual violence is regularly discussed in staff meetings.*

The SVPPC as a whole disagreed with the following statement:

- *My organization commits unrestricted financial resources to activities for the primary prevention of sexual violence.*

There were four non-RPE funded organizations that identified sexual violence primary prevention strategies in their work, including: the Women's Center at the University of Connecticut, the Children's Trust Fund, Planned Parenthood of Connecticut, and St. Francis Hospital and Medical Center. These organizations, in addition to CONNSACS and its RPE Funded centers, were identified as Connecticut's leaders in primary prevention and serve as exemplary models for the implementation of the state's strategic plan.

The four RPE funded centers in the state include: The Center for Women and Families, Meriden; Susan B Anthony Project, Inc., Torrington; The Women and Families Center, Bridgeport and The YWCA, New Britain-Sexual Assault Crisis Service. Each site has at least one full time RPE funded staff member. Table 8 illustrates the percentages of RPE funding and the various activities they support. A graphical presentation of RPE funded budget allocations can be found in Appendix D.

By far the greatest effort and allocation of resources targets Connecticut's students. In order to prioritize target communities, a strategic planning effort needs to include the RPE funded member centers. This priority setting process will include the breakdown of resources being allocated to the prevention of victimization and perpetration, identifying priority populations within these two categories and defining the professional community who is in the most likely position to reinforce prevention efforts and strategies of the SVPPC.

Table 8: Funding Allocation by Service/Activity of RPE Funded Members

Activity	Funding
Surveillance (2% cap)	0.00%
Operation of hotlines	1.00%
Community mobilization	1.00%
Education on date rape drugs	2.00%
Awareness efforts, including to underserved and disabled populations	2.00%
Public campaigns/social norm changing activities	3.00%
Administrative activities (5% cap)	3.00%
Educational Seminars for general public	7.00%
Preparation of informational materials	8.00%
Coalition building, including advocacy for primary prevention	8.00%
Training programs for professionals	13.00%
Strategic planning (assessments, partner mobilization, report development)	14.00%
Education and training for students and campus personnel	38.00%

Survey II

To help identify strengths and resources within our state so that future prevention activities could build on those strengths, members were sent a second survey that asked for the target population served, focus of prevention, priorities and assets in addressing sexual violence, challenges in addressing sexual violence and the evidence based strategies used to address their priorities.

Thirty-three surveys were sent to SVPPC members (including the RPE funded centers). Twenty-seven surveys were returned. Of the responses, eight indicated they were involved in primary prevention efforts, six were involved with secondary prevention activities, and two were involved with tertiary prevention. Seven indicated they were conducting all three levels of prevention and four were involved in secondary and tertiary levels of prevention.

Target populations served included: Children from 0-18 years, youths, adolescents, college students, adults, and professionals. Some programs served populations across the lifespan, while others served specific and at risk populations such as:

- victims and survivors of sexual abuse and their families
- men and women from 13–44 year olds
- people involved in violent relationships
- South Asian women and their families
- men arrested for intimate partner violence
- low income/non-custodial fathers, teen fathers
- men transitioning from prison to the community
- juvenile offenders
- victims of domestic violence
- crime victims
- convicted sex offenders
- children from birth to 17 years who allege sexual abuse
- chronic, long term and acute care patients

Survey respondents identified their agency's priorities in addressing sexual violence and responses are recorded below. The responses have been compiled by similarity but have not been ranked by SVPPC. Priorities include:

- Educating and empowering: women's rights and how to record complaints, safety, victim defined advocacy, available resources

- Improving the collection of forensic evidence and support prosecution of sex offenders

- Preventing early childhood and youth violence
    - Saturation of instruction on the greatest threats to sexual safety

- Building a safe learning environment, reducing street and/or random sexual assault

- Reducing intimate partner violence including the development of healthy relationships and developing skills and knowledge for healthy lifetime behaviors

- Building an infrastructure statewide through partnerships and identification of strengths and expertise of partners to help frame solutions to sexual violence as a public health problem (reduce overlapping services and increase complimentary care)
    - Collaborative system response to sexual abuse and neglect of children

- Decreasing sexual abuse and increase public safety through the treatment of sex offenders

- Implementing the Prison Rape Elimination Act

Evidenced based resources utilized by SVPPC members include:

- *Programs that Work* described by Douglas Kirby suggest several common elements: a) identification of supportive family members, mentors and peers to engage in the program, b) strategize with teens and adults to develop prevention program curriculum that focuses on the promotion of pro-social behavior, development of problem solving skills and competency in self advocacy and; c) build connections between individuals and community resources.
- *American Academy of Pediatrics Guidelines for Parents*
- *Healthy and Balanced Living,* Curriculum Framework
- *Guidelines for a Coordinated Approach to School Health*, Department of Public Health Adolescent Strategic Plan
- Michael Flood's theory that effective educational campaigns contain cognitive and behavioral components
- Toby B. Simon and Bethany N. Golden's guide to setting up a peer education program for preventing sexual harassment and violence.
- Multi-session programs evaluated by pre-and post testing of knowledge, attitudes and behaviors in middle, elementary and high schools, with evaluation follow-up activities involving teacher perception of student behavior change.
- Incorporate evidenced-based strategies from other established programs and theories such as the *Tough Guise* program.
- Social Problem Solving Training: Measuring fidelity and outcomes with significant positive outcomes
- Best practices and evidence based treatment provided through the Association for Treatment of Sex Abusers (ATSA)

Key Informant Interviews

The DPH conducted site visits to interview the following key stakeholders to gather in depth information on primary prevention strategies, organizational capacity, training and technical assistance needs.

- State Attorney for Danbury District and Co-Chair of the Executive Committee of the Governor's Task Force (GTF) on Justice for Abused Children: The GTF identified and provided the need for greater coordination of agencies involved in the investigation, intervention and prosecution of child sexual abuse and serious physical abuse cases. The GTF meets on a quarterly basis for planning, decision-making, and information sharing. Its membership is large, diverse and active, consequently, the GTF has established several committees to focus on key issues as identified by the Task Force. An example of such committees is the Child Representation Committee. The purpose of the committee is to recognize the disparity in legal representation for children and parents in Juvenile Court and to address the quality of representation for minor children and their parents in Connecticut. The GTF also developed multidisciplinary teams that

provide critical coordination and maximization of community resources that strengthen and improve interagency responses and interventions during a child abuse investigation.

- CONNSACS: The mission of Connecticut Sexual Assault Crisis Services, Inc. (CONNSACS) is to end sexual violence, and the coalition is dedicated to effectively achieving this goal. Primary prevention efforts play a key role in this mission. CONNSACS currently funds primary prevention and education activities through four member centers with offices in Bridgeport, Meriden, Torrington, and New Britain. In addition, CONNSACS provides technical assistance, training, and other resources to ensure that activities of these programs successfully shift from more traditional secondary prevention approaches to strategies that effectively prevent the first-time perpetration of sexual violence.
- A.J. Pappanikou Center for Excellence in Developmental Disabilities at the UCONN Health Center: The A.J. Pappanikou Center is funded by the Administration on Developmental Disabilities, the U.S. Department of Health and Human Services and through other grants. The Center is committed to improving the lives of individuals with disabilities and their families. The Center provides model programs in innovative disability related research, training and technical assistance. It collaborates with the University of Connecticut, University of Connecticut Health Center and Disability Network to advance policies and practices to support individuals with disabilities and work with organizations to address systems change.
- The Rape Aggression Defense System Training Coordinator, Department of Public Health: This is a program of realistic self-defense tactics and techniques for women. Rape Aggression Defense, known as R.A.D., is a system specifically designed for women who are willing to consider defense as a viable option in situations where their life/safety is in jeopardy. The R.A.D. system offers a basic education of confrontation principles and personal defense. It ranges from awareness, risk reduction and avoidance to basic physical defense and is the largest women's self-defense network in the United States. R.A.D. is a 12 hour class broken down into two sessions, day one is 8 hours and day two is typically four to five hours depending on class size. The program ends with a simulated assault where participants have the opportunity to utilize their newly acquired skills in a safe training environment. It provides women with the knowledge to make an educated decision about resistance, because "you are your best defense." The course is taught by certified R.A.D. instructors and provides each participant with a workbook/reference manual.

State Level Assets

Even though the government agencies currently have fewer partners working in primary prevention, than treatment and intervention of sexual violence, the following indicates Connecticut has a strong network of partners.

The Rape Prevention and Education (RPE) Program is currently housed under the Family Health Section of the Public Health Initiatives Branch of the Connecticut Public

Health Department. The RPE program is funded by the Centers for Disease Control and Prevention. DPH is the lead coordinator/authority for overseeing the implementation of the state plan. DPH contracts with the Connecticut Sexual Assault Crisis Services, Inc. (CONNSACS), who subcontracts with four rape crisis centers. The DPH reviews the RPE Guidance Document and shares necessary information with group members, and participates in ongoing CDC conferences and webinars to inform and guide the group process**.**

The Department of Public Health (DPH) contracted with the Consultation Center, Department of Psychiatry, and Yale University School of Medicine, to examine intimate partner violence, including sexual assault and domestic violence as a public health issue and to define best practice protocols engaging men and boys in developing comprehensive strategies towards building healthy relationships and enhancing primary prevention efforts. The result was the development of a booklet entitled *Building Healthy Relationships: Engaging Men in Prevention Strategies to End Sexual Assault and Intimate Partner Violence*.

Connecticut General Statutes 54-250 through 54-261 mandate that the Connecticut Department of Public Safety establish and maintain a central registry of persons who have been convicted of certain sexual offenses and are required to register under the general statutes. The Governor signed a bill into law which increases penalties for child sex predators and establishes a new crime that requires a mandatory 25-year prison sentence for those who sexually abuse a child under 13. The legislation is referred to as "Jessica's Law" in memory of Jessica Lunsford, a 9-year-old Florida girl who was raped and killed by a repeat sex offender.

In July 2004 Public Act No. 04-121, An Act Concerning a Sexual Assault Victims Account went into effect. The result is that court-imposed fines on sexual assault offenders are deposited in a sexual assault victim account. The funds are granted to DPH for sexual assault crisis services.

The Department of Children and Families (DCF) trained social workers to investigate allegations of sexual abuse and provide services to the victim and offender when the offense is between family members and is substantiated. The agency also provides funded treatment programs and residential care for victims, and treatment services for youth who are incarcerated at Manson Youth Institution.

The Judicial Branch, Court Support Services Division, has established relationships with Yale University, the University of California, and the University of Connecticut to develop and implement risk reduction models in detention facilities, residential facilities and non-residential programs. This program also measures risk factors in the juvenile detention facilities.

The Judicial Branch, Office of Victim Services works with individuals who have suffered personal injuries during crimes and of violent crimes, as well as serving surviving family members of homicide victims. Services include:

- Crime victim compensation
- Court-based victim services advocates
- In-state toll-free helpline
- Victim notification
- Services for families of homicide victims
- Funding to community-based non-profit agencies
- Community education and training on victims' rights and service

The State Department of Education offers resources and guidance to local school districts in curriculum development, after school programs, parents/families and youth service bureaus.

The Governor's Task Force on Justice for Abused Children identified the need for greater coordination of agencies involved in the investigation, intervention and prosecution of child sexual abuse and serious physical abuse cases. Some members of the task force also sit on the SVPPC.

Local/Community Level Assets

The State's Sexual Assault Crisis Services, Inc. (CONNSACS) has 27 years experience in providing services to victims and families and promoting primary prevention programs. The mission of CONNSACS is to end sexual violence through victim assistance, community education, and public policy advocacy in Connecticut, which is consistent with the mission of the Sexual Violence Prevention Planning Committee. CONNSACS is a statewide coalition of individual sexual assault crisis programs. CONNSACS offers participation in collaborative efforts to promote social change with national, state and local organizations, procurement and distribution of funds to develop and support its member organizations, a forum for the exchange of skills and information regarding the response to and prevention of sexual assault, and a mechanism for the development and maintenance of appropriate standards of services for rape crisis centers. CONNSACS also offers presentations and trainings for statewide organizations and agencies.

CONNSACS provides statewide technical assistance for sexual violence prevention and intervention training for member centers. They have a strong statewide network and actively participate in and/or convene the following committees or commissions:

- Working Against Violence Everywhere (WAVE, formerly called the LGBTQ Sexual Assault & Domestic Violence Task Force)
- Interagency Task Force on Trafficking in Persons
- Juvenile Justice Advisory Committee
- Office of the Victim Advocate Advisory Board

- Criminal Justice Policy Advisory Commission
- Connecticut College Consortium Against Sexual Assault
- Sexual Assault Nurse Examiner/Sexual Assault Forensic Examiner (SANE/SAFE) Coalition
- University of Connecticut's Institute for Violence Prevention and Reduction
- Commission on the Standardization of the Collection of Evidence in Sexual Assault Investigations

Aetna Foundation's Children's Center has a staff of 15 psychologists, psychotherapists, family advocates, forensic interviewers, outreach workers and educators, specially trained sexual abuse examiner pediatricians and nurses to address sexual violence.

Barnaba Institute is a non-profit organization that raises awareness about human trafficking and sexual exploitation through lectures, workshops, media, law enforcement training and by reaching out with support and guidance to exploited and trafficked victims.

The Center for Women and Families of Eastern Fairfield County, Inc. (Bridgeport) provides: advocacy and crisis services to victims of sexual assault and domestic violence; clinical services geared toward children and their families; community education for schools, businesses, and other community members; a multi-disciplinary investigative team; and services to women in the York Correctional Institution who are being released back to the community.

The Connecticut Coalition Against Domestic Violence has a strong membership statewide and is part of a nationwide coalition. CCADV is comprised of 18 programs throughout the state, providing services to victims of domestic violence. Their services are confidential and available to all individuals regardless of age, race, religion, sexual preference, class, or physical ability. They offer safety planning, advocacy, information, referrals, counseling, support groups and emergency shelter.

The Connecticut Chapter of the National Organization of Sisters of Color Ending Sexual Assault (SCESA) received a federal grant from the Office of Violence Against Women in the amount of $400,000 in 2007 to provide technical assistance to culturally specific organizations and programs for, improving delivery of culturally appropriate and linguistically relevant victim services and skill development. SCESA is a nonprofit organization dedicated to creating a just society in which women of color are able to live healthy lives free of violence.

The Consultation Center of Yale University, School of Medicine, has a long history in working with men arrested for intimate partner violence and with fathers who are at risk to commit violent acts. They collaborate with the Department of Children and Families and the Department of Social Services to serve individuals exposed to personal and family violence.

Rape Crisis Center of Milford is solely a rape crisis center providing: crisis intervention; advocacy; information/referral; and other support to victims of sexual

assault. In addition, the center provides community education to schools, police, and other community organizations.

Safe Haven of Greater Waterbury focuses on services to victims of sexual assault and domestic violence, which include: crisis intervention; emergency shelter; counseling; advocacy; and information/referral. The center also maintains the Southbury Community Thrift Shop, which helps to support services at Safe Haven's Southbury satellite office.

Sexual Assault Crisis and Education Center (Stamford), solely a rape crisis center, provides: crisis intervention; counseling; advocacy; information/referral; and other support to sexual assault victims. The center also provides community education to schools, community groups, parents, and professionals.

Sexual Assault Crisis Center of Eastern Connecticut (Willimantic) is solely a rape crisis center and provides: crisis intervention; counseling; advocacy; information/referral; and other support to sexual assault victims. The center also provides prevention and education programs to schools, parents, and professionals.

Sneha, Inc., a South Asian women's local organization serves women and families from India, Pakistan, Sri Lanka, Nepal, Burma and Afghanistan in their native languages and within their cultural contexts.

Susan B. Anthony Project (Torrington) provides: sexual assault crisis services; domestic violence services; transitional living assistance; STRIVE (Seeking To Realize Independent Values and Esteem) program; and community education and outreach. Transitional living assistance is offered to previously sheltered families, and STRIVE supports women in transition.

Women's Center of Greater Danbury focuses on services to victims of sexual assault and domestic violence, which include: crisis intervention; emergency shelter; counseling; advocacy; and information/referral. In addition, community education and training are provided to a wide range of audiences.

Women and Families Center (Meriden) provides: sexual assault crisis services; primary prevention education; child care and education programs; Project REACH (Reaching Every Adolescent to Create Hope); SAIR*Corps (Support, Awareness, Information and Referral*Corps); and Open DOHR (Developing Opportunities in Human Resources. Project R.E.A.C.H. is dedicated to providing services that empower youth (ages 12 – 21) to make choices in the best interest of their safety, wellbeing, and future selves. Open DOHR is an employment and training program serving low-income men, women, and youth.

YWCA of New Britain Sexual Assault Crisis Services provides: infant and toddler child care; Family Support Network; education and professional services; sexual assault crisis services; STRIVE (Strength, Teamwork, Respect, Individuals, Vision, Excellence); performing arts program; and fitness and health program. Education

and professional services include certified nursing assistant training, family literacy, and firefighter training programs. STRIVE is an after-school development program serving girls in grades 6-8 in New Britain Public Schools.

Barriers, Challenges, and Gaps in Prevention Services

The collective experience of the SVPPC concluded that sexual violence remains a sensitive issue that community groups struggle to discuss in open forums. Difficulty bringing the cause and prevention of sexual assault and violence into the public arena prevents local communities from viewing sexual violence awareness and prevention as a priority. Thus, community engagement in prevention activities has been limited to those communities that are "ready" to address the issue. However, readiness may or may not correlate with other factors and conditions that would suggest the importance of intervening in a particular community. Furthermore, primary prevention needs to target the universal or general population to be truly effective. The ultimate goal is the development of healthy, interdependent relationships, and a higher level of functioning than reducing risk alone.

The Planning Committee does not have the capacity to conduct a comprehensive evaluation assessment. Of those who completed the survey of state and local programming, conducting evaluation activities were not consistently reported. Moving forward, the Toolkit & Resource Guide provides generic evaluation tools to allow for evaluation data to be compared across programming. Currently the only funding source available to address primary prevention of sexual violence is through CDC's RPE Cooperative Agreement. State funding supports the Connecticut Sexual Assault Crisis Services and its member centers, however, funding issues remain uncertain today with the state facing unprecedented deficits.

A related challenge is securing the financial resources, expertise, and technical assistance necessary to effectively evaluate both victimization and perpetration with a focus on primary prevention programs. As demonstrated in listing state and local assets, programs by far focus on victims of sexual violence and known perpetrators. For the SVPPC to move in the direction of primary prevention in both areas, a consultant to help guide programmatic activities and their evaluation is seen as being beneficial. The use of a consultant during the development of the plan fostered open and objective discussions and a sense of "shared" ownership and commitment to the final plan. Most of the agencies and organizations represented on the SVPPC are not involved in primary prevention of sexual violence. In addition, they do not receive funding to provide sexual violence prevention as their primary focus, therefore their participation on the committee is voluntary. The plan supports the transitional move toward primary prevention efforts, in that, agencies have to work within their limited budgets. The SVPPC is a way to pool efforts, but it does not offer infrastructure support to the implementation and evaluation process of the strategic plan.

Cultural norms and attitudes have a tendency to accept relatively high levels of coercion and emotional/verbal abuse from partners as normal. The constant messaging in media, community/public reinforcement, peer pressure and other venues encourage violent

behavior and the use violence as a means to gain power and control over others. Cultural norms in the United States support the use of violence by tolerating sexism, racism, blaming the victim and holding onto misconceptions regarding sex, consent, and relationships. These deeply ingrained social beliefs are very difficult to confront and to break. Ending sexual violence requires significant socio-cultural change at the individual, interpersonal, community, and societal levels. Workforce diversity reflecting the diversity of target populations is also an issue for health and human service organizations across the state and will need to be considered with intervention planning.

Available data that links demographic information to the prevalence of sexual violence has been included in the plan, however, this is incomplete. The SVPPC is in the process of identifying other potential sources of data. Prevention and program planning cannot be data-driven at this point because of very limited evaluation on primary prevention activities and seemingly fewer partners working in the area of primary prevention. Suggestions to increase data capacity include: PRATS (Pregnancy Risk Assessment Tracking System) data, agency data on sexual violence, CT sex offender registry, youth intake date, and youth disclosure data (from trainings/programs).

The SVPPC could not determine what capacity the state has to address violence prevention at this time, as the committee did not have the resource to conduct a comprehensive assessment of the state. Capacity to address sexual violence needs to be conducted within the current financial, administrative and personnel level of resources dedicated to prevention. If funding levels change, goals and objectives may be modified. Committee members however, have committed to move their members toward primary prevention activities. The roles of members are identified in the work plan under responsibility for each action item.

V. STRATEGIC PLAN AND PREVENTION STRATEGIES

Vision Statement: *Connecticut Communities-Healthy, Safe, and Free of Sexual Violence*

Mission Statement: *Prevent sexual violence by promoting positive individual, relationship, community, and societal attitudes and behaviors*

Target Populations

The primary prevention of sexual violence from a public health perspective focuses on preventing first-time perpetration and first-time victimization. To facilitate this approach, the SVPPC identified and addressed the needs of the selected populations. These populations are classified into two separate categories: universal and selected populations. Two subcommittees were formed to address the universal population and the selected population. Professional experiences and literature reviews guided the subcommittees' decision-making processes.

A *universal* population is a population within a state or community that is defined without regard to individual risk for sexual violence perpetration or victimization. A universal population may include individuals with elevated risk for experiencing sexual violence, individuals at lower risk for experiencing sexual violence, as well as individuals who have already experienced or perpetrated sexual violence. The universal population selected by SVPPC includes all residents of Connecticut.

A *selected* population is a group or population within a universal population that is defined by increased risk for experiencing or perpetrating sexual violence based on one or more modifiable risk factors. For our selected population, SVPPC focuses on youth in Connecticut, including young children, adolescents, and college students.

Primary prevention initiatives are directed toward the public at large (universal), particularly young people, in developing pro-social attitudes and behavior, believing in gender equity, and learning how to develop and maintain healthy personal and social relationships. Addressing these issues is accomplished in Goal 1 of the work plan.

Risk factors for selected populations focus on social norms that directly or indirectly support sexual violence. The work plan describes in Goal 2 antiviolence training for risk groups and professional training to intervene with such social norms.

Sexual Violence Prevention Plan Goals, 2009-2017

The Connecticut Sexual Violence Prevention Plan adopts a comprehensive approach to preventing sexual violence. The prevention plan goals were created to reduce incidence of first-time sexual violence perpetration particularly among youth by promoting primary prevention training activities for both RPE and NON- RPE programs. RPE-funded trainings were designed to focus on reducing the risk factors associated with sexual

violence perpetration. The aim to change behaviors and norms through educational sessions is achieved by providing information and examples via various media, facilitating discussion, and using exercises to engage the participants in key topics. Depending upon the educational session, topics include: qualities of and behaviors to support healthy, respectful, equality-based relationships; gender roles, gender stereotypes, and their impact; identifying and managing emotions; identifying and addressing bullying/harassment; relationship rights and responsibilities; consent, including role of alcohol; respectful communication; responsibility of perpetrator versus victim; bystander intervention; societal, media, and cultural messages and impact; critical thinking skills; gender-based violence; linking language to violence; power and control in relationships. The non RPE-funded trainings were designed to educate providers and partners so they are prepared to disseminate primary prevention messages to target audiences.

Listed below are the goals, strategies, and objectives of the strategic plan. The full plan begins on page 47.

Goal 1: To promote healthy relationships and sexual violence prevention across Connecticut (UNIVERSAL POPULATION).

Strategy: Promoting community education through information and resources that encourage healthy relationships and sexual violence prevention.

Objectives:

1) Children and adolescents will demonstrate a 20%-25% increase in their understanding of gender equality and pro-social knowledge, attitudes, and behaviors towards the primary prevention of first-time sexual violence perpetration.

2) Each of the four RPE funded centers will conduct primary prevention education for children and adolescents in one new town annually from 2011-2017.

3) Parents/caregivers in three new towns will receive sexual violence primary prevention education and training by June 30, 2010.

4) Revise and modify training curricula that are used for professionals, until 75% of training curricula content contains primary prevention information for selected professional groups (e.g., teachers and social workers).

5) Education and training in the primary prevention of sexual violence will be literacy level appropriate, culturally and linguistically responsive.

Goal 2: To reduce the incidence of first time perpetration of sexual violence among youth (SELECTED POPULATION).

Strategy: Reaching groups of people with information and resources to promote healthy relationships and the prevention of sexual violence.

Objectives:

1) Youth in high risk populations will experience a 20%-25% increase in their understanding of gender equity and pro-social knowledge, attitudes, and behaviors towards the primary prevention of first-time sexual violence perpetration.

2) Multi-session training events for universal and selected audiences will increase until a minimum of 75% of all primary prevention training provided are multi-sessions.

3) Target, without segregating, populations at higher risk to be victimized (e.g., children with disabilities, youth in foster care and independent living, LGBTQI) to participate in programs that are designed to meet their needs and offer protective strategies and safety measures.

4) Colleges and universities will promote gender equity, mutual respect, violence prevention strategies and safety measures through a collaborative effort between the SVPPC and the College Consortium.

5) Professionals working with children and adolescents in high risk communities will receive sexual violence prevention training annually and at least three new community locations will be added by 2012.

Goal 3: To increase capacity to prevent sexual violence.

Strategy: Informing providers who will transmit skills and knowledge to others.

Objectives:

1) Increase annual primary prevention social marketing events from three to six, including one statewide SVPPC sponsored event (e.g., Walk/Run event) by 2015.

2) Develop a comprehensive training inventory and toolkit by mid-2010 that is updated a biennial basis.

3) RPE funded member centers will model programmatic environments that promote gender equity and the intolerance of gender discrimination.

Goal 4: To increase the capacity to collect, analyze, interpret, disseminate and use information about sexual violence to improve prevention efforts.

Strategy: Develop a mechanism for centralize reporting of statewide sexual violence prevention activity.

Objectives:

1) Eighty percent of the SVPPC members in programmatic roles (including RPE funded centers) will collect and submit data and/or progress reports to DPH.

2) Monitor existing data collection repositories related to sexual violence to target high risk communities in the prevention of first time perpetration.

3) Statewide implementation of the Sexual Violence Safe Zone Program.

4) Evaluate the implementation process and effectiveness of the strategic plan.

Goal 5: To advance policies, legislation, and partnerships that promote healthy relationships, reduce the incidence of first-time perpetration, and increase capacity to prevent sexual violence and improve prevention efforts.

Strategy: Developing strategies to change laws and policies to influence outcomes.

Objectives:

1) Support and encourage key legislation that promotes the primary prevention of sexual violence.

STRATEGIC PLAN

Goal 1: To promote healthy relationships and the prevention of sexual violence across Connecticut (UNIVERSAL POPULATION).
Strategy: Promoting community education through information and resources that encourage healthy relationships and sexual violence prevention.

Objectives	Activities	Outcomes	Evaluation	Time Frame	Organization Responsible
1.1 Children and adolescents will demonstrate a 20-25% increase in their understanding of gender equality and pro-social knowledge, attitudes, and behaviors towards the primary prevention of first-time sexual violence perpetration.	A. CONNSACS will provide training and support to RPE funded centers to effectively implement gender equity programming. CONNSACS will convene and facilitate quarterly technical assistance meetings to monitor curriculum implementation and evaluation. CONNSACS will monitor resources regarding best practices and effective primary prevention strategies of sexual violence and share with SVPPC.	A. Audience demonstrates a 20-25% increase in knowledge over eight years. RPE funded centers share information quarterly regarding primary prevention curriculum efforts to strengthen post evaluation results. CONNSACS disseminates (quarterly) RPE funded center primary prevention progress information to SVPPC for their use.	A. Schewe-informed survey tools are utilized to evaluate prevention curricula. CONNSACS compiles, analyzes, and reports the primary prevention progress information.	2009-2017	CONNSACS Prevention & Training Coordinator

Objectives	Activities	Outcomes	Evaluation	Time Frame	Organization Responsible
	B. RPE funded centers will annually provide gender equity/ pro-social training events for approximately 550-600 children and adolescents in grades K-12. Standard curricula elements (i.e. learning objectives, content, methods of instruction, evaluation) will be incorporated into all training programs, while being culturally and linguistically responsive to the audience's needs.	B. Approximately 550-600 children and adolescents participate annually in healthy relationships and gender equity curricula promoting the likelihood of adopting pro-social behavior. By 2017 all training programs will include standard curricula elements based on the *SVPPC Toolkit & Resource Guide*, Training Components page 16.	B. Pre & post test scores and other evaluation strategies will be calculated for each curriculum by grade level and compared.	2009-2017	RPE funded programs CONNSACS Prevention & Training Coordinator Community Partners
1.2 Each of the four RPE funded centers will conduct primary prevention education for children and adolescents in one new town annually from 2011 to 2017.	A. Each RPE funded center will conduct targeted outreach to towns that historically have not requested/permitted primary prevention education in their public schools.	A. In approximately 24 new towns children and adolescents will participate in healthy relationships and gender equity curricula increasing their knowledge by 20-25% over six years.	A. RPE funded member centers report statistical information to CONNSACS by the types of training provided, target audiences and their locations. Pre & post-test scores and results of other evaluation tools, will be	2011-2017	CONNSACS Prevention & Training Coordinator Community Partner

Objectives	Activities	Outcomes	Evaluation	Time Frame	Organization Responsible
			analyzed annually for each curriculum by grade level.		
1.3 Parents and caregivers in three new towns will receive sexual violence primary prevention education and training By June 30, 2010.	A. A task force within the SVPPC will be created to select, plan and implement extended parent trainings. SVPPC members will provide primary prevention training to parents/caregivers in the seven towns they are currently serving. CONNSACS will provide primary prevention training to parents/caregivers in the 15 towns they are currently serving.	A. SVPPC members will annually train approximately 100 new parents/caregivers to promote gender equity and mutual respect in the home. RPE funded centers will annually train approximately 70-100 parents/caregivers to promote gender equity and mutual respect in the home.	A. Parent Satisfaction Survey results and data from standardized bi-annual reporting will identify primary prevention strategies, primary prevention content, challenges and successes associated with programs/trainings. Parent Satisfaction Survey and Trainer Program Evaluation data will be collected and analyzed to improve programming.	2009-2011	SVPPC Educational & Training Task Force CONNSACS
1.4 Revise and modify training curricula that are used for professionals until 75% of training curricula	A. RPE funded centers will identify one professional group to receive primary prevention training each year.	A. Each RPE funded center annually presents the revised or new primary prevention training to their targeted professional group.	A. CONNSACS conducts annual site visits and reviews new and/or significantly revised member center primary prevention curricula for approval prior to its implementation.	2009-2015	RPE funded member centers and CONNSACS

Objectives	Activities	Outcomes	Evaluation	Time Frame	Organization Responsible
content contains primary prevention information for selected professional groups (e.g. teachers and social workers).	The existing training curriculum for selected professional groups will be modified so the content is 75% primary prevention; or a new training curriculum will be developed that fully meets the 75% primary prevention content standard.	By 2015, all trainings for professional groups will be primary prevention focused. (At least 70% of the content focuses on addressing perpetrator risk factors; no more than 5% will describe sexual assault services and no more than 25% will address victimization.)			
1.5 Education and training in the primary prevention of sexual violence will be literacy level appropriate, culturally and linguistically responsive.	A. Recommendations and guidance on developing culturally and linguistically appropriate materials will be posted on DPH website/SVPPC page. SVPPC members will submit their pilot-tested and translated materials to the committee coordinator.	A. The DPH will select and post education and training materials that are in accordance with health literacy standards of practice as described in the *SVPPC Toolkit & Resource Guide*, Training Components page 24.	A. New education and training materials will be pilot tested by consumer groups prior to their implementation and/or dissemination.	2009-2017	SVPPC Members DPH

Objectives	Activities	Outcomes	Evaluation	Time Frame	Organization Responsible
	Materials in other languages will be made available as needs and resources emerge. New materials will be available as resources allow (e.g. audio, CDs, MP3s, pod-casts, links to websites, etc).				
	B. SVPPC members will collaborate with community partners and law enforcement officials to incorporate changing technology issues and responsible social networking in training.	B. Educational and training programs will be reviewed annually to reflect changing technologies that may cause children, adolescents and young adults to be vulnerable to sexual abuse or violence.	B. New technologies that may increase vulnerability will be shared during quarterly meetings and documented in the minutes.	2009-2017	DPH and law enforcement officials

GOAL 2: To reduce the incidence of first-time perpetration of sexual violence among youth (SELECTED POPULATION).

Strategy: Reaching groups of people with information and resources to promote healthy relationships and the prevention of sexual violence.

Objectives	Activities	Outcomes	Evaluation	Time Frame	Organization Responsible
2.1 Youth in high risk populations will experience a 20%-25% increase in their understanding of gender equity and pro-social knowledge, attitudes, and behaviors towards the primary prevention of first-time sexual violence perpetration.	A. RPE funded programs will annually provide 755 anti-violence training events for children and adolescents in grades K-12. Standard curricula elements (i.e. learning objectives, content, methods, evaluation) will be incorporated into all training programs, while being culturally and linguistically responsive to the audience's needs.	A. Audience demonstrates a 20-25% increase in knowledge over eight years. Curricula activities are modified based on pre & post test scores and student and teacher feedback.	A. Pre & post test scores and results of other evaluation tools, will be analyzed annually for each curriculum by grade level.	2009-2017	RPE funded programs CONNSACS Prevention and Training Coordinator Community Partners
	B. The Good Lives Model will be implemented for juvenile and young adult offenders in preparation for community re-entry. *The Good Lives Model	B. Every year, 10 juvenile and young adult offenders will be better prepared to develop appropriate intimate relationships, pro-social friendships,	B. Exit research/ interview. Actuarial Risk Assessment on young adult offenders.	2010-2017	Correctional Managed Health Care / Department of Corrections

Objectives	Activities	Outcomes	Evaluation	Time Frame	Organization Responsible
	is a rehabilitation model utilizing a strength-based approach that seeks to secure primary goods (goals) in socially meaningful ways. It provides a systematic and comprehensive framework for intervening therapeutically with sexual offenders of all types, [lxii]	and appropriate bystander actions.			
	C. Activities will be designed to encourage young people to engage voluntarily in mental health programs while incarcerated.	C. 10 inmates of the Manson Youth Institution will voluntarily register and complete mental health programming annually.	C. Monitor and report voluntary registration for mental health programs, program slots available, and completion/dropout rates.	2010-2017	Correctional Managed Health Care/ Department of Correction
2.2 Multi-session training events for universal and selected audiences will increase until a minimum of 75% of all primary prevention training provided are multi-	A. RPE funded centers will target the same audiences for multi-session training events at least 75% of the time by 2015.	A. By 2017, a minimum of 75% of all primary prevention training events provided are multi-sessions.	A. RPE funded centers report statistical information to CONNSACS by the types of training provided and the audiences reached. CONNSACS will review educational materials, implementation	2010-2017	RPE funded Member Centers CONNSACS Prevention & Training Coordinator

Objectives	Activities	Outcomes	Evaluation	Time Frame	Organization Responsible
sessions.			strategies, and barriers annually.		
2.3 Target, without segregating, populations at higher risk to be victimized (e.g. children with disabilities, youth in foster care and independent living, LGBTQI) to participate in programs that are designed to meet their needs and offer protective strategies and safety measures.	A. SVPPC members, in collaboration with advocacy groups, will design and implement targeted safety and violence prevention programs for populations at high risk for victimization.	A. 10-25% of training curricula content will address violence prevention for populations at high risk for victimization.	A. Standardized bi-annual reporting will track training curricula content.	2009-2017	SVPPC Members
2.4 Colleges and universities will promote gender equity, mutual respect, violence prevention strategies and safety measures through a	A. SVPPC members will appoint a liaison to participate on the College Consortium whose mission is to prevent sexual violence on campuses. Students will receive violence prevention	A. SVPPC liaison will attend at least 75% of the College Consortium meetings and report to the SVPPC. College Consortium and SVPPC annually	A. Evaluation strategies will be designed according to the types of activities that will be implemented.	2009-2017	SVPPC College Consortium Liaison SVPPC

Objectives	Activities	Outcomes	Evaluation	Time Frame	Organization Responsible
collaborative effort between SVPPC and the College Consortium.	messages and safety recommendations through multimedia dissemination.	conduct one violence prevention multimedia campaign on college campuses.			
	B. A pilot program will be developed and implemented with Wesleyan University Public Safety Officers that includes a program for students and training of the Sexual Assault Response Team to recognize signs of dating violence.	B. Students and the Sexual Assault Response Team participating in the program will be able to identify signs of dating violence. Sexual Assault Response Teams are culturally and linguistically responsive.	B. Standardized biannual reports on the types of training and content messaging will be provided to SVPPC. Evaluation strategies will be designed according to the types of activities that will be presented on college campuses.	2009-2017	CONNSACS
2.5 Professionals working with children and adolescents in high risk communities will receive sexual violence prevention training annually and at least three new community locations will be	A. CONNSACS will provide train-the-trainer training in primary prevention for SVPPC committee members.	A. SVPPC committee members will understand the 9 core principles of primary prevention and how to incorporate them into prevention education and training by Dec. 2012.	A. Participant evaluations will be used to rate knowledge and skill level in terms of understanding and implementing the 9 core principles of primary prevention. Professional training events and evaluation results will be reported and discussed at a	2012	CONNSACS

Objectives	Activities	Outcomes	Evaluation	Time Frame	Organization Responsible
added by 2012.			SVPPC meeting.		
	B. SVPPC members will train juvenile justice review board members, DCF social workers, and other juvenile justice professionals on primary prevention and the recognition of sexual abuse and violence.	B. Juvenile justice professional groups receive standardized training in the primary prevention of sexual violence in six locations across the state by Dec. 2012.	B. Professional training events and evaluation results will be reported biannually to DPH.	2010-2012	DCF Committee Representative SVPPC Committee Members
	C. SVPPC members will develop stronger relationships with law enforcement training departments and multi-disciplinary boards to implement and co-facilitate sexual violence prevention training. Two - three SVPPC members will be certified by the Connecticut Police Officer Standards and Training (POST) Council to enable more in-house law enforcement training.	C. Each POST trained SVPPC member will conduct one sexual violence primary prevention training annually for law enforcement (may include: gender roles and stereotypes, as a primary prevention strategy to increase awareness of their ability to role model, in addition to their intervention focused roles).	C. Professional training events and evaluation results will be reported biannually to DPH.	2010-2017	SVPPC Education and Training Task Force

Objectives	Activities	Outcomes	Evaluation	Time Frame	Organization Responsible
	D. A pilot training program will be developed and implemented with Hartford DCF-mandated reporters that address primary prevention of victimization and perpetration.	D. DCF Mandatory Reporter Training Curriculum that addresses sexual violence primary prevention will be submitted to the DCF director of training and education.	D. The proposed DCF Mandatory Reporter Training Curriculum is taken under consideration by DCF. Professional training events and evaluation results will be reported biannually to DPH.	2010-2015	SVPPC members DCF Committee Representative

GOAL 3: To increase capacity to prevent sexual violence.

Strategy: Informing providers who will transmit skills and knowledge to others.

Objectives	Activities	Outcomes	Evaluation	Time Frame	Organization Responsible
3.1 Increase annual primary prevention social marketing events from three to six, including one annual statewide SVPPC sponsored event (e.g. Walk/Run event) by 2015.	A. The Center for Women & Families (RPE-funded center in Bridgeport) will coordinate the White Ribbon Campaign. SVPPC members will discuss and promote Sexual Assault Awareness Month (SAAM) events annually. Opportunities for new initiatives will be reviewed and discussed during statewide SVPPC meetings and conference calls.	A. Community awareness events occur six times a year with an annually sponsored event coordinated by the SVPPC members.	A. SVPPC will review the planning, implementation and outcome of each project during committee meetings. Recommendations for future events will be documented in the committee's record of minutes.	2010-2015	The Center for Women & Families SVPPC

Objectives	Activities	Outcomes	Evaluation	Time Frame	Organization Responsible
3.2 Develop a comprehensive training inventory and toolkit by mid-2010 that is updated on a biennial basis.	A. Toolkit content will consist of SVPPC information, including member list and trainings offered (promotional packet). Inventory of sexual violence educational & training programs for children, youth and young adults, parents/caregivers, and the professional community will be listed. A description of each training program (e.g. target audience, mode of instruction, materials needed) will be provided. Resource guide and toolkit will be updated on a biennial basis.	A. Educational and training program inventory and experts in the field of prevention are identified with contact information in *SVPPC Toolkit & Resource Guide*.	A. Published and linked to DPH and CONNSACS websites.	June 2010	SVPPC members

Objectives	Activities	Outcomes	Evaluation	Time Frame	Organization Responsible
3.3 CONNSACS and RPE funded centers will model programmatic environments that promote gender equity and the intolerance of gender discrimination.	A. RPE funded centers will model and demonstrate how to work toward an environment that promotes and reinforces equity and safety across groups of people.	A. RPE funded centers practice and promote intolerance of discrimination in the workplace.	A. CONNSACS conducts annual site visits and reviews policies and practices of the RPE-funded centers.	2009-2017	CONNSACS

GOAL 4: To increase the capacity to collect, analyze, interpret, disseminate and use information about sexual violence to improve prevention efforts.

Strategy: Develop a mechanism for centralized reporting of statewide sexual violence prevention activity.

Objectives	Activities	Outcomes	Evaluation	Time Frame	Responsible Organization
4.1 Eighty percent of the SVPPC members in programmatic roles (including RPE funded centers) will collect and submit data and/or progress reports to the DPH.	A. SVPPC members will compile and submit bi-annual reporting documents as required by DPH. (RPE funded centers report to CONNSACS who compiles the data and then forwards to DPH.)	A. Decision-making and priorities established will be based on data.	DPH has the data needed to complete state and federal reports.	2010-2017	SVPPC members DPH
	B. DPH will research and compile data on at risk populations (e.g. elderly receiving home care, institutionalized elderly, adults with disabilities, adult inmates, adult LBGTQI, etc.).	The DPH will present to the SVPPC new findings about at risk populations on an annual basis or as needed.	SVPPC members report using data to support their programmatic decisions.	2010-2017	DPH

Objectives	Activities	Outcomes	Evaluation	Time Frame	Responsible Organization
4.2 Monitor existing data collection repositories related to sexual violence to target high-risk communities in the prevention of first time perpetration.	A. Existing surveillance program data will be monitored and assessed for potential risk and protective factors that could be used by sexual violence primary prevention programs. Demographic trends will be followed to prepare educational programs and materials for cultural, linguistic and literacy responsiveness.	A. DPH will present to the SVPPC new findings from existing data repositories as needed.	SVPPC members report using data to base their decisions.	2009-2017	DPH Data & Surveillance Task Force
4.3 Statewide implementation of the Sexual Violence Safe Zone Program.	A. SVPPC members will search for funding to implement the safe zone program. SVPPC members will collaborate with CONNSACS to recruit	A. Funding for implementation of the Sexual Violence Safe Zone Program is secured. By 2017, the Sexual Violence Safe Zone will have the support of 200 individuals and/or organizations.	A. Safe Zone sites, once implemented, will be monitored for activity, including number of those seeking safety and those asking for more information and training workshops.	2011-2017	Lead Grant Applicant, TBD SVPPC

Objectives	Activities	Outcomes	Evaluation	Time Frame	Responsible Organization
	at least 200 individuals and organizations to display the safe zone sticker.				
4.4 Evaluate the implementation process and effectiveness of the strategic plan.	A. SVPPC meeting agendas will reflect the strategic plan and include a review of the previous reports.	A. Modifications will be made to the plan based on trends and resources.	A. SVPPC members evaluate and modify the strategic plan annually.	2009-2017	DPH SVPPC members

GOAL 5: To advance policies, legislation and partnerships that promote healthy relationships, reduce the incidence of first-time perpetration, and increase capacity to prevent sexual violence and improve prevention efforts.

Strategy: Developing strategies to change laws and policies to influence outcomes.

Objectives	Activities	Outcomes	Evaluation	Time Frame	Organization Responsible
5.1 Support and encourage key legislation that promotes the primary prevention of sexual violence.	A. Legislative activities will be monitored and action will be taken as needed.	SVPPC members will be informed of proposed legislation related to the prevention of sexual violence.	A. Review impact of SVPPC member actions (i.e. contacts with legislature) related to proposed legislation.	2010-2017	SVPPC Members

CONNECTICUT'S SEXUAL VIOLENCE PRIMARY PREVENTION PLAN
LOGIC MODEL FOR RPE FUNDED ACTIVITIES

Inputs: Centers for Disease Control and Prevention funding for primary rape prevention activities, CDC Staff for Technical Assistance, SVPPC Members, Committee Leadership, CONNSACS, other Community Partners, Department of Public Health, Socio-Ecological Model, Social-Cognitive Theory.

Needed Capacity: Stabilized funding resources, Community Engagement and Readiness, Program Evaluation Resources, Increase SVPPC membership

ACTIVITIES/STRATEGIES	OUTPUTS	SHORT TERM OUTCOMES	LONG TERM OUTCOMES
Implement and evaluate anti-violence curricula; healthy relationships curricula, risk reduction curricula and public awareness curricula.	RPE funded organizations engage in statewide educational activities.	Curricula activities will be modified based on pre and post-test scores and student feedback.	Increased pro-social knowledge, attitudes and behavior among Connecticut youth.
Provide multi-session primary prevention curricula to strengthen individual knowledge and skills.	Increased use of multi-session primary prevention curricula.	Increased number of multi-sessions will be provided.	Improved knowledge, attitudes and skills related to sexual violence prevention.
Engage community partners in collaborative efforts to influence organizational practices.	Increased participation of community partners to advance the Sexual Violence Prevention Plan.	Increased knowledge of Sexual Violence Education Prevention opportunities.	Increased implementation of new organizational practices.
Increase information sharing and technical guidance among SVPPC.	Continued focus and emphasis on primary prevention.	Achievements and successes in primary prevention efforts will be shared by SVPPC members	Strategies will be implemented consistently across state in a culturally and linguistically competent manner.
Promote and reinforce primary prevention efforts by providing community and professional education.	Sexual Violence Primary prevention education will be provided to the public and targeted professionals.	Target populations are better prepared to develop appropriate pro-social interpersonal relationships.	Primary sexual violence prevention has broad based support in the community.

ACTIVITIES/STRATEGIES	OUTPUTS	SHORT TERM OUTCOMES	LONG TERM OUTCOMES
Outreach to legislature.	Sponsors in Assembly, Senate and Governor's support.	Influence policy and legislation.	Policy and legislative changes.
Create and disseminate sexual violence prevention materials.	Tool kit and resource guide and other educational materials.	Materials are accessible on the CONNSACS website.	Increased awareness and access to resources.
Evaluation: Explore potential resources to assist with evaluation of the impact of the sexual violence prevention plan.			

CONNECTICUT'S SEXUAL VIOLENCE PRIMARY PREVENTION PLAN
LOGIC MODEL FOR NON RPE FUNDED ACTIVITIES

Inputs: SVPPC Members, Committee Leadership, CONNSACS, other Community Partners, Department of Public Health, Socio-Ecological Model, Social-Cognitive Theory.

Needed Capacity: Stabilized funding resources, Community Engagement, Increase SVPPC membership, Government Support, Program Evaluation Resources

ACTIVITIES/STRATEGIES	OUTPUTS	SHORT TERM OUTCOMES	LONG TERM OUTCOMES
Research and share best practices, successes, and evidence based curricula.	Providers will implement primary prevention programs to different audiences.	Curricula activities will be modified based on pre and post-test scores and participant satisfaction.	Improved knowledge, attitudes and skills related to sexual violence prevention statewide.
Outreach to high-risk populations.	Provide prevention education activities for high-risk populations.	Increased pro-social knowledge and behavior.	Prevent sexual violence.
Outreach to legislature	Sponsor in the Assembly, Senate, and Governor's support	Influence policy and legislation	Policy and legislative changes.
Create and disseminate sexual violence prevention materials.	Tool kit and resource guide and other educational materials	Materials are accessible on designated web site.	Increased awareness and access to resources.
Engage community partners in prevention activities.	Collaborate with communities to support primary prevention activities.	Communities receive information that is culturally and linguistically appropriate to increase readiness to reduce sexual violence.	Reduced sexual violence.

Evaluation: Explore potential resources to assist with evaluation of the impact of the sexual violence prevention plan.

Summary and Recommendations

Under the directive of the Centers for Disease Control and Prevention (CDC), a working Sexual Violence Prevention Planning Committee (SVPPC) was formed by Connecticut Department of Public Health to develop a strategic plan for the next eight years. Connecticut Sexual Assault Crisis Services (CONNSACS), its nine community-based rape crisis programs (four RPE funded), and numerous other agencies addressing gender equality, sexual health, victim services, and punishment/intervention for offenders participated in the planning process. The work plan of the strategic planning document reflects the complimentary goals and activities of the SVPPC. Responsibilities are designated between RPE funded programs and SVPPC members (the committee as a whole).

The capacity to address primary prevention is based on the strength and commitment of the SVPPC. DPH in partnership with the SVPPC will implement and monitor the plan.

The first step toward the implementation of the strategic plan is to address the leadership and governance for the strategic plan's intervention:

- *Expand membership to include agencies with similar program goals or activities.*
- *Decide on committee leadership roles and responsibilities.*
- *Establish Ad Hoc committees to take on specific projects/objectives and identify experts to participate on the corresponding goal area.*
- *Create and reach consensus on the bi-annual reporting form to be used by SVPPC members to monitor progress.*
- *Identify potential resources or partners to assist with the evaluation of the impact of the Sexual Violence Prevention Plan.*

The recommendations made in this report are based on a thorough review of the literature, organizational and staff professional experience, and an estimate of the scope of work that is considered reasonable by the SVPPC members. The financial status of organizations represented on the SVPPC committee may need to be taken into consideration as the strategic plan is implemented and modified over the next eight years.

APPENDIX A

Definitions of Commonly Used Terms

Child Sexual Abuse: Forced, tricked, bribed, blackmailed, or coerced sexual behavior between a child and another child, a young person, or an adult.

Consent: Words or overt actions by a person who is legally or functionally competent to give informed approval, indicating a freely given agreement to have sexual intercourse or sexual contact.

Disability: Describes how people live with their health condition: body functions and structures, activities and participation.

Inability to Consent: A freely given agreement to have sexual intercourse or sexual contact could not occur because of age, illness, disability, being asleep, or the influence of alcohol or other drugs.

Inability to Refuse: Disagreement to have sexual intercourse or sexual contact was precluded because of the use of guns or other non-bodily weapons, or due to physical violence, threats of physical violence, real or perceived coercion, intimidation or pressure, or misuse of authority.

Intimate Partner Violence (IPV): Is abuse that occurs between two people in a close relationship. The term “intimate partner” includes current and former spouses and dating partners. IPV exits along a continuum from a single episode of violence to ongoing battering.

Perpetrator: Person who inflicts the sexual violence

Protective Factors: Factors that may lessen the likelihood of sexual violence victimization or perpetration by buffering against risk.

Risk Factors: Factors associated with a greater likelihood of sexual violence perpetration. They are contributing factors and may or may not be direct causes.

Sexual Abuse: Is forcing a partner to take part in a sex act when the partner does not consent.

Sex Act (or Sexual Act): Contact between the penis and the vulva or the penis and the anus involving penetration, however slight; contact between the mouth and the penis, vulva, or anus; or penetration of the anal or genital opening of another person by a hand, finger, or other object.

Sexual Violence: Nonconsensual completed or attempted contact between the penis and the vulva or the penis and the anus involving penetration, however slight; nonconsensual contact between the mouth and the penis, vulva, or anus; nonconsensual penetration of the anal or genital opening of another person by a hand, finger, or other object; nonconsensual intentional touching, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or buttocks; or nonconsensual non-contact acts of a sexual nature such as voyeurism and verbal or behavioral sexual harassment. All the above acts also qualify as sexual violence if they are committed against someone who is unable to consent or refuse.

Victim: Person on whom the sexual violence is inflicted. Survivor is often used as a synonym for victim.

APPENDIX B

TABLE 11. Percentage of high school students who experienced dating violence* and who were ever physically forced to have sexual intercourse,† by sex, race/ethnicity, and grade — United States, Youth Risk Behavior Survey, 2007

	Dating violence						Forced to have sexual intercourse					
	Female		Male		Total		Female		Male		Total	
Category	%	CI§	%	CI	%	CI	%	CI	%	CI	%	CI
Race/Ethnicity												
White¶	7.4	6.1–9.1	9.3	7.6–11.4	**8.4**	**7.2–9.9**	11.0	9.4–12.7	3.2	2.3–4.3	**7.0**	**6.1–8.2**
Black¶	13.2	11.5–15.2	15.2	12.5–18.2	**14.2**	**12.6–15.9**	13.3	10.3–17.1	7.8	6.3–9.6	**10.5**	**8.8–12.5**
Hispanic	10.1	8.2–12.5	12.0	9.8–14.6	**11.1**	**9.5–12.9**	11.4	9.3–13.8	6.2	4.8–7.9	**8.8**	**7.3–10.4**
Grade												
9	6.3	4.8–8.2	10.5	8.6–12.7	**8.5**	**7.3–9.8**	9.2	7.3–11.5	4.1	3.1–5.4	**6.6**	**5.4–7.9**
10	8.8	6.6–11.5	9.1	7.5–10.9	**8.9**	**7.4–10.7**	13.1	10.6–16.0	3.4	2.5–4.7	**8.2**	**6.6–10.0**
11	10.2	8.7–12.0	10.8	8.5–13.5	**10.6**	**9.2–12.2**	12.0	9.8–14.5	5.0	3.9–6.5	**8.5**	**7.2–10.0**
12	10.1	8.3–12.2	14.1	11.8–16.7	**12.1**	**10.6–13.8**	10.9	9.2–12.8	5.7	4.3–7.5	**8.3**	**7.3–9.5**
Total	**8.8**	**7.6–10.3**	**11.0**	**9.7–12.4**	**9.9**	**8.9–11.1**	**11.3**	**9.9–12.8**	**4.5**	**3.8–5.3**	**7.8**	**7.0–8.8**

* Hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend during the 12 months before the survey.
† When they did not want to.
§ 95% confidence interval.
¶ Non-Hispanic.

APPENDIX C

ED encounters for sexual violence in CT: FYs 1998 - 2007 (aggregated)

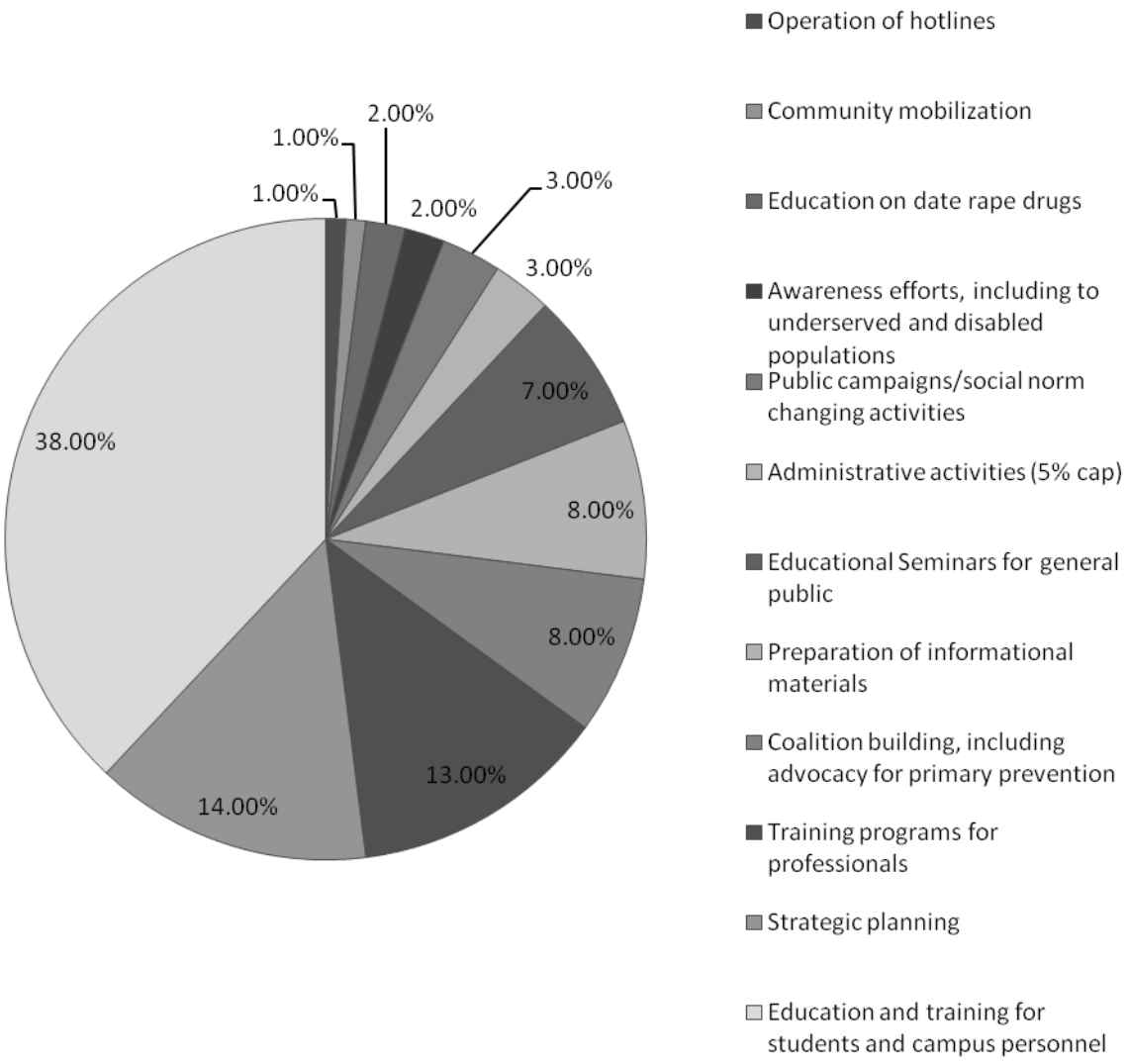
Age Groups	Female	%	Male	%	Total	%
<15	2,473	32.6	467	62.4	2,940	35.3
15 - 18	1,606	21.2	72	9.6	1,678	20.2
19 - 24	1,470	19.4	66	8.8	1,536	18.4
25 - 44	1,657	21.9	106	14.2	1,763	21.2
45 - 64	301	4	30	4	331	4
65+	71	0.9	7	0.9	78	0.9
<18	3,645	48.1	522	69.8	4,167	50
18+	3,933	51.9	226	30.2	4,159	50
18 - 64	3,862	51	219	29.3	4,081	49
65+	71	0.9	7	0.9	78	0.9
All Ages	7,578		748		8,326	

Source: *CT Hospital Association Chime Data Inc. Emergency Room Database*

Discharges assigned at least one of the ICD-9-CM codes V71.5 (exam after alleged rape), E960.1 (rape), 995.53 (child sexual abuse) and 995.83 (adult sexual abuse).

APPENDIX D

RPE Funded Center Budget Allocations



APPENDIX E

SVPPC Bi-annual Reporting Form

*Please note that this is an abridged and unformatted version of the reporting tool. The actual reporting form is available for SVPPC members online.

Reporting Period:

- October through March (Due May 30th) or
- April through September (Due November 30th)

Contact Information:

- Organization/Taskforce:
- Contact Person:
- Email Address:
- Phone Number:

Goal/Objective Reporting:

Please report on each of the objectives you have been working on this reporting period.

- Goal:
- Objective:
- Please identify the activity (or activities) you have worked for this objective. Describe what was done (e.g., what was presented, the outcome, etc) for each activity:
- Briefly describe any successes and/or challenges you encountered while working on the listed activity(activities):

Trainings and Educational Programs Reporting:

Please enter the information, as appropriate, for each training or educational program conducted by your organization, since you last submitted a report to the SVPPC.

- Training Program Name:
- Please provide a brief description of the training/program (including activities conducted and strategies used):
- Target Audience:
- Total number of times training/program was offered:
- Total number served (unduplicated):
- Where was this training/program held? Please list all cities/towns:

- Most of the time, this program/training was: Single Session or Multi-session
- Is this training/program theory driven?
    - Yes or
    - No
- If yes, please specify the theoretical justification to the best of your ability:
- Is this training/program evaluated?
    - Yes or
    - No
- If yes, please specify how (e.g., pre/post test, focus group, satisfaction survey, etc):
- Is this training/program currently culturally and linguistically responsive to audience member needs?
    - Yes or
    - No
- If yes, please specify how (e.g., the program is offered in Spanish, the program can be changed to address the needs of people with disabilities, etc.)
- To the best of your ability, indicate what percentage of the training/program focuses on each level of prevention.
    - % Primary Prevention
    - % Secondary Prevention
    - % Tertiary Prevention
- Describe any successes and/or challenges you encountered during training/program implementation.
- Please describe any technical assistance needs you may have.

APPENDIX F

STATE PROFILE

State: Connecticut

Source of data: American Community Survey U.S. Census Bureau Year: 2006

Community type: Urban _X__ Rural ____ Suburban __X_ Other _____

Geographic size of description: 703 Persons Per/ Square mile; US 80 Persons Per/ Square Mile

Total population

Unemployment rate:	6.2%
Per capita income:	$34,048
Families below poverty level (%):	8.3%

Age distribution in years

Age	%	No.
0-14	19.0%	665,698
15-24	13.5%	471,600
25-64	54.1%	1,897,046
≥ 65	13.4%	470,465
Total population:		3,504,809

(23% under 18)

Type of households

Married –couple families	51%
Other Families	16%
People Living Alone	27%
Other Non-family Households	5%

Annual household income

Amount	%	No.
< $15,000:	5.2%	46,723
$15,000-$24,999:	5.7%	50,757
$25,000-$49,999:	18.0%	160,836
$50,000+:	71.1%	636,032

Marital status*

			No. by sex	
	%	No.	Male	Female
Single:	31.0%	879,704	465,858	413,846
Married:	51.4%	1,459,339	732,500	726,839
Separated:	1.6%	44,462	16,944	27,518
Widowed:	6.4%	181,942	37,595	144,347
Divorced:	9.6%	273,664	112,482	161,182
	Total:	2,839,111	1,365,379	1,473,732

* Includes persons 15 years of age and older.

Racial / ethnic composition

	No.	%
White:	2,610,863	74.5%
Black:	321,569	9.2%
Hispanic*:	391,935	11.2%
American Indian+:	6,493	.2%
Asian#:	117,236	3.3%
Other:	13,958	.4%
2 or more Races	42,755	1.2%

* Includes both blacks and whites. +Or Alaska Native. #Or Pacific Islander.

Education

Number of person currently enrolled:

Nursery/ Preschool	59,849
Kindergarten	45,312
Elementary school (1-8)	372,025
High school	207,214
College	249,417

Educational achievement (% of adults who completed):

Elementary school plus 3 years high school		12%
High school		30%
College:	Some - No Degree	17%
	Associate's Degree	7%
	Bachelor's Degree	19%
	Graduate/Professional Degree	14%

(88% High School Degree or higher)

APPENDIX G

LETTERS OF SUPPORT

CONN SACS

Connecticut Sexual Assault Crisis Services, Inc.

96 Pitkin Street
East Hartford, CT 06108
Phone/TTY: 860-282-9881
Fax: 860-291-9335
www.connsacs.org

June 17, 2009

Ms. Regina Owusu, RN., BSN., MPH
Program Coordinator
Rape Prevention and Education
Department of Public Health
410 Capitol Avenue
PO Box 340308, MS#11MAT
Hartford, CT 06134-0308

Dear Ms. Owusu:

I am pleased to offer my support of the statewide sexual violence prevention plan developed by the Sexual Violence Prevention Planning Committee (SVPPC).

Connecticut Sexual Assault Crisis Services, Inc. (CONNSACS) is a statewide coalition of individual, community-based sexual assault crisis programs. CONNSACS' mission is to end sexual violence and to ensure high quality, comprehensive, and culturally competent sexual assault victim services. CONNSACS works to end sexual violence and address its impact through victim assistance, primary prevention education, and public policy advocacy.

CONNSACS has served as an active member of the SVPPC. The statewide sexual violence prevention plan will help to enhance existing efforts and promote new collaborations. The plan and the work of the SVPPC also reinforce the ideas that sexual violence can be prevented and that preventing sexual violence is a shared responsibility.

Sincerely,

Nancy Kushins
Executive Director

Women's Center
of Southeastern
Connecticut Inc.

Administration:
16 Jay Street
New London, CT
06320-5910

860.447.0366

Fax 860.440.3327

www.womenscenterofsect.org

January 11, 2010

J. Robert Galvin, MD, MPH, MBA
Commissioner
State of Connecticut Department of Public Health
410 Capitol Avenue
P.O. Box 340308
Hartford, CT 06134-0308

Dear Commissioner Galvin:

It is our pleasure to write this letter of support on behalf of Connecticut's Sexual Violence Prevention Planning Committee in its pursuit of promoting primary prevention efforts in order to prevent first time perpetration and victimization of sexual violence in Connecticut. We join this Committee's vision of creating Connecticut communities that are healthy, safe, and free of sexual violence.

We agree that the public health approach, that has successfully been utilized to mitigate other health issues, is the model utilized in the primary prevention of sexual violence. Sexual violence is a serious public health issue with numerous health and cost ramifications. Encouraging community mobilization and partnerships to create healthy relationships and social norms change is a challenging but stellar goal that we are passionate about being a part of.

As vested partners in Connecticut, we recognize the importance of reinforcing sexual violence primary prevention social messaging, training, and education. Planning and utilizing primary prevention initiatives to the public at large, and targeting youth, will certainly help move us toward the development of pro social attitudes and behavior, gender equity, and healthy relationships. Primary prevention also supports those who may have an increased risk of victimization.

We look forward to continued partnership with the Sexual Violence Prevention Planning Committee to carry out the goals of the Sexual Violence Prevention Plan. Thank you for the opportunity to assist in the coordination of primary prevention activities across the state.

Sincerely,

Catherine Zeiner
Executive Director
Women's Center of Southeastern CT

THE CENTER FOR WOMEN AND FAMILIES

January 11, 2010

J. Robert Galvin, MD, MPH, MBA
Commissioner
State of Connecticut Department of Public Health
410 Capitol Avenue
P.O. Box 340308
Hartford, CT 06134-0308

Dear Commissioner Galvin:

It is our pleasure to write this letter of support on behalf of Connecticut's Sexual Violence Prevention Planning Committee in its pursuit of promoting primary prevention efforts in order to prevent first time perpetration and victimization of sexual violence in Connecticut. We join this Committee's vision of creating Connecticut communities that are healthy, safe, and free of sexual violence.

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We look forward to continued partnership with the Sexual Violence Prevention Planning Committee to carry out the goals of the Sexual Violence Prevention Plan. Thank you for the opportunity to assist in the coordination of primary prevention activities across the state.

Sincerely,

Debra Greenwood
CEO & President

WOMEN & FAMILIES CENTER
Serving Connecticut families for over 100 years

January 12, 2010

J. Robert Galvin, MD, MPH, MBA
Commissioner
State of Connecticut Department of Public Health
410 Capitol Avenue
P.O. Box 340308
Hartford, CT 06134-0308

Dear Commissioner Galvin:

It is our pleasure to write this letter of support on behalf of Connecticut's Sexual Violence Prevention Planning Committee in its pursuit of promoting primary prevention efforts in order to prevent first time perpetration and victimization of sexual violence in Connecticut. We join this Committee's vision of creating Connecticut communities that are healthy, safe, and free of sexual violence.

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We look forward to continued partnership with the Sexual Violence Prevention Planning Committee to carry out the goals of the Sexual Violence Prevention Plan. Thank you for the opportunity to assist in the coordination of primary prevention activities across the state.

Sincerely,

Robyn-Jay Bage, M.P.A
Chief Executive Officer
Women and Families Center

Southeastern Regional Action Council
620 Norwich/NL Tpke
Uncasville, CT 06382
Ph. 860-848-2800
Fax 860-848-2801

January 12, 2010

J. Robert Galvin, MD, MPH, MBA
Commissioner
State of Connecticut Department of Public Health
410 Capitol Avenue
P.O. Box 340308
Hartford, CT 06134-0308

Dear Commissioner Galvin:

It is our pleasure to write this letter of support on behalf of Connecticut's Sexual Violence Prevention Planning Committee in its pursuit of promoting primary prevention efforts in order to prevent first time perpetration and victimization of sexual violence in Connecticut. We join this Committee's vision of creating Connecticut communities that are healthy, safe, and free of sexual violence.

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We look forward to continued partnership with the Sexual Violence Prevention Planning Committee to carry out the goals of the Sexual Violence Prevention Plan. Thank you for the opportunity to assist in the coordination of primary prevention activities across the state.

Sincerely,

Michele Devine

Michele Devine
Executive Director
Southeastern Regional Action Council

The Bridge
Eleanor House
367 Fairfield Ave., Hartford, CT 06114 • (860) 956-8845 • Fax (860) 956-8854

1/13/10

J. Robert Galvin, MD, MPH, MBA
Commissioner
State of Connecticut Department of Public Health
410 Capitol Avenue
P.O. Box 340308
Hartford, CT 06134-0308

Dear Commissioner Galvin:

It is our pleasure to write this letter of support on behalf of Connecticut's Sexual Violence Prevention Planning Committee in its pursuit of promoting primary prevention efforts in order to prevent first time perpetration and victimization of sexual violence in Connecticut. We join this Committee's vision of creating Connecticut communities that are healthy, safe, and free of sexual violence.

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As vested partners in Connecticut, we recognize the importance of reinforcing sexual violence primary prevention social messaging, training, and education. Planning and utilizing primary prevention initiatives to the public at large, and targeting youth, will certainly help move us toward the development of pro social attitudes and behavior, gender equity, and healthy relationships. Primary prevention also supports those who may have an increased risk of victimization.

We look forward to continued partnership with the Sexual Violence Prevention Planning Committee to carry out the goals of the Sexual Violence Prevention Plan. Thank you for the opportunity to assist in the coordination of primary prevention activities across the state.

Sincerely,

Marji Vitale, Psy.D.
Program Director, The Bridge Family Center, Inc.

Connecticut Children's
MEDICAL CENTER

January 15, 2010

J. Robert Galvin, MD, MPH, MBA
Commissioner
State of Connecticut Department of Public Health
410 Capitol Avenue
P.O. Box 340308
Hartford, CT 06134-0308

Dear Commissioner Galvin:

We support the Connecticut's Sexual Violence Prevention Planning Committee in its pursuit of promoting primary prevention efforts in Connecticut. We join this Committee's vision of creating Connecticut communities that are healthy, safe, and free of sexual violence.

Sexual violence is a serious public health issue with numerous health and cost ramifications. Encouraging community mobilization and partnerships to create healthy relationships and social norms change is a challenging goal but one that can be achieved working together.

We recognize the importance of reinforcing sexual violence primary prevention social messaging, training, and education. Planning and utilizing primary prevention initiatives to the public at large, and targeting youth, will certainly help move us toward the development of pro social attitudes and behavior, gender equity, and healthy relationships.

We look forward to continued partnership with the Sexual Violence Prevention Planning Committee to carry out the goals of the Sexual Violence Prevention Plan. Thank you for the opportunity to assist in the coordination of primary prevention activities across the state.

Sincerely,

Kevin Borrup, JD, MPA
Senior Program Manager, Injury Prevention Center
Tel. (860) 545-9984

STATE OF CONNECTICUT
DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES
A Healthcare Service Agency

M. JODI RELL
GOVERNOR

PATRICIA A. REHMER, MSN
COMMISSIONER

January 11, 2010

J. Robert Galvin, MD, MPH, MBA
Commissioner
State of Connecticut Department of Public Health
410 Capitol Avenue
P.O. Box 340308
Hartford, CT 06134-0308

Dear Commissioner Galvin:

It is our pleasure to write this letter of support on behalf of Connecticut's Sexual Violence Prevention Planning Committee in its pursuit of promoting primary prevention efforts in order to prevent first time perpetration and victimization of sexual violence in Connecticut. We join this Committee's vision of creating Connecticut communities that are healthy, safe, and free of sexual violence.

We agree that the public health approach, that has successfully been utilized to mitigate other health issues, is the model utilized in the primary prevention of sexual violence. Sexual violence is a serious public health issue with numerous health and cost ramifications. Encouraging community mobilization and partnerships to create healthy relationships and social norms change is a challenging but stellar goal that we are passionate about being a part of.

As vested partners in Connecticut, we recognize the importance of reinforcing sexual violence primary prevention social messaging, training, and education. Planning and utilizing primary prevention initiatives to the public at large, and targeting youth, will certainly help move us toward the development of pro social attitudes and behavior, gender equity, and healthy relationships. Primary prevention also supports those who may have an increased risk of victimization.

We look forward to continued partnership with the Sexual Violence Prevention Planning Committee to carry out the goals of the Sexual Violence Prevention Plan. Thank you for the opportunity to assist in the coordination of primary prevention activities across the state. Please feel free to contact Karen Ohrenberger of my staff at (860)418-6900 should you have any questions.

Sincerely,

Patricia A. Rehmer, MSN
Commissioner

(AC 860) 418-7000
410 Capitol Avenue, P.O. Box 341431, Hartford, Connecticut 06134
www.dmhas.state.ct.us
An Equal Opportunity Employer

STATE OF CONNECTICUT

DEPARTMENT OF EDUCATION

January 14, 2010

J. Robert Galvin, MD, MPH, MBA
Commissioner
State of Connecticut Department of Public Health
410 Capitol Avenue
P.O. Box 340308
Hartford, CT 06134-0308

Dear Commissioner Galvin:

It is our pleasure to write this letter of support on behalf of Connecticut's Sexual Violence Prevention Planning Committee in its pursuit of promoting primary prevention efforts in order to prevent first time perpetration and victimization of sexual violence in Connecticut. We join this Committee's vision of creating Connecticut communities that are healthy, safe, and free of sexual violence.

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We look forward to continued partnership with the Sexual Violence Prevention Planning Committee. Thank you for the opportunity to assist in the coordination of primary prevention activities across the state.

Sincerely,

Bonnie J. Edmondson

Bonnie J. Edmondson, Ed.D.
Education Consultant

DEPARTMENT of CHILDREN and FAMILIES
Making a Difference for Children, Families and Communities

Susan I. Hamilton, M.S.W., J.D.
Commissioner

M. Jodi Rell
Governor

Date 1/13/09

J. Robert Galvin, MD, MPH, MBA
Commissioner
State of Connecticut Department of Public Health
410 Capitol Avenue
P.O. Box 340308
Hartford, CT 06134-0308

Dear Commissioner Galvin:

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We look forward to continued partnership with the Sexual Violence Prevention Planning Committee to carry out the goals of the Sexual Violence Prevention Plan. Thank you for the opportunity to assist in the coordination of primary prevention activities across the state.

Sincerely,
Duckworth Grange
Duckworth Grange, SWS Adolescent/Juvenile Justice Unit
Hartford Area Office

STATE OF CONNECTICUT
Phone (860) 418-8000 • Fax (860) 418-8327
250 Hamilton Street, Hartford, Connecticut 06106-2910
www.state.ct.us/dcf
An Equal Opportunity Employer

PREVENTING DISEASE, ILLNESS AND INJURY

Ledge Light
Health District

January 12, 2010

J. Robert Galvin, MD, MPH, MBA
Commissioner
State of Connecticut Department of Public Health
410 Capitol Avenue
P.O. Box 340308
Hartford, CT 06134-0308

Dear Commissioner Galvin:

It is our pleasure to write this letter of support on behalf of Connecticut's Sexual Violence Prevention Planning Committee in its pursuit of promoting primary prevention efforts in order to prevent first time perpetration and victimization of sexual violence in Connecticut. We join this Committee's vision of creating Connecticut communities that are healthy, safe, and free of sexual violence.

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We look forward to continued partnership with the Sexual Violence Prevention Planning Committee to carry out the goals of the Sexual Violence Prevention Plan. Thank you for the opportunity to assist in the coordination of primary prevention activities across the state.

Sincerely,

Baker Salsbury, Director of Health, Ledge Light Health District

943 North Road • Groton, Connecticut 06340 • phone. 860.448.4882 • fax. 860.448.4885 • www.ledgelighthd.org

Administrative Headquarters
345 Whitney Avenue
New Haven, CT 06511
203.865.5158

111 Point Street
Providence, RI 02903
401.421.7820

www.ppsne.org

Planned Parenthood®
of Southern New England, Inc.

Serving Connecticut & Rhode Island

January 12, 2010

J. Robert Galvin, MD, MPH, MBA
Commissioner
State of Connecticut Department of Public Health
410 Capitol Avenue
P.O. Box 340308
Hartford, CT 06134-0308

Dear Commissioner Galvin:

I am writing to express Planned Parenthood of Southern New England's support for the Sexual Violence Prevention Planning Committee efforts to prevent first time perpetration and victimization of sexual violence in Connecticut. PPSNE shares the Committee's vision of creating Connecticut communities that are healthy, safe, and free of sexual violence. PPSNE has had a representative on the committee since its inception and is committed to continuing to participate in this important work.

In particular, we support the strategic plan that the committee has recently completed and agree that the public health approach, which has been utilized successfully to mitigate other health issues, is the best model for primary prevention of sexual violence.

PPSNE is the state's largest provider of reproductive health care and the region's leading sexuality educator. PPSNE operates 19 health centers in Connecticut and Rhode Island and provides clinical services to about 70,000 women, men and teens each year. We reach another 11,000 people—parents, young people, social workers, teachers-- through our community education and professional development programs.

Through our work in reproductive health, we know first hand that sexual violence is a serious public health issue with numerous health and cost ramifications. Encouraging community mobilization and partnerships to create healthy relationships and social norms change is a challenging but stellar goal that we are passionate about being a part of. We also know from experience that families

and communities that are better able to openly and honestly discuss issues related to sexuality are better able to prevent sexual violence. For this reason, we applaud the committee's commitment to promoting programs that increase communication between parents and children and that encourage schools to offer comprehensive sex ed.

We look forward to continued partnership with the Sexual Violence Prevention Planning Committee to carry out the goals of the Sexual Violence Prevention Plan. Thank you for the opportunity to assist in the coordination of primary prevention activities across the state.

Sincerely,

Judy Tabar

Judy Tabar
President & CEO
Planned Parenthood of Southern New England

NARAL
Pro-Choice Connecticut

January 13, 2010

J. Robert Galvin, MD, MPH, MBA
Commissioner
State of Connecticut Department of Public Health
410 Capitol Avenue
P.O. Box 340308
Hartford, CT 06134-0308

Dear Commissioner Galvin:

NARAL Pro-Choice Connecticut is pleased to write this letter of support on behalf of Connecticut's Sexual Violence Prevention Planning Committee in its pursuit of promoting primary prevention efforts in order to prevent first time perpetration and victimization of sexual violence in Connecticut. We join this Committee's vision of creating Connecticut communities that are healthy, safe, and free of sexual violence.

We agree that the public health approach, that has successfully been utilized to mitigate other health issues, is the model utilized in the primary prevention of sexual violence. Sexual violence is a serious public health issue with numerous health and cost ramifications. Encouraging community mobilization and partnerships to create healthy relationships and social norms change is a challenging but stellar goal that we are passionate about being a part of.

As vested partners in Connecticut, NARAL Pro-Choice Connecticut recognizes the importance of reinforcing sexual violence primary prevention social messaging, training, and education. Planning and utilizing primary prevention initiatives to the public at large, and targeting youth, will certainly help move us toward the development of pro social attitudes and behavior, gender equity, and healthy relationships. Primary prevention also supports those who may have an increased risk of victimization.

NARAL Pro-Choice Connecticut looks forward to continued partnership with the Sexual Violence Prevention Planning Committee to carry out the goals of the Sexual Violence Prevention Plan. Thank you for the opportunity to assist in the coordination of primary prevention activities across the state.

Sincerely,

Jillian Gilchrest, MSW
Executive Director
NARAL Pro-Choice Connecticut

References

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