

New Jersey
Sexual Violence Primary Prevention Plan



August 2009

Submitted by the State Prevention Team
via
New Jersey Department of Community Affairs
New Jersey Department of Health and Senior Services



State of New Jersey
DEPARTMENT OF COMMUNITY AFFAIRS
101 SOUTH BROAD STREET
PO Box 800
TRENTON, NJ 08625-0800

JON S. CORZINE
Governor

CHARLES A. RICHMAN
Acting Commissioner

Ms. Karen Lang, Project Officer
National Center for Injury Prevention and Control
4770 Buford Highway, NE Mailstop K-60
Atlanta, GA 30341

August 13, 2009

Dear Ms. Lang:

The New Jersey Department of Community Affairs (DCA) is pleased to express its support of the state's Sexual Violence Primary Prevention Plan. This plan represents a continued joint endeavor between this department, the New Jersey Department of Health and Senior Services (DHSS) and the New Jersey Coalition Against Sexual Assault (NJCASA). These three entities have been the co-leaders for the State Prevention Team, which has prepared this plan for the State of New Jersey.

DCA is committed to prevention efforts that make our state safer for all people. In 1992, the Office on the Prevention of Violence Against Women was established by Executive Order and placed in DCA's Division on Women. In 1996, DCA accepted programmatic and administrative responsibility for the Rape Prevention and Education Program. DCA is also the host agency of other programs that provide support to victims and victim service provider such as the Address Confidentiality Program, Women's Shelter Grants Program and the Domestic Violence Fatality and Near Fatality Review Board.

DCA is particularly proud of New Jersey's current designation as an EMPOWER state. New Jersey takes seriously its role as a leader in this endeavor and is poised to continue its successful efforts in partnering with stakeholders such as the New Jersey Coalition Against Sexual Assault and its member programs as well as other government and non-government partners who have committed their resources to prioritizing sexual violence primary prevention. These partners have joined DCA as part of the State Prevention Team of the EMPOWER project and DCA intends to provide the necessary leadership to continue the project into its next phase.

We look forward to working with our partners in New Jersey and the Center for Disease Control and Prevention on the continued progress of New Jersey's planning, capacity building and evaluation regarding sexual violence primary prevention.

Sincerely,

Charles A. Richman
Acting Commissioner





State of New Jersey

DEPARTMENT OF HEALTH AND SENIOR SERVICES

PO BOX 360

TRENTON, N.J. 08625-0360

JON S. CORZINE
Governor

www.nj.gov/health

HEATHER HOWARD
Commissioner

June 30, 2009

Ms. Karen Lang, Project Officer
National Center for Injury Prevention and Control
4770 Buford Highway, NE Mailstop K-60
Atlanta, GA 30341

Re: Funding Opportunity Number CDC-RFA-CE09-902

Dear Ms. Lang:

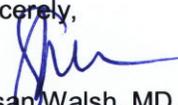
The New Jersey Department of Health and Senior Services (NJDHSS) is pleased to partner with the New Jersey Department of Community Affairs (DCA) for the continuation of New Jersey's work in planning, capacity building and evaluation regarding the primary prevention of sexual violence through the State Sexual Violence Primary Prevention Plan (see enclosure).

Sexual violence is viewed by NJDHSS as a public health issue, and to that end, the Department is uniquely situated to bring a public health perspective to the discussion on primary prevention. The Department sees the continued work toward the development of a comprehensive, statewide rape prevention plan focused on primary prevention strategies as being essential to addressing the goals of Healthy People 2010, which are to reduce rape, attempted rape and other forms of sexual violence. New Jersey's ultimate goal is to eliminate sexual violence.

As the legislated administrator of the Preventive Health and Health Services Block (PHHSB) Grant and the Rape Prevention and Education (RPE) Grant, the NJDHSS has an established track record in working on sexual violence. The Department also participates in the Attorney General's Violence Against Women Act (VAWA) Advisory Committee, and recently piloted the Intimate Partner Violence and Sexual Violence Modules for the Behavioral Risk Factor Surveillance System.

We look forward to working with the Centers for Disease Control and Prevention toward continuing to build a sexual violence primary prevention program planning, implementation and evaluation model in New Jersey.

Sincerely,


Susan Walsh, MD, FACP
Deputy Commissioner

Enclosure

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Executive Summary

Over the last few years, New Jersey has embarked on a new direction in the area of primary prevention of sexual violence. For the first time, there is a concerted effort to look at ways to end sexual violence perpetration before it begins rather than to solely focus on interventions for victimization. The Centers for Disease Control and Prevention, National Center for Injury Prevention and Control (NCIPC) selected New Jersey as one of six (6) pilot sites for the EMPOWER (Enhancing and Making Programs and Outcomes Work to End Rape) Project. The goal was to build New Jersey's capacity to conduct comprehensive planning, implementation and evaluation of sexual violence prevention efforts. This project, with shared leadership from the New Jersey Departments of Community Affairs and Health and Senior Services, and the New Jersey Coalition Against Sexual Assault, has been underway since 2005. Since primary prevention of sexual violence is in its infancy as a field, this project has required intensive, long term capacity building for planning, including the establishment of new collaborations of state level and local partners, and preparation for intensive research and evaluation of final plan goals and strategies.

The purpose of this plan is to document both the planning process and the final decisions made by the Prevention and Public Education Committee (PPEC) of the Governor's Advisory County Against Sexual Violence (GACSV), also referred to as the State Prevention Team (SPT).

When New Jersey was selected as an EMPOWER state, the PPEC was identified to serve as the SPT for the project. A State Capacity Building Team (SCBT) of four members was created to serve as the steering committee for the SPT. An Empowerment Evaluator was hired as the fifth member of the SCBT and to coach both groups through the EMPOWER Project. The SPT was expanded to include many stakeholders of likely and unlikely partners throughout the state.

One of the initial tasks of the SPT was to develop a vision statement:

In New Jersey all individuals will be free of the threat, fear or acts of sexual violence in all its forms.

Additionally, the SPT agreed on an expanded definition of sexual violence which included prostitution and pornography as forms of sexual violence.

Using the *Getting To Outcomes* (GTO) framework, the SPT completed a needs and resources assessment for New Jersey including a review of current prevention methods, the magnitude of sexual violence, identified risk and protective factors and system capacity issues. This information informed the decisions of the SPT as it embarked on goal setting and strategy selection for implementation of those goals.

The work of the SPT revealed that there was limited data available to make an accurate assessment of the magnitude of sexual violence as well as limited funding and system capacity for primary prevention work. In fact, there were limited number of strategies being implemented anywhere that have been evaluated to show a decrease in perpetration. The SPT responded to that information by moving forward in this ground breaking work and setting the following goals:

State and Community Level Norms Change Goals:

- **Create and market social norms in New Jersey that promote gender equity and respect for women and girls by reducing rigid sexual stereotypes and**
- **Increase bystander intervention along the continuum of sexual violence behaviors among middle school, high school, and college communities.**

State Level Policy Change/Systems Advocacy Goals:

- **Create and implement institutional and agency strategies that prevent the perpetration of sexual violence against people with developmental disabilities and inmates of correctional facilities.**
- **Identify and support delivery systems that would increase parental/caregiver attachment and increase empathy skills in children.**
- **Increase opportunities for healthy community connectedness for young males (middle, high school and college level) who have been exposed to family violence.**

State Capacity Goals: Improve Funding, Data and Sexual Violence Provider System Capacity

- **Increase funding available for sexual violence prevention strategies, data collection and system capacity upgrades and minimize negative financial impact on intervention activities**
- **Build a coordinated system for data collection and analysis in New Jersey**
- **Provide technical assistance and training to enable RPE funded SVP's to implement and sustain viable strategies for long term reduction and primary prevention of sexual violence in New Jersey.**
- **Develop a baseline and track changes for New Jersey on societal perceptions, norms and attitudes toward key risk factors of sexual violence.**

The SPT's intention in preparing a comprehensive primary prevention plan is that it will influence state, local, public and private efforts aimed at reducing the perpetration of sexual violence. The plan as it exists is focused on reducing risk factors for perpetration while simultaneously promoting protective factors.

The EMPOWER Project

The Centers for Disease Control and Prevention, National Center for Injury Prevention and Control (NCIPC) selected New Jersey as one of six (6) pilot sites for the EMPOWER (Enhancing and Making Programs and Outcomes Work to End Rape) Project. The goal was to build New Jersey's capacity to conduct comprehensive planning, implementation and evaluation of sexual violence prevention efforts. This project, administered by the New Jersey Department of Community Affairs' Division on Women, has been underway since 2005. Since primary prevention of sexual violence is in its infancy as a field, this project has required intensive, long term capacity building for planning, including the establishment of new collaborations of state level and local partners, and preparation for intensive research and evaluation of final plan goals and strategies.

Plan Contents

The purpose of this plan is to document both the planning process and the final decisions made by the Prevention and Public Education Committee (PPEC) of the Governor's Advisory County Against Sexual Violence (GACSV), also referred to as the State Prevention Team (SPT) for the purposes of the project. Since the planning process was iterative, there are sections that are time specific and others that were reviewed and revised several times along the way. The project used the CDC pilot *Getting To Outcomes* framework and the contents of this plan following Steps 1-6 of that 10 step framework. The narrative on each step is a summary of the process and capacity building tasks undertaken as well as decision points reached and revised along the way.

Pre-Planning – Establishing the State Prevention Team (Fall 2006)

The GACASV was established by Executive Order 40 in November of 2002 and held its first meeting in October 2003. As part of this Council, the PPEC was created in May 2004 with six GACASV members to address the Governor's charge to recommend solutions to prevent sexual violence. Major activities of the PPEC prior to involvement as the SPT for the EMPOWER Project included:

- increasing knowledge through participation in the University of North Carolina's PREVENT 2004 workshops and 2005 Institute about effective principles for primary prevention planning using a public health approach
- developing a mission statement for the PPEC, which was to "*...develop and promote a statewide strategic plan that focuses on primary prevention efforts that keep individuals from committing acts of sexual violence in New Jersey*"
- planning and conducting focus groups to identify community readiness for prevention activities and to identify community perceptions of risk factors of sexual violence
- conducting telephone interviews with other prevention providers to assess the size and scope of various primary prevention efforts in New Jersey

When New Jersey was selected as an EMPOWER state in 2005, the PPEC was identified to serve the SPT for the project. A State Capacity Building Team (SCBT) of four members was created to serve as the steering committee for the SPT. An Empowerment Evaluator was hired as the fifth member of the SCBT and to coach both groups through the EMPOWER Project.

With the help of the SCBT, seven new members were added to the SPT to assist in the creation of membership materials and processes for selecting additional members, and to ensure the SPT was representative of the stakeholders of New Jersey.

SPT Selection Process

The original thirteen members of the PPEC met over four months in 2006 to identify key current and future stakeholders in sexual violence prevention. It was determined that the core requirements for membership would be:

- A. dedication to a vision of a world free of sexual violence.
- B. dedication to helping shift the focus of prevention and education to primary prevention efforts aimed at keeping individuals from committing acts of violence.
- C. dedication to fostering collaborative relationships with diverse communities.
- D. commitment to a minimum two-year membership on the PPEC.
- E. regular attendance at monthly three to six-hour meetings generally held in Mercer County.
- F. notification to the PPEC Chair in advance if unable to participate in a scheduled meeting.
- G. commitment to completion of all related tasks, including reading, information analysis, and work on special projects.
- H. participation in the planning, implementation and evaluation capacity-building activities regarding primary prevention of sexual violence in New Jersey. Work to be done within the guidelines and models approved by the CDC for the EMPOWER Project, including Empowerment Evaluation principles within a *Getting to Outcomes* (GTO) framework.
- I. sharing of expertise and input from members' individual background and/or community/constituency to further the goals of the project and the work of the PPEC.
- J. discussion of relevant information from the PPEC with their community or constituency, as appropriate.
- K. commitment to respectful, constructive participation in all PPEC work honoring all participants' diverse and equally important voices.

SPT Representation

Member selection was carefully done to ensure that key constituencies would be represented on the SPT regardless of whether they had been active in the field of sexual violence prevention/intervention in the past. This included careful attention to adequate representation in the following areas:

- the state sexual violence coalition – New Jersey Coalition Against Sexual Assault (NJCASA)
- local Rape Prevention and Education Grant (RPE) funded Sexual Violence Programs (SVPs)
- other prevention fields (addictions, bullying, child abuse, etc.)
- colleges and universities
- offender treatment specialists
- racial/ethnic groups

- the lesbian, gay, bisexual and transgender (LGBT) community
- religious communities/faith-based providers of service
- immigrants
- key departments of state government (Health and Senior Services, Community Affairs, Law and Public Safety, Education, Children and Families, and Human Services)
- civic and business groups
- the media

A final prospect list of sixty five names was developed and calls were placed to each person introducing them to the work of the SPT and ascertaining their interest in joining. Over 50 people expressed interest and formal invitation packets to join the group were sent to each one. While at least half were expected to decline or not respond, over half of the Potential Member Profiles were returned. In 2006 the thirteen member SPT grew to a core group of thirty five members that researched and created this prevention plan.

SPT Process Notes

Empowerment Evaluation Principles

The Empowerment Evaluation (EE) principles are appended to each meeting agenda and members are asked to assess the group's adherence to these items at the end of each SPT meeting. The SCBT also reviews the list when creating the agenda for the meetings in order to ensure that the principles come alive in the discussions.

Member activity levels

- An average of twenty to twenty five members representing a variety of disciplines and backgrounds attended monthly SPT meetings from Nov. 2006 to April 2009. However, it was difficult to regularly engage members from the business community, the media and education although there were representatives from other agencies that work with schools on related prevention issues.
- There was consistent and strong participation from a variety of areas within New Jersey state government including: Department of Health and Senior Services; Department of Community Affairs; Department of Children and Families; Department of Human Services; New Jersey State Police; Administrative Office of the Courts; University of Medicine and Dentistry of New Jersey; and The College of New Jersey.
- NJCASA, the state sexual assault coalition was heavily involved in the planning process, including active participation on the SCBT and SPT, and regular attendance at CDC technical assistance trainings and conference calls.
- Private nonprofits were very active, including the New Jersey Association of Mental Health, Catholic Charities, New Jersey Coalition for Battered Women, Jewish Family Services, New Jersey School Boards Association and the New Jersey Association for Treatment of Sexual Abusers
- Two representatives from local RPE funded SVP's were regular members of the SPT. An additional 10 local SVP staff from around the state participated

as resource people on workgroups during the various steps of *Getting to Outcomes*.

- All SVP's, by invitation from the SCBT, attended special SPT trainings/presentations on the topics of Consent; Prostitution and Pornography; and Social Norms Marketing. This gave the two groups the opportunity to begin working collaboratively on the prevention of sexual violence.

Subcommittees

The only subcommittee of the SPT was the SCBT, which was made up of the key partners in the work. This included the Executive Director of NJCASA, the RPE Coordinator from DCA, the Supervisor of the Office on the Prevention of Violence Against Women from DCA and the Director of the Office on Women's Health from DHSS. The Empowerment Evaluator who was also a member of the SCBT acted in an advisory capacity.

The SCBT met monthly to plan upcoming SPT agendas, plan capacity building efforts, integrate workgroup efforts, and check progress on planning efforts. It also communicated regularly via e-mail to solve problems, address unexpected issues and check perceptions. The SCBT had a strong team focus and shared leadership of the group both through rotating meeting facilitation and sharing in the CDC's twice monthly EMPOWER Project conference calls. The group proved especially important in preparing for potentially difficult conversations at the SPT level. This pre-work ensured that the process stayed committed to the EE principles and did not veer off track.

The SCBT also included workgroup chairs/delegates at critical points in the process, including at the goal setting stage and later in the development of the final workplan. This "expanded" SCBT was also called during Step 3 of the GTO process in order to help devise a capacity building plan for working through this very labor intensive step in the process.

Workgroups

Task-based workgroups were used extensively in the planning process. Workgroups were given specific tasks in each step of the process, and workgroup membership changed based on the task at hand. SPT members volunteered to form the basis of each workgroup with additional resource people added as needed. *See GTO step descriptions for a listing of the various workgroups.*

Decision making

Most decision making was done using a consensus-based approach with discussion continuing until all members present felt comfortable with the direction/decision. However, this process was amended for the final discussion of the SPT's definition of sexual violence where full consensus was not achievable. It was agreed that the minimum level of approval be set at 80% of those present in order to be able to move ahead with the rest of the process.

Early discussions with SPT members made clear that the final plan would require the approval of the Governor's Advisory Council Against Sexual Violence.

Vision and Mission

The following vision was developed and approved at the December 2006 SPT-PPEC meeting:

In New Jersey all individuals will be free of the threat, fear or acts of sexual violence in all its forms

Process for Achieving Consensus on the Definition of Sexual Violence

Achieving full agreement on the definition of sexual violence presented a challenge and a learning opportunity. While the entire group was generally comfortable with the overall definition, there was initial reluctance to include pornography and prostitution as types of sexual violence.

The SCBT engaged nationally recognized speakers to assist the SPT in exploring these topics so that the group could make an informed decision about its definition for sexual violence. In June 2007 a special session was held with a presentation by Scott Hampton, Psy.D., Director of Ending the Violence in Dover, NH (home of the Consexuality Project, a sexual violence prevention initiative) on issues of consent and abuse in sexually exploitative industries. In November 2007 there was a special presentation on the mainstreaming of pornography by Robert Jensen, Ph.D., Associate Professor in the School of Journalism and Director of the Senior Fellows Honors Program of the College of Communication at the University of Texas at Austin.

The SPT followed these presentations with open discussions and ultimately decided to include both prostitution and pornography in the final definition. The following definition for sexual violence was approved by the SPT in November 2007.

SPT Definition of Sexual Violence

Sexual Violence is any criminal and non-criminal violation of a person, where this violation is of a sexual nature. Sexual violence can occur between any persons including acquaintances, strangers, family members or in dating relationships and is often part of domestic violence situations. Sexual violence occurs between individuals but is perpetuated at the system level by a set of community norms, behaviors and attitudes that allow for the sexual degradation, exploitation and objectification of individuals. The term "sexual violence" refers to the following verbal, pictorial, written or physical acts that form a continuum of sexual violence:

- Child Pornography - visual images or sometimes written passages depicting minors under the age of legal consent in explicit sexual activity
- Child Sexual Abuse - any sexual activity with a child by a person in a dominant position

- Drug-Facilitated Sexual Assault - the administration of any drug, including but not limited to alcohol, taken voluntary or involuntary to render a victim physically incapacitated or helpless and thus incapable of giving or withholding consent. Victims may be unconscious (incapacitated) during all or parts of the sexual assault and, upon regaining consciousness, may experience anterograde amnesia--the inability to recall events that occurred while under the influence of the drug
- Exposure/Lewdness - revealing of a person's body, especially genitals, in a public setting
- Female Genital Mutilation - often referred to as 'female circumcision,' comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural, religious or other non-therapeutic reasons
- Incest - sexual activity, either consensual or nonconsensual, between members of the same family
- Internet Predation (specifically in reference to children) - use of the internet to solicit children for sexual acts, sending sexually explicit emails or text messages to children, or arranging to meet children who are under the legal age of consent for the purpose of sexual intercourse or sexual activities
- Molestation - the act of subjecting someone to unwanted or improper sexual advances or activity (used mostly in reference to children)
- Pornography - exposure to the representation of the human body or sexual activity that is sexually exploitative, degrading and objectifies individuals. This includes, but is not limited to, the increased "pornification" of mainstream media messages.
- Professional Abuse - misuse of power or coercion by a professional (clinician, physician, etc.)
- Prostitution - when an individual, be it a child or an adult, is forced or coerced to engage in sex work that is degrading, exploitative and objectifying and/or obliged to give their earnings to another individual, organization or party.
- Sex Trafficking - the recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act, also referred to as human trafficking and commercial sexual exploitation
 - the recruitment, transportation, transfer, harboring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation ¹

¹ Definition of "trafficking in persons" United Nations Convention Against Transnational Organized Crime, Supplemental Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children

- the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion, for the purpose of subjecting that person to involuntary servitude, peonage, debt bondage, or slavery²
- Sexual Assault—the forced, manipulated or coerced oral, vaginal or anal penetration of a person without consent.
 - Rape—the carnal knowledge of a female forcibly and against her will. All assaults and attempts to rape are counted, but carnal abuse, rape without force (statutory rape) and other sex offenses are not included .³
 - Martial/Intimate Partner Rape—when one spouse/intimate partner forces, coerces, and/or manipulates the other spouse/intimate partner into participating in sexual activity against his or her will
 - Statutory Rape—sexual intercourse between an adult and a child under the legal age of consent and between an older child and younger child under the legal age of consent
 - Frottage—rubbing against another person while fully clothed for sexual pleasure (without consent), also known as “grinding.”
 - Sexual contact—an intentional touching by the victim or actor, either directly or through clothing, of the victim’s or actor’s intimate parts for the purpose of degrading or humiliating the victim or sexually arousing or sexually gratifying the actor. Sexual contact of the actor with himself must be in view of the victim whom the actor knows to be present.⁴
- Sexual Harassment—any unwanted and unwelcome behavior of a sexual or gender-specific nature (may include fondling, lewd comments, demanding sexual favors or you’ll be fired from your job, etc.). May also be known as “sexual bullying” and “professional boundary violation”
- Stalking—when an individual willfully and repeatedly engages in an intentional, constant harassment directed at another person, which reasonably and seriously alarms, torments, or terrorizes that person
- Voyeurism (Peeping)—deriving sexual satisfaction while secretly watching others undress or engage in sexual activity

Sexual violence can occur in the home, workplace, school, prison, religious institution and community. It includes the use of mainstream media messages that portray people as sexual

² Trafficking Victims Protection Act (TVPA) of 2000

³ Definition used by the Uniform Crime Report, State of New Jersey, Division of State Police. This definition utilizes a very restrictive means of reporting.

⁴ N.J.S.A.2C:14-1

objects. All the above acts also qualify as sexual violence if they are committed against someone who is unable to consent or refuse.

Purpose of Plan

The SPT's intention in preparing a comprehensive primary prevention plan is that it will influence state, local, public and private efforts aimed at reducing the perpetration of sexual violence. The plan as it exists is focused on reducing risk factors for perpetration while simultaneously promoting protective factors.

It is the intention of the New Jersey Division on Women (DOW) to use the plan to inform decision making on existing state and federal funding dedicated to sexual violence prevention. Future RPE funds administered by DOW will require conformity to the plan's goals while allowing for local decision making on strategies appropriate for use in the community. Building capacity for community collaboration and evaluation is underway as of 2009 and those efforts are being coordinated with the state planning efforts.

It is a goal of this plan to build state prevention capacity by attracting new partners and identifying/integrating alternative funding streams that can be re-focused on the plan's goals. Current resources dedicated to sexual violence prevention in New Jersey are clearly inadequate to achieve plan goals, and new partners and funding will need to be considered.

One particularly significant state goal identified in this plan is to provide technical assistance to county-based SVP's in order to build their capacity to plan and implement primary prevention programs. As a result NJCASA has contracted with the nationally renowned *Vera Institute for Justice* to provide capacity building technical assistance to each local program during the 2009 RPE grant year. This Sexual Violence Prevention Capacity Development Initiative (SVPCDI) project is currently underway during the state planning process to ensure adequate local capacity for needed community organizing and to ensure that local plans are responsive to local needs and state plan guidelines. Plans are required by DOW and due at the culmination of the 2009 RPE grant cycle.

Step 1: Needs and Resources Assessment (2007 with updates)

Committee Assignment and Leadership

Three subcommittees were established for the Needs and Resource Assessment requirements in Step 1 of GTO. SCBT members were assigned to lead and staff these committees. SPT members were asked to choose among the committees and only minor changes were made from these requests in order to ensure an even distribution of members. Each workgroup had from 5-10 active members and meetings were held in person and through telephone conferencing. Each workgroup met a minimum of five times. The workgroups included:

Magnitude of Sexual Violence Workgroup – This group focused on developing the state profile and critically reviewing all data concerning the prevalence of sexual violence and characteristics on perpetrators/perpetration.

Risk and Protective Factors Workgroup – This group reviewed available research on the risk and protective factors for perpetration as well as perpetrator focus group results. The groups' task was to identify those risk and protective factors that should be prioritized in any New Jersey prevention effort.

Resources and Assets Workgroup – This group reviewed the capacity of the current sexual violence system in New Jersey to identify strengths and weaknesses that will impact on future prevention work. This included review of results of SVP surveys, phone interviews with other prevention providers in the state, current funding streams for prevention, parent/teen and therapist focus group results and the findings from the Mathematica Policy and Research's initial Individual Prevention Capacity Questionnaire (IPCQ) instrument.

Each workgroup provided interim progress reports at the May and November 2007 SPT meetings. These reports facilitated the coordination and integration of the work across committees.

Additionally, each workgroup had a corresponding listserv (Google group) where all communications were archived and all reviewed data was stored. All SCBT members were added to all workgroups' listservs in a further effort to coordinate work and stay aware of each workgroup's progress.

Current prevention efforts

In late 2006 a survey was conducted of all the RPE funded SVP's to assess the range of prevention efforts in place, existing evaluation capacity, funding diversity and understanding of primary prevention. This internal capacity assessment was completed prior to the development of the EMPOWER tools. At that time the focus of local strategies was on sexual violence awareness raising and risk reduction.

Phones surveys were also completed in 2006 with targeted prevention providers outside the sexual violence field to assess whether they were conducting primary, secondary or tertiary prevention activities; for overlapping issues and possible points of integration of work and opportunities to partners; and to determine if evidence-based prevention strategies were being employed in other fields.

The VERA Institute for Justice completed a more comprehensive follow-up assessment of local SVP prevention capacity in late 2008. The full report is part of the Appendix. This assessment identified foundational programs that, with expansion, could be used as a foundational tactic from which to build a larger plan-oriented strategy should programs decide that this direction is the most relevant for their community. These foundational programs speak to each site's capacity to develop and design new programs or adapt existing programs. Sites would need to develop complementary tactics to sufficiently meet the criteria of the Nine Principles of Effective Prevention Programs and to address multiple levels of the social ecological framework.

The following foundational prevention programs were in place as of early 2009:

- **Part of the Solution**
Extensive men's campaign supporting pro-social messages for men and boys regarding violence against women which includes a public pledge ceremony and a broad-based community media distribution strategy
- **Denim Day Plus**
Awareness day plus follow-up freshman assembly (300+ students) followed by breakout workshops for discussion groups and art projects related to sexual violence
- **Act It Out**
Currently under development—a socio-drama program using skits and workshops run by student volunteers to teach other students skills for addressing sexual violence
- **Peer Education Program Using Expect Respect and Choose Respect**
Currently suspended to do prevention planning—Ocean County had developed a two-day session with middle school-aged students to address healthy dating and relationships including prevention of sexual violence
- **SCREAM Theater and SCREAM Athletes**
A freshman and athlete orientation program for college-aged students. SCREAM uses skits to demonstrate real-life scenarios for the purpose of education and awareness regarding responses to situations involving sexual violence
- **Steppin' Into Manhood**
A day-long annual conference for young boys to address issues regarding cultural expectations of manhood and providing knowledge and skills to develop healthy relationships and avoid domestic and sexual violence
- **Interpersonal Violence Prevention Program**
An eight week, multi-level, interactive pilot program that encourages healthy relationships and social competence in middle-school aged students. It includes a component in which students participate in developing a program to address violence-related issues in their school community. It uses program outcome measures including pre and post-tests.

Geographic Focus

The geographic focus of this sexual violence prevention plan is the state of New Jersey. New Jersey has a very diverse population and many urban, suburban and even rural centers. While there are state level guidelines and standards on many issues, the final decision-making authority in New Jersey often rests with local municipalities or other local entities. This home rule tendency is very important to consider for planning prevention strategies to use within in this state.

New Jersey is also part of two major media markets, New York and Philadelphia, which makes it difficult to use major media outlets for messaging. Both the expense and the focus on those urban centers create a second class status for New Jersey media needs.

State profile

<i>People QuickFacts</i>	New Jersey	USA
Population, 2007 estimate	8,685,920	301,621,157
Population, percent change, April 1, 2000 to July 1, 2007	3.2%	7.2%
Persons under 5 years old, percent, 2007	6.4%	6.9%
Persons under 18 years old, percent, 2007	23.8%	24.5%
Persons 65 years old and over, percent, 2007	13.1%	12.6%
Female persons, percent, 2007	51.1%	50.7%
White persons, percent, 2007 (a)	76.3%	80.0%
Black persons, percent, 2007 (a)	14.5%	12.8%
American Indian and Alaska Native persons, percent, 2007 (a)	0.3%	1.0%
Asian persons, percent, 2007 (a)	7.5%	4.4%
Native Hawaiian and Other Pacific Islander, percent, 2007 (a)	0.1%	0.2%
Persons reporting two or more races, percent, 2007	1.3%	1.6%
Persons of Hispanic or Latino origin, percent, 2007 (b)	15.9%	15.1%
White persons not Hispanic, percent, 2007	62.2%	66.0%
Foreign born persons, percent, 2000	17.5%	11.1%
Language other than English spoken at home, pct age 5+, 2000	25.5%	17.9%
High school graduates, percent of persons age 25+, 2000	82.1%	80.4%
Bachelor's degree or higher, pct of persons age 25+, 2000	29.8%	24.4%
Persons with a disability, age 5+, 2000	1,389,811	49,746,248
Homeownership rate, 2000	65.6%	66.2%
Housing units in multi-unit structures, percent, 2000	36.1%	26.4%
Persons per household, 2000	2.68	2.59
Median household income, 2007	\$67,142	\$50,740
Persons below poverty, percent, 2007	8.5%	13.0%

New Jersey State Prevention Plan for Sexual Violence

<i>Business QuickFacts</i>	New Jersey	USA
Private nonfarm establishments, 2006	243,055	7,601,160
Private nonfarm employment, 2006	3,645,381	119,917,165
Private nonfarm employment, change 2000-2006	2.7%	5.1%
Nonemployer establishments, 2006	573,819	20,768,555
Total number of firms, 2002	708,837	22,974,655
Black-owned firms, percent, 2002	5.1%	5.2%
American Indian and Alaska Native owned firms, percent, 2002	0.4%	0.9%
Asian-owned firms, percent, 2002	7.3%	4.8%
Native Hawaiian and Other Pacific Islander owned firms, percent, 2002	0.1%	0.1%
Hispanic-owned firms, percent, 2002	7.0%	6.8%
Women-owned firms, percent, 2002	26.1%	28.2%
Land area, 2000 (square miles)	7,417.34	3,537,438.44
Persons per square mile, 2000	1,134.5	79.6
<p>(a) Includes persons reporting only one race. (b) Hispanics may be of any race, so also are included in applicable race categories. Source: US Census Bureau State & County QuickFacts</p>		

Demographics and projections (state/county/region)

Source: New Jersey Economic Indicators As of January 2009

<http://lwd.dol.state.nj.us/labor/lpa/pub/econind/indjan9.pdf>

According to the latest population estimates, New Jersey had 8,682,661 residents as of July 1, 2008, a net gain of 29,535 residents from a year ago. The 0.34 percent growth rate between 2007 and 2008 was slower than 39 other states in the nation. Total population increased by 0.92 percent nationally between 2007 and 2008. Parallel to the population trend in the Northeast region (includes 6 New England and 3 Middle Atlantic states), New Jersey has gained population at an increasing rate since 2006, a turnaround from its declining growth rate between 2000 and 2006. Population growth in New Jersey decelerated gradually from 0.7 percent per annum in the 2000-2001 period to 0.1 percent per annum in the 2005-2006 period. The deceleration of growth resulted mainly from the state's estimated net losses in migration. Although New Jersey has the nation's third highest percentage of foreign born population, after 2003, the state's net gains in international immigration were no longer large enough to offset its net losses due to domestic migration. However, the state's flow of domestic out-migrants has subdued after reaching a peak in 2006 and its population growth rate has accelerated somewhat to 0.15 percent and 0.34 percent per annum during the 2006-2007 and 2007-2008 years.

New Jersey was the nation's eleventh most populous state in 2008, unchanged from its 2007 status. New Jersey's population ranked ninth nationally in 2000. Its rank descended to the tenth and eleventh in 2002 and 2005, respectively. New Jersey's distinctive status as the nation's most densely populated state (with 1,171 persons per square mile in 2008) remains unchallenged. Rhode Island (population density: 1,006 persons per square mile) was the only other state with

more than 1,000 persons per square mile as of 2008. By comparison, the nation’s 2008 population density was 86.0 persons per square mile, while Alaska’s 1.2 persons per square mile made it the most sparsely populated state in the nation

New Jersey’s net gain from international migration (384,700), thus far this decade, was the sixth largest in the nation. However, the state also lost 438,600 residents to other states due to domestic migration during this eight-year period. Natural increment (344,000 more births over deaths) was another major source of the state’s population growth from 2000 to 2008.

Economic Information

Source: New Jersey Economic Indicators As of January 2009

<http://lwd.dol.state.nj.us/labor/lpa/pub/econind/indjan9.pdf>

As the recession in the national economy deepened at the end of 2008, New Jersey felt the impact with a steep increase in the unemployment rate and widespread employment losses. Construction and planned homebuilding continued to trend down providing little optimism in the troubled housing market. Weakening economic conditions eroded consumer confidence in the Middle Atlantic region during the past year with December’s index down more than 50 percent from the level of a year ago. Employment fell by 15,200 in December 2008, following a revised loss of 19,600 jobs in November 2008. Compared with a year ago, payrolls were down by 63,000, a decline of 1.5 percent. More than half of the annual employment decline occurred during the last two months.

Magnitude of Sexual Violence – Workgroup Final Report

Data Reviewed and Findings

A full listing of data reviewed for this planning process is part of the Appendix and includes the strengths and limitations of each data set.

Data Problem/Needs Statements	Desired Data Outcomes in 5 Years
There is no longitudinal data on either perpetrators or survivors so, as a result, we cannot track individual or group trends.	1. There will be a coordinated system for data collection and analysis in New Jersey that: <ol style="list-style-type: none"> 1. has demographic data on perpetrators and victims/survivors. 2. tracks cases over time including relevant past history. 3. demonstrates the effectiveness of strategies. 4. has sufficient state, county and major urban area data. 5. identifies shared characteristics of perpetrators. 6. makes optimal use of existing data collection systems, for example, add SV module to BRFSS, YRBS and other student health surveys. 2. New Jersey is able to measure changes in
There is little uniform, regular analysis of sexual violence data. Data is collected but not collated or analyzed at the state level.	
There is serious lack of integration for sexual violence data across functions/departments. This includes data from DCJ, State Police, DOW, DHSS, DCFS, DOE, DOC, JJC, Colleges, NJCASA and NJCBW. Each has some data but there is no standardization of definitions, time frames, cross functionality, etc.	
There is no New Jersey data available about people’s perceptions, norms and attitudes toward sexual violence to use as a baseline for prevention work.	

<p>There is little data on child sexual assault publically available. There is data on child abuse but not on the subset of child sexual abuse.</p>	<p>perceptions, norms and attitudes of the general public and select populations especially:</p> <ol style="list-style-type: none"> 1. increased willingness to intervene. 2. decrease in rape myths/rape culture.
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Potential Priority Select Populations

Highest Risk of Perpetration (UCR, DOC, PREA, SANE data)

- Males
 - Ages 13-39
 - Witnessing family violence/community violence
- Caregivers of vulnerable populations (disabled, unsupervised youth, prisoners)

Highest Risk of Victimization (American Community Survey, National Accessing Safety Initiative, Student Health Survey, SANE data, Emergency Room data)

- African American males who are sexually active before the age of 13
- Disabled community
- Unsupervised youth
- Children under the age of 11 (especially African American and Hispanic)

Best Opportunities for Prevention Strategies

- Bystanders (Friends, Peers, Guidance Counselors, etc)
- Youth under the age of 13, before norms change is difficult
- Caregivers
- Parents

Special Note: While there was significant data that suggest overrepresentation of minority males (both African American and Hispanic) as perpetrators, it was strongly felt that this data may be misleading. The data reflects those most likely to be arrested and in prison, not necessarily those most likely to offend. A similar issue exists for victims of child sexual abuse (under age 11) in terms of possible overrepresentation in emergency rooms.

Risk and Protective Factors – Workgroup Final Report

<u>Data Problem/Needs Statements</u>	<u>Desired Outcomes in 5 years</u>
<ul style="list-style-type: none"> • There is limited data on risk and protective factors regarding perpetration of sexual violence in New Jersey. • Of the data that is available on perpetrators, it is potentially skewed toward a population involved in the criminal justice system(re: meta analysis). There are some studies, however, that looked at undetected perpetrators - those not involved in the 	<ul style="list-style-type: none"> • Maximize use of scarce resources by integrating data collection in New Jersey for all issues that have overlapping risk and protective factors. • New Jersey is able to use the risk and protective factors highlighted by the workgroup as part of the primary prevention strategy implementation and will be able to

<p>criminal justice system.</p> <ul style="list-style-type: none"> • Significant historical New Jersey data exists on similar risk and protective factors for addictions but the Division of Addictions Services has recently changed the survey to focus more on patterns of use. • Many more data sources focus on victimization and on girls and women. 	<p>document measurable outcomes.</p>
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Potential Priority Protective and Risk Factors

After review of relevant research, the annotated bibliography and the CDC’s Table of Risk and Protective factors for bullying and sexual violence perpetration, the workgroup identified this list of risk and protective factors to be elevated above the rest on the existing list. The factors are separated into three categories: first priority, second priority and third priority risk and protective factors.

- **Protective Factors**
 - First Priority
 - Attachment/Parenting/Empathy
 - Social Support, including community connectedness, security and a sense of having options and hope
 - Second Priority
 - Media Literacy
 - Pro Social Moral Reasoning
 - Third Priority
 - Emotional Health
 - Healthy Sexuality
 - Self-esteem
- **Risk Factors**
 - First Priority
 - Hyper-masculinity - encompassing rigid gender roles, high levels of anger toward women, bullying, anti-social behavior, and substance abuse
 - Second Priority
 - Witnessing Family Violence
 - Third Priority
 - Early Sexual Behavior
 - Entitlement
 - Lack of Attachment/Empathy
 - Pornography

Sexual Violence Prevention System Capacity Assessment – Workgroup Final Report
Problems with Data on Prevention: Capacity, Assets and Resources

- All data sources are based on self-reporting.
- There is a lack of data related specifically to the capacity to prevent sexual violence.
- Responses and data are still largely anecdotal.
- Numbers of participants in existing data is very low making it difficult to have a broad scope of capacity, resources, or assets.
- Data is not collected with the intent to include either targeted populations or broad and representative communities.
- There is no direct information on State and/or Federal pass-through funding for Sexual violence prevention or prevention in other fields.
- Definition of “prevention” used in various surveys is vague or not consistently presented to participants, or poorly understood by participants.
- Data sources do not specifically address the “two-tiered” system in place for sexual violence - one for adults and one for children - making it nearly impossible to assess capacity in either of these areas specifically or to which area data sources were referring.

Summary of Sexual Violence Prevention Capacity Assets

- A diversity of skills and knowledge as well as agencies and communities is represented on SPT.
- Large SPT is actively engaged in process.
- Other organizations are doing prevention work in New Jersey in other fields.
- Some other umbrella agencies do exist in New Jersey for possible collaboration: NJCASA, NJCBW, Public Health Departments (state, local, and university related), NJ Prevention Network.
- Sexual Violence Programs are already doing educational outreach in every county and already have some training in primary prevention.
- There is support of DOW, GACASV, NJCASA, and CDC for prevention work in New Jersey.
- “SCREAM” theater is already a state-wide project.
- EMPOWER has support from CDC.
- State laws regarding sexual offenses are already inclusive.

Summary of Challenges in Sexual Violence Prevention Capacity

- There is a general lack of understanding of “primary prevention”. Prevention has overlapped with intervention for too long.
- There is a low level knowledge of how to implement primary prevention.
- There is a lack of sufficient tools, resources, curricula in primary prevention, including in the CDC.
- There is a lack of knowledge about how much it would cost to implement statewide primary prevention of sexual violence.

- The current level of state/federal funding specifically for prevention of sexual violence is approximately \$1 million, which is allocated to DOW, NJCASA and 21 county sexual violence programs and Rutgers University “Scream” theater.
- There is a lack of knowledge as to level of support and/or commitment by agencies, departments, and communities represented by individuals on SPT.
- There is low level of community representation on the SPT that is crucial to planning and implementation. Specifically men, young people, college students, and the disabled are under-represented
- There is a limited expertise among SPT members in areas of planning, implementation, and evaluation

Capacity Outcome/Desired Result

Sufficient skill, experience, funding, leadership, information, human resources, plans, evaluative tools, and statewide collaboration through governmental and community-based systems to implement and sustain a viable and effective plan for long-term reduction and prevention of sexual violence in New Jersey.

Recommendations for Increasing Capacity (Short Term and Long Term)

- Develop public institutional commitment (financial, human and other resources) from state leadership for the state-wide prevention of sexual violence plan implementation and for integrated data collection/data analysis including, but not limited to, the following offices and departments:
 - Governor’s office,
 - Department of Community Affairs/ Division on Women (DCA/DOW)
 - Department of Corrections (DOC)
 - Department of Education (DOE)
 - Department of Law and Public Safety (DLPS)
 - Department of Human Services. Divisions of Developmental Disabilities and Mental Health (DHS/DDD/DMH)
 - Department of Health and Senior Services (DHSS)
 - Department of Children and Families (DCF)
 - Department of Military and Veteran’s Affairs (DMVA)
- Ascertain and develop as necessary commitment of agencies and communities represented by individuals on the SPT to the plan and its implementation to prevent SV in New Jersey.
- Develop skill level of SPT members in planning, implementation and especially evaluation.
- Develop skill level of SVPs in planning, implementation, and evaluation.
- Develop specific guidelines and criteria for the prevention model (and activities that are excluded) to assist SVPs and others in developing their prevention capacity and plans.
- Develop and maintain additional funding resources.
- Utilize collaborative approaches to disseminate and use funding in addition to SVPs.
- Develop a process to engage community members and groups in planning, implementation and evaluation.
- Develop resources and practices for extensive evaluation tools and processes to measure the effectiveness of the plan and its implementation on all levels.

Step 2 – Goal Setting (January 2008 with April 2009 revisions)

SPT Priority Setting Process

After all workgroups reported to the SPT in November 2007, a special subcommittee was established to integrate the findings and prepare recommended goals and outcomes. The Step 2 workgroup was made up of SCBT members and at least one representative from each of the assessment workgroups. This group met twice in January 2008 and created recommendations that were reviewed, revised and approved in late January 2008. Score sheets were created for both the workgroup process and the final goal selection process. The workgroup scored goals based on criteria contained in Step 2, including whether the goal was realistic, focused on perpetration, had convincing data or community knowledge and addressed real norm change in the community/society. The SPT members ranked the recommended goals in priority order, giving separate rankings to the prevention goals and the system capacity goals.

The goals were revisited at the end of Step 3 and modified to reflect new information acquired during the strategy selection process. The modifications were made in February of 2009.

The following goals are the results of this process:

Final New Jersey Need, Goal and Outcome Statements for Sexual Violence

SYSTEM CAPACITY GOALS

System Capacity Goal – Increase and Diversify Funding

Needs Statement - Funding

- a. Funding for sexual violence prevention in New Jersey is \$1 million of RPE funding, which also covers hotlines. This level of funding will need to be supplemented to meet the data needs, systems capacity upgrades and core prevention strategies covered by this plan.
- b. There are additional resources being allocated for data collection and risk reduction in other prevention fields (i.e.: ATOD, Bullying, child abuse) that have overlapping risk and protective factors. There is no current coordination or integration with these other systems and the sexual violence system.

Goals

- a. **Increase funding available for sexual violence prevention strategies, data collection and system capacity upgrades and minimize negative financial impact on intervention activities.**
- b. **Maximize use of scarce resources by integrating data collection in New Jersey for issues that have overlapping risk and protective factors with a priority focus on addictions, bullying, domestic violence and child abuse.**

Outcomes

- a. There will be a new, dedicated state level funding stream based on user fees (to be determined), increased federal and private support for use in sexual violence prevention

and intervention strategies. This increase in funding will at least double the resources available for both prevention and intervention.

- b. There will be cooperative agreements in place for cross-departmental cooperation, funding and integration on data collection for overlapping risk and protective factors.

System Capacity Goal – Develop Integrated Data and Commitment

Needs Statement – Institutional Collaboration and Commitment

- a. Levels of commitment and support by agencies, departments and communities currently represented on the SPT need to be clarified so that local commitments can be developed, pointing to these models of high level support.
- b. There is no longitudinal data on either perpetrators or survivors so, as a result, we cannot track individual or group trends.
- c. There is little uniform, regular analysis of sexual violence data (data is collected but not collated or analyzed at the state level).
- d. Standardization of data definitions, timeframes and cross functionality does not exist between state departments collecting data related to sexual violence. This includes data from the Department of Law and Public Safety, Department of Community Affairs, Department of Health and Senior Services, Department of Children and Families, Department of Education, Department of Corrections, the Juvenile Justice Commission (JJC), Colleges and the New Jersey Coalition Against Sexual Assault. Each has some data but there is no standardization as previously mentioned.
- e. The lack of integrated data results in the lack of data driven strategies for prevention.

Goals

- a. **Ascertain and develop clear commitment of state agencies and communities represented on the SPT for the sexual violence prevention plan and its implementation.**
- b. **Create a coordinated system for data collection and analysis in New Jersey**

Outcomes

- a. There will be formal sign off from other state department leadership to the plan goals.
- b. A core group of identified liaisons that are empowered to share data, improve data collection and pool resources between departments will be identified.
- c. Data collection systems will be integrated and will produce:
 - i. demographic data on perpetrators and victims/survivors.
 - ii. data that tracks cases over time, including relevant past history.
 - iii. data that demonstrates the effectiveness of strategies.
 - iv. sufficient state, county and major urban area data.
 - v. data that identifies shared characteristics of perpetrators.
 - vi. optimal use of existing data collection systems (i.e., add sexual violence module to BRFSS, YRBS and other student health surveys).

System Capacity Goal – Increase Capacity of Sexual Violence Programs (SVP)

Needs Statement – Planning, Implementing and Evaluating Primary Prevention

There is a recently emerging understanding of and varying levels of local capacity for “primary prevention” and an overlap between prevention and intervention for local sexual violence programs. This results in difficulty sustaining sufficient individual and institutional commitment to primary prevention efforts. This is exacerbated by a lack of sufficient tested tools, resources and curricula for planning and implementing primary prevention and a lack of knowledge and infrastructure for program evaluation at the state and local level.

Goal

Establish sufficient skill, experience, leadership, information, human resources, evaluation tools and collaboration in RPE funded SVP’s to implement and sustain viable strategies for long-term reduction and primary prevention of sexual violence in New Jersey.

Outcomes

- New Jersey will develop a required list of core competencies for sexual violence prevention provider staff.
- All RPE-funded SVP’s will commit to the principles of CDC primary prevention, including community organizing, community planning, norms change and prevention of first time perpetration.
- All RPE- funded SVP’s will demonstrate a clear understanding of primary prevention and community organizing/community planning when responding to RFP’s for funding.
- Local RPE-funded SVP’s will establish collaborative relationships with other local prevention providers in order to create funding and operational efficiencies.
- There will be sufficient state level and local expertise in program evaluation so that prevention strategies can demonstrate that they reduce risk factors and increase protective factors of perpetration.
- RPE sub-grant awards will require the use of evidence informed prevention strategies, the existence of core competencies for prevention staff, and the existence of sufficient internal capacity for required evaluation.

System Capacity Goal – Track Changes in Attitudes

Needs Statement – System Capacity and Lowering Risk of Perpetration

Our review of New Jersey data clearly indicates that there is no statewide data available about perceptions, norms and attitudes toward sexual violence to use as a baseline for prevention work.

Goal

Develop a baseline and track changes for New Jersey on societal perceptions, norms and attitudes toward key risk factors of sexual violence.

Outcomes

- Comparative data will be gathered on gender norms for strategy refinement and evaluation.
- The ability to measure change in attitudes on gender norms over time will be developed.

PRIMARY PREVENTION GOALS

State Level Policy Change and Systems Advocacy

Prevention Goal – Decrease Perpetration against Highly Vulnerable Populations

Needs Statement – Select Populations and Risk Reduction – Community Level

Perpetration and victimization data in New Jersey and nationally identified the disabled population and prisoners as highly vulnerable to victimization.

Goal

Create and implement institutional and agency strategies that prevent the perpetration of sexual violence against people with developmental disabilities and inmates of correctional facilities.

Outcomes

These strategies will:

- increase supervision of caregivers.
- improve screening of staff for potential of perpetration.
- create and implement educational programs for a wide range of service recipients, caregivers, and supervisors (organizational, family and peers) on primary prevention of sexual violence.
- revise and upgrade existing policies and procedures and expand implementation of prevention standards to a variety of settings and across populations.

Prevention Goal – Increase Empathy and Attachment

Needs Statement – Select Populations and Risk Reduction – Individual Level

Numerous studies point to a lack of empathy and low attachment as risk factors for perpetration. Since these conditions are set early in life, it is critical that prevention activities must be focused on children (birth to 12 years) and their parents/caregivers.

Goal

Identify and support delivery systems that would increase parental/caregiver attachment and increase empathy skills in children.

Outcomes

- Providers of identified empathy and attachment strategies will understand the connection between these risk and protective factors and sexual violence perpetration and will integrate age appropriate content about sexual violence into their curriculum.
- Providers of identified empathy and attachment strategies and sexual violence programs will have developed collaborative relationships through periodic meetings and cross training opportunities.

Prevention Goal – Increase Community Connectedness

Needs Statement – Select Populations and Risk Reduction – Individual and Community level

Arrest data show that males between the ages of 13-39 are at higher risk of perpetration. Other perpetration data shows a linkage between exposure to family violence and sexual violence perpetration.

Protective factor research demonstrates that adequate social support, including community connectedness, security and a sense of having options and hope can reduce perpetration.

Goal

Increase opportunities for healthy community connectedness for young males (middle, high school and college level) who have been exposed to family violence.

Outcome

Partnering with NJCBW and domestic violence programs through DELTA Prep, the SPT will identify cooperative strategies for targeted high risk young males. The resulting strategies will demonstrate increased healthy community connectedness within their school community based on pre- and post -testing. This community connectedness initiative will link with other programs and settings that have demonstrated social norms supporting healthy sexuality and non-rigid sex roles.

PRIMARY PREVENTION GOALS – State and Local Level Community/Societal Norms Change

Prevention Goal – Increase Gender Equity Norms

Needs Statement – Lowering Risk of Perpetration

Focus group responses demonstrated that New Jersey residents continue to focus on victim blaming based on rigid expectations of female behavior. This has been identified as a risk factor for perpetration by the following studies: Carr, Forbes, Baron, Lisak and Roth 1990; Koss and Dinero, 1998; Malamuth, 1986; Malamuth, et al., 1996; Seidman, Marshall, Hudson, and Robertson, 1994; Murnen, Wright and Kaluzny, 2002. In addition focus group participants also expressed concern about media messaging and its impact on youth. A number of studies show that exposure to unfiltered, uncensored media messages, sexualized media messages in all forms and a lack of media literacy (the ability to filter/judge messages) supports community norms about sexual violence.

Goal

Create and market social norms in New Jersey that promote gender equity and respect for women and girls by reducing rigid sexual stereotypes and

Outcomes

- Social norms that support rigid sexual stereotyping will decrease by 20%, and social norms which support healthy sexuality and male accountability will increase by 20% as

measured by a periodic community and school-based surveys administered to a representative sample of males and females.

- Recognition of the impact of sexualized mass media on gender inequality, healthy sexuality and gender roles will increase by 20% as measured by periodic community and school-based pre- and post-tests.

Prevention Goal – Increase Bystander Intervention

Needs Statement – Select Populations and Risk Reduction – Relationship Level

Research by Carlo, Suzuki, Lisak and Kirnburg demonstrate that Pro Social Moral Reasoning demonstrated through self- reflection, learning from past experience and focusing on “ally” behavior can be a protective factor for perpetration and can change community norms about perpetration.

Goal

Increase bystander intervention along the continuum of sexual violence behaviors among middle school, high school, and college communities.

Outcome

- Students’ skills and knowledge on how to intervene will increase by 50% as measured by pre- and post-testing.
- Skills and knowledge on how to intervene will also increase for other allies by 50% as measured by pre- and post-tests
- Students' willingness to intervene as engaged bystanders will increase 25% as measured by pre- and post-tests
- Students' helping bystander behaviors will increase by 25% for those who have the opportunity to intervene as measured by pre- and post-tests

Steps 3- Strategy Selection (April – December 2008)

Process for Researching and Selecting Strategies

We decided to focus on the primary prevention goals during Step 3 of the process and leave the capacity goals to be integrated in Step 5. The SPT broke into four workgroups (details below) and the Empowerment Evaluator provided a comprehensive list of strategy resources for evidence based programs in a variety of fields. Workgroup Co-Chairs were identified from the SPT membership and SCBT members were assigned to staff each workgroup. Workgroup members also received a strategy vetting form to pilot (since the final form for Step 3 was not yet available). Workgroups adapted the vetting form several times for their specific uses. The Step 3 process began in April 2008 with final workgroup recommendations made to the full SPT in December 2008.

Step 3 activities proved to be very difficult for the workgroups and full SPT. The concepts in Step 3 (especially: activities/strategies/programs, the theoretical basis and the continuum of evidence) were difficult for members to operationalize and the time needed to actually research strategies was considerable. This placed both a time and lack of confidence burden on members that hindered forward progress. Even with capacity building efforts all along the way (detailed below), workgroup members expressed a repeated concern about not feeling they had the expertise for the task. The SCBT intervened several times to get the workgroups re-focused and to streamline the strategy research workload.

The following workgroups were created and SPT members volunteered to serve on one workgroup each:

- Gender Equality and Media Literacy – This group researched approximately fifty media and gender equity strategies that included social norms campaigns and media literacy programs.
- Empathy, Attachment and Community Connectedness – This group researched eighteen strategies related to these risk factors. There was a dearth of evidence based strategies for community connectedness that focused on former child victims of domestic violence.
- Bystander Intervention – This group researched nine strategies that included evidence informed and “home grown” strategies currently in use in New Jersey.
- Vulnerable Populations – A lack of institution based strategies for both the disabled and prison populations resulted in a strong focus on pending PREA standards and public policy options. The group researched about a dozen existing strategies, all of which focused on reducing victimization and ensuring timely intervention. The workgroup decided that these strategies did not meet the needs of the original goal.

Resource People

During Step 3 of the process, we added a number of resource people from local RPE programs and other prevention programs in New Jersey. It was important to get local buy-in to the process for selecting strategies and to have practical strategy expertise in each workgroup. Each workgroup had at least one local RPE program representative actively engaged during the vetting process. The additional expected long-term benefit of adding resource people was to ensure

transparency and regular communication (through the NJCASA Prevention Committee) to all current local prevention providers under RPE.

Workgroup Process for Vetting Strategies

The workgroups met at least monthly and some had additional phone conference calls between meetings. Each monthly SPT meeting was either wholly or partially devoted to workgroup meeting needs. Google groups were used to share files and create targeted listservs for ongoing communication between group members. The use of this technology was helpful, but there were significant capacity issues that made the technology cumbersome:

- State employees experienced the most difficulty in the use of Google groups since access to the groups was denied by the state IT system. We routinely had to create “work-arounds” to ensure that state employees received the materials and could participate in group e-mail communication.
- A significant number of SPT members had never used online groups and had to be individually coached in how to sign up as a user, access/post materials and send/reply to messages. NJCASA staff and the Empowerment Evaluator spent considerable time doing technical assistance.
- Maintaining the various lists used by the SPT was cumbersome and required significant coordination between NJCASA and the Division on Women. The addition of Resource people to the workgroups added a level of complexity that needed regular coordination between NJCASA and DOW. There was some initial confusion about whether resource people would be invited to full SPT meetings with a final decision to keep the SPT invitee list as inclusive as possible.

Responding to SPT Capacity Issues During Step 3

The following capacity building steps were taken during the Step 3-5 process:

- In April 2008 the full SPT used Expect Respect and Safe Dates to pilot the strategy vetting forms, after receiving training on the continuum of evidence and the RPE theories of change. Small group discussion and full group report out helped identify problem areas and concepts that needed reinforcement.
- In May 2008 Karen Lang from CDC visited the group to discuss the differences between activities, strategies and programs and the CDC continuum of evidence. We subsequently used a Jeopardy game format to reinforce these concepts while engaging the group in low risk problem solving.
- Continued difficulty in applying the core concepts of Step 3 and increasing concern about the work by workgroup leaders and SCBT members in June 2008 resulted in the need to step back from the process, affirm frustrations and reduce expectations (See Strategy Vetting Workgroup Notes from 7/30/08 in the Appendix). A meeting of workgroup Co-Chairs and the SCBT resulted in a plan to bring in representatives from other EMPOWER states to hear about their Step 3 process and to share strategy research results across states. Additionally, we set clear expectations regarding finding evidence based strategies for sexual violence (few actually exist) and the degree to which a workgroup should continue researching during this Step. It was critical to avoid the “analysis paralysis” that was setting in and to affirm that there were no perfect choices of

- strategies. It was also reinforced at this time that the New Jersey goals could/should be amended to reflect the community learning during this step in the process.
- In September 2008 the SPT hosted Kentucky and North Carolina representatives in face-to-face conversations about strategy choices. Massachusetts and North Dakota joined the meeting by conference call. The New Jersey SPT found this dialogue extremely helpful in refocusing on goal related strategies. There was also significant excitement on the SPT about the opportunity for cross-state strategies that could create wider and stronger communities of practice and better prepare us all for future research opportunities.
 - In November 2008 the SPT met as a whole body to hear workgroup reports and to begin the integration of strategies and refinement of goals. The SCBT created a Bingo game that aligned potential strategies with the elements of the social ecology and targeted age groupings. We also discussed the need for aligning strategies at the state and local level to ensure “mutually enhancing” strategies and a reasonable set of expectations at the state and local level.
 - In February 2009 the SPT heard final recommendations from each of the workgroups. These recommendations included final revisions to the goal statements and revisiting the Theory and Activities models to ensure that the plan was consistent with these models. The work of strategy selection was long and intense and the GTO tools available were confusing and too complicated. The Theory Model was especially difficult to absorb by many members and required several reminders during the process that this was the guiding document for the final plan. The process design was not sufficient for keeping the focus on state level work and community and system level strategies.
 - A special joint SPT-PPEC and RPE provider session was held in February 2009 to learn more about the concept of Positive Social Norms Marketing from Michael Haines, former Director of the National Social Norms Resource Center. This joint session included both a presentation on the model and small group discussion on how best to implement this strategy as part of a larger comprehensive program that includes bystander strategies, media literacy and system level advocacy. This event also afforded an opportunity for SPT members to interact directly with local sexual violence providers and create plan guidelines that are directly responsive to local capacity needs. New Jersey deemed it vital to include local sexual violence providers in the final discussions of the plan to develop an ownership interest in the final plan recommendations.

Strategy Selection

The following strategies were recommended by the workgroups:

State Level Strategies

- Positive Social Norms Marketing
 - Baseline data collection
 - Setting of implementation standards and core messaging
- Advocacy and Support for Empathy and Attachment Strategies
 - Addition of sexual violence content to identified strategies
 - Advocacy for increased funding and expanded implementation of identified strategies

- Integration of efforts with DCF (Strengthening Families), DOE (I Can Problem Solve, Incredible Years, Second Step, Social Decision Making and Dare to be You) and PCANJ (Healthy Families), which oversee and fund the noted strategies
- Advocacy for use of PREA Standards in Prisons, Disabled Institutions and community based programs. This includes integration of standards in the certification process for Home Care Workers.
- Advocacy for use of Offender Registry in institutional hiring for vulnerable populations
- Advocacy for changes to 2C14 regarding the definitions of sexual assault and aggravated sexual assault with a focus on attributes of caregivers of vulnerable individuals
- Bystander Strategies
 - Customization of strategies for specific populations or to meet CDC standards for primary prevention
 - Capacity building for SVPs to implement strategies
- Capacity Building
 - SV Data development, upgrades and integration
 - System buy-in
 - Funding alternatives
- Build SV prevention strategies into DOE Core Standards

Local Level Strategies

- Bystander Strategies
 - Middle school through college
 - Caregivers of vulnerable populations
- Media Literacy
- Men Can Stop Rape - MOST Clubs
- Positive Social Norms Marketing
 - Customizing communication channels to implement state strategy for targeted local communities

Step 4 - Evaluating Community Context and Need for Adaptation (January – March 2009)

Process Description

Each workgroup created core standards for strategies that either ensured adherence to the goal or ensured fidelity for evidence based strategies from other fields. A core issue for adaptation was the need to develop sexual violence specific content for strategies from other fields. Additional adaptation issues under consideration included the opportunities for piloting core strategies in targeted communities.

A key concern for the SCBT was that a number of valued SPT members that represented critical ethnic/cultural communities and local nonprofits had dropped out of the planning process due to work pressures in their own areas. There was a concern that these voices in the final discussions would be muted or missing altogether at a critical point in the planning process. The following attempts were made to ensure the inclusion of these important community voices:

- Reaching out to key SPT members who represent key constituency groups but who could not sustain their long term involvement in the SPT. These individuals will be asked to review the final recommendations and provide input on how best to ensure the plan is responsive to community needs.
- Asking that the Plan Workgroup, made up of SCBT members and Step 3 Workgroup representatives, consider piloting strategies and incorporating strategy focus groups into the workplan design

Adaptation Considerations

At the Feb 4th SPT meeting the full group brainstormed contextual issues that will impact on strategy implementation and adaptation. See final Plan in Step 6 for a full list of considerations.

Step 5 – Aligning Strategies With State and Local Capacity (January – March 2009)

Core components of this step include integrating System Capacity goals into each workgroup final report and using the local capacity assessment completed by NJCASA and VERA Institute for Justice for setting implementation timelines for overall strategies. The SPT reviewed the above-mentioned reports in January – March and approved the final list found in the Step 6 Plan.

Capacity Considerations

Preliminary capacity issues included: (see final Plan for full list of capacity issues)

- SVPs have serious resource limitations and high turnover rates for prevention staff. Capacity building in community organizing/community mobilization must continue to focus on finding nontraditional allies and collaborators who will also “do” the work. The local program must take on the task of being a trainer, not just a “doer.” We will never reach the desired community saturation if SVPs continue to take on sole responsibility for this work.
- Even if there is success in changing the norms in SVPs about their role, there remain serious funding limitations at both the state and local levels. Constant threats of funding loss for intervention work and minimal funding for prevention work poses an unfair burden on the field. Alternative funding streams must be a capacity priority and realistic expectations for plan implementation must be considered. We need both quick, low priced strategies and longer term, more intensive strategies that are timed in a manner that support resource growth.

Step 6 – The Plan (Feb – April 2009)

Process Description

The level of detail needed to create the final timeline was not conducive to full SPT discussion, so a smaller, but highly informed team was created to do this work. Representatives of each of the strategy workgroups were added to the SCBT to develop a final timeline for plan implementation, taking into consideration the January and February SPT (and local sexual violence provider discussions) about context and capacity. The final workplan was presented to the full SPT in April 2009 for final discussion and approval.

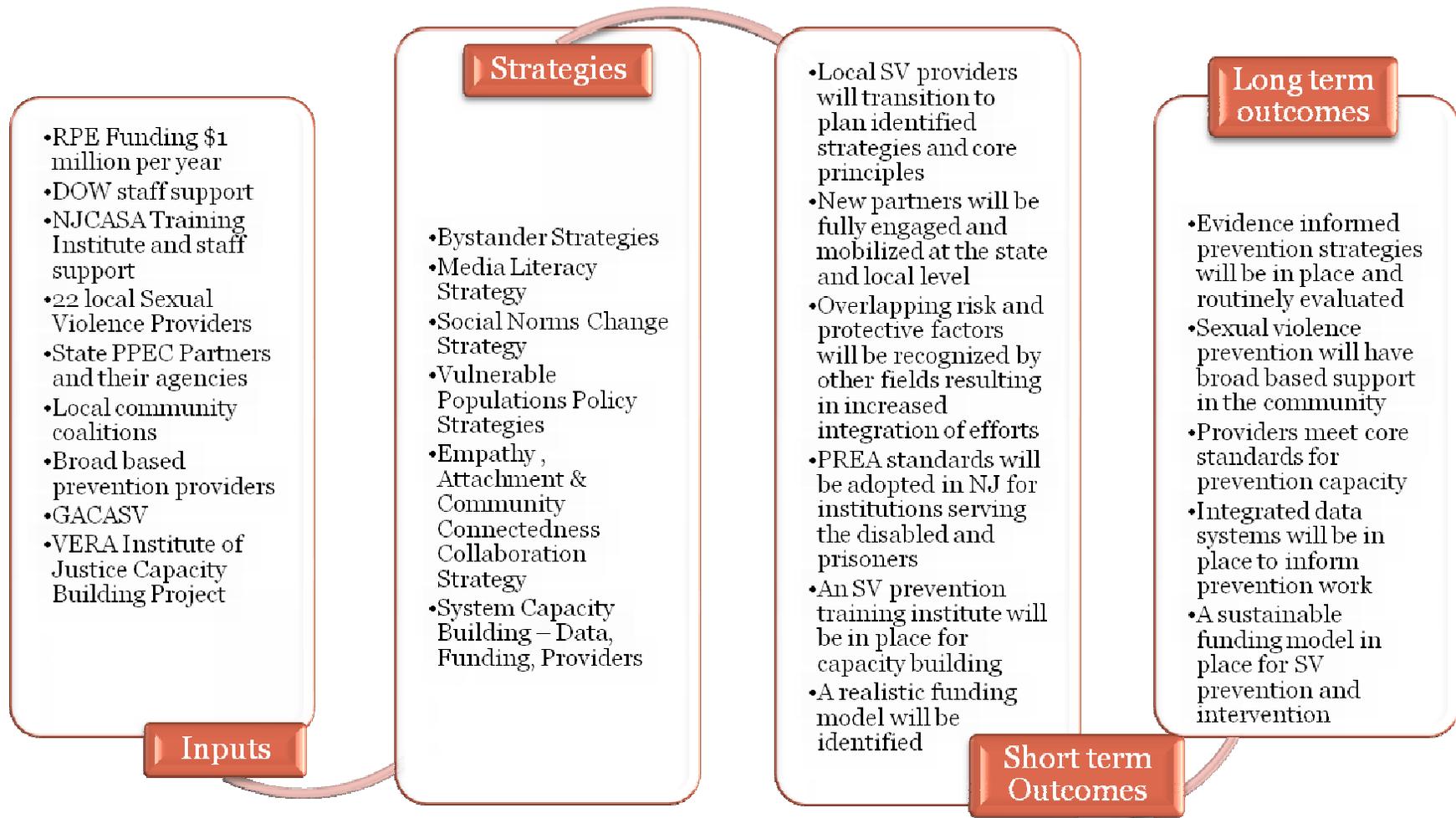
SPT members received the summary of selected strategies, the workplan and revised goals. At the April 22nd meeting, the SPT approved the plan for submission to the CDC and each member present has an opportunity to share what they saw as their role in plan implementation over the next eight years. There was a very high level of member engagement in the discussion of the workplan and a clear commitment to sustaining an “ownership” interest during the implementation and evaluation stages. Discussion of the plan centered on the following questions:

- Does the plan hang together as a whole while addressing appropriate populations?
- Is New Jersey's context and capacity for prevention accurately accounted for in the plan and timeline? If not, what needs to be changed?
- Are there items that need more work or clarification?
- Can you and your organization get behind this plan and become involved in the implementation of the plan?
- Do we have support for submitting this plan to CDC?

The following issues were raised and addressed during the meeting:

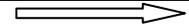
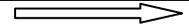
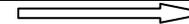
- Year One and Two tasks must be realistic considering the limited capacity available. PPEC partner involvement will be critical for the implementation phase
- The proposed DDD Central Registry is not a public document like the New Jersey Sex Offender Internet Registry. This should be made clear in the plan and to other people.
- We need to advocate with the publisher of SAFE DATES to add sexual violence content
- We need to add a strategy on how to collaborate with RWJF on SAFE DATES. It makes sense to be in the loop on evaluation work and asking them to join our PPEC during that phase.
- There is a need for mandating PREA-like standards for other fields. There are already mandates for prisons but not the developmentally disabled or mental health populations.
- What will be the impact of the plan on the funding model for RPE in New Jersey?
- What opportunities are there for funding based on stimulus funding at state and federal level?
- What will be the non-RPE funded agency involvement? There are opportunities to integrate plan strategies but no funding to do so. Joining county coalitions is not enough. Strong consideration should be given to looking for opportunities for joint grant writing as partners in implementation.

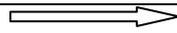
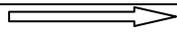
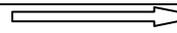
NJ Sexual Violence Prevention Plan



Capacity Building Goals:

- **Increase funding available for sexual violence prevention strategies, data collection and system capacity upgrades and minimize negative financial impact on intervention activities**
- **Build a coordinated system for data collection and analysis in New Jersey**
- **There will be sufficient skill, experience, leadership, information, human resources, evaluation tools and collaboration in RPE funded SVP's to implement and sustain viable strategies for long term reduction and primary prevention of sexual violence in New Jersey.**
- **Develop a baseline and track changes for New Jersey on societal perceptions, norms and attitudes toward key risk factors of sexual violence.**

Inputs 	Strategies 	Outputs 	Interim Outcomes 	Impact
\$1 million dollars per year in RPE funding for prevention	Research and advocacy for dedicated funding stream	Feasibility plan with options for dedicated funding stream	Sponsors in Assembly and Senate and Governor's Support	At least a 100% increase in funding available for prevention and intervention
\$1 million dollars per year in state funding for intervention	Collection of baseline attitudinal and norms data	\$100K in public/private funding for data collection	State/SVPs use data for implementing norms change strategies and evaluation	Comparative norms data available for strategy refinement and evaluation Measure change in attitudes on gender norms over time
Proposed 10% cut to state intervention funding and elimination of Governor's Grant in Aid funding shared with DV.	Integrate prevalence data collection and analysis	Formal affiliation agreements with State Police, DCJ, DOW, DOE, DHSS	Core standards in place on data collection and sharing	Demographic and trend data on perpetration informs future targeting of prevention resources
22 Local SVPs currently providing foundational prevention services	NJCASA Training Institute focus on strategy implementation, cultural competency, evaluation and community mobilization	Minimum of 1 training biannually on each prevention strategy, cultural competency and evaluation for SVPs and community partners	Plan strategies implemented consistently across state and in a culturally competent manner	Fidelity of strategy implementation is at least 80%
NJCASA Training Institute				
Interested community partners (other non RPE funded prevention providers)				
DOW mandated technical assistance in RPE contracts				

State Level Policy Change/Systems Advocacy Goals:				
<ul style="list-style-type: none"> • Create and implement institutional and agency strategies that prevent the perpetration of sexual violence against people with developmental disabilities and inmates of correctional facilities. • Identify and support delivery systems that would increase parental/caregiver attachment and increase empathy skills in children. • Increase opportunities for healthy community connectedness for young males (middle, high school and college level) who have been exposed to family violence. 				
Inputs 	Strategies 	Outputs 	Interim Outcomes 	Impact
Federal PREA Standards DDD current work on central registry and consent redefinition NJ Dept of Children and Families (Strengthening Families) NJ Dept. of Community Affairs – Div. On Women NJ Dept. of Education – Office of Educational Support Services – Drug Free Schools (I Can Problem Solve, Incredible Years, Second Step, Social Decision Making, Dare to be You) Prevent Child Abuse NJ (Healthy Families America) NJCBW Rutgers VAWC	Systems advocacy for Central registry of offenders in DDD system of care Policy change on Consent definition in 2C14 PREA policy adoption, monitoring and adaptation Bystander strategy for caregivers Cross systems advocacy and training with child abuse community DV systems advocacy for targeted community connectedness	Registry implemented DDD representation added to goal workgroup Formal agreement for policy implementation by DOC, DDD and DMH State level caregiver groups attend bystander training At least one cross system training session Quarterly meeting between partners for integration work EBI identified	Central registry lists all identified perpetrators who care for DDD population 2C14 amended Implement PREA standards for Prisoners, DD and MH clients Customized bystander strategy for caregivers Sexual violence content added to empathy/attachment strategies Cross advocacy for funding Goal inclusion in DV Prevention Plan	Known perpetrators not re-hired in DDD system of care Caregivers held accountable for consent, rather than victim Increased screening and supervision in institutions and community care facilities Increased caregiver intervention in institutions and community care settings Increased early intervention for potential risk factors of perpetration Increased funding for both systems increased protective factor of community connectedness for targeted high risk youth

State and Community Level Norms Change Goals:				
<ul style="list-style-type: none"> • Create and market social norms in New Jersey that promote gender equity and respect for women and girls by reducing rigid sexual stereotypes and • Increase bystander intervention along the continuum of sexual violence behaviors among middle school, high school, and college communities. 				
Inputs 	Strategies 	Outputs 	Interim Outcomes 	Impact
22 Local SVPs currently providing foundational prevention services DOW NJCASA Interested community partners (other non RPE funded prevention providers and community groups)	Gender Equality: New Mexico Media Literacy MOST Clubs Positive Social Norms Marketing Bystander: Green Dot Mentors in Sexual Violence Learning to Scream Other approved locally designed strategies that meet core principles of each goal area	A minimum of one strategy implemented in each county that selects these goals 10% of private, public and parochial schools implementing bystander strategies at the middle school, high school and college level Each county program will recruit and engage 1-3 community partners to share in implementation	Strategy customization to meet core principles of plan Local SVPs will transition foundational services to align with plan strategy choices and/or core principles Community partners will adopt and implement plan strategies in cooperation with local SVPs	Social norms that are supportive of rigid sexual stereotyping will decrease by 20%, and social norms which support healthy sexuality and male accountability will increase by 20% Recognition of the impact of sexualized mass media on gender inequality, healthy sexuality and gender roles will increase by 20% Student's skills and knowledge on how to intervene will increase by 50% Skills and knowledge on how to intervene will also increase for other allies by 50% Students' willingness to intervene as engaged bystanders will increase 25% Students' helping bystander behaviors will increase by 25% for those who have the opportunity to intervene

New Jersey Context and Capacity Considerations - Workplan Introduction

The New Jersey Sexual Violence Prevention Plan for 2009-2017 is based on several years of hard work by the Prevention and Public Education Committee of the Governor's Advisory Council Against Sexual Violence. This committee acted as the State Prevention Team (SPT) for the Centers for Disease Control and Prevention, NCIPC - Division of Violence Prevention, EMPOWER pilot project on sexual violence prevention. The following workplan takes into consideration several very important assumptions and current realities:

- The work of sexual violence prevention cannot be the sole responsibility of those individuals and organizations who currently provide critical services to survivors of sexual violence. Prevention will take a coordinated state and community effort that engages new partners, mobilizes communities to act and change societal norms in significant and profound ways. This plan assumes that current RPE funded Sexual Violence Programs (SVPs) will act as facilitators, trainers and community liaisons for these new partnerships and that other organizations and communities will take an ownership interest in the work of prevention. The SPT welcomes and needs new partners and strongly encourages others to be part of the plan implementation and evaluation.
- Funding currently available for prevention under the Federal Rape Prevention and Education (RPE) Program will be treated as seed money for supporting state and county level work for facilitation, training and community mobilization. The workplan includes strategies and tasks that go far beyond the capability and resources currently available through this RPE funding.
- New Jersey is not starting from ground zero in the work of sexual violence prevention. State level and county sexual violence programs have been learning, adapting and working in the field of sexual violence primary prevention throughout the planning process and there are strategies in use that may or may not be reflected in the workplan. Transitioning the collective work into this integrated system will require multi-year efforts at testing and piloting new practices, assessing system development, customizing best practices and realigning the work. A full transition to priority strategies and best practices is not expected to occur until year three to four of the plan. The SPT also expects that current local efforts at innovation might be combined with plan priorities to create hybrid strategies that meet core principles, reflect best practices but also integrate local community priorities and efforts to date. Not all plan strategies will be implemented in all communities due to very limited resources for implementation. The plan encompasses a range of suggested strategies, including low cost, less intensive strategies and higher cost, more staff and capacity intensive strategies. New Jersey will need a balanced approach along this range while we build resources and internal capacity across the state.

Other Contextual Considerations

Final adaptation considerations include:

Political

- As a strong home rule state, we must make sure that there is both top down and bottom up buy-in strategies that match the culture in each area. A key example is that the SPT must add our strategy recommendations to the state level Department of Education Core Curriculum Standards while also engaging local schools districts directly. While the state standards have some clout, local decision making takes precedence.

Geographic Location

- New Jersey is a highly diverse state where each county has a mix of urban, suburban and rural attributes. Any considerations for piloting strategies and data collection would not be at the county level but must be a representative mix of urban, suburban and rural settings.
- New Jersey has two strong media markets, neither located in the state itself. Broadcast media (TV and Radio) is heavily controlled out of New York City and Philadelphia, both high cost markets. Any social norms messaging will need to use a variety of alternative local and community media channels in order to be cost effective and accessible.

Institutional and Organizational Culture

- New Jersey government is under-resourced in these challenging economic times which creates an environment of complex approval processes for new initiatives. Research has substantiated a lack of coordination among and within state departments. The SPT must be sure to find allies within the departments while also getting higher level buy-in to support collaboration.
- In today's environment, many state departments' smaller bureaus consist of one or two people who are responsible for a number of priority projects. This plan must emphasize the benefits of collaboration—how will these items make their work easier and how do we support the initiatives they must manage? Additionally, each state department has its own culture and this work will require careful consideration of the cultural norms.
- There is no single state agency or body that has responsibility for this work and/or has authority over the variety of strategies recommended. All the strategies, especially those requiring policy advocacy, will require strong collaborations across departments. Our capacity goal of getting high level buy-in across departments will be crucial to success and will require that the SPT transform into a long term implementation group.
- The Robert Wood Johnson Foundation, located in New Jersey, has funded two significant projects dealing with intimate partner violence. One is a national initiative *Start Strong: Building Healthy Teen Relationships* and the other is a New Jersey specific initiative to implement the *Safe Dates* curriculum in eight school districts. While the *Safe Dates* curriculum is identified as evidence based for IVP, it was deemed as having only limited sexual violence content and applicability by our strategy workgroups. We will however work closely with RWJF to track implementation and success in these very important initiatives.
- The New Jersey Department of Children and Families (DCF) is currently developing a prevention plan for child abuse and New Jersey has been selected as a DELTA Prep site

by the CDC. We continue to work closely with DCF and the New Jersey Coalition for Battered Women (NJCBW) to integrate the sexual violence, child abuse and intimate partner violence plans and strategies.

Social Context and Demographics

- Sexual violence issues are difficult to get on the radar screen in the general population. SVPs routinely experience reluctance in a variety of communities to discuss this topic. We must adapt the language of our strategies and our final plan to meet people where they are in terms of “readiness” to discuss issues and act on them. Terms like “gender equity” are important in the field but may need to be expressed differently in public. Sexual violence content added to strategies must be accessible, age appropriate and linked to other valued community norms such as public safety or emotional health. At the same time we must retain our feminist history and stay focused on the critical and valued goals and outcomes.
- A number of strategies will require the use of POLs (public opinion leaders). As a highly diverse state, we must add core components to each strategy that ensures careful consideration of cultural/ethnic/community norms about who is a credible POL.

Aligning Strategies with State and Local Capacity

Final capacity issues include:

- SVPs have serious resource limitations and high turnover rates for prevention staff. Capacity building in community organizing and community mobilization must continue to focus on finding nontraditional allies and collaborators who will also “do” the work. The local program must take on the task of being a trainer, not just a “doer.” New Jersey will never reach the desired community saturation if SVPs continue to take on sole responsibility for this work.
- Even if there is success in changing the norms in SVPs about their role, there remain serious funding limitations at both the state and local levels. Constant threats of funding loss for intervention work and minimal funding for prevention work poses an unfair burden on the field. Alternative funding streams must be a capacity priority and realistic expectations for plan implementation must be considered.
- New Jersey needs both quick, low priced strategies and longer term, more intensive strategies that are timed in a manner that support resource growth and funded in a manner that supports quality implementation. Pilot implementation is a strong consideration for the most labor-intensive strategies including social norms marketing and bystander intervention. Local SVPs should be strongly discouraged from choosing more than one strategy and/or goal because of resource limitations.
- SVPs continue to feel the stress of adequately staffing both intervention and prevention activities and it is often the case that the prevention staff have responsibilities for intervention. The skills sets needed for prevention vary considerably from those needed for intervention and when one person shares these tasks, prevention becomes a secondary priority. Whenever possible, plan implementation must maximize opportunities for

collaborative implementation of strategies across counties to make the best use of limited staff.

- Culture drives worldview and perception and the sexual violence field is still overwhelmingly white (especially in agency leadership positions). It is vital that the field be able to ask the right questions (especially for social norms) and be open to hear answers that do not “fit” for them so that culturally specific responses can break through and be heard. There is required capacity building and culturally appropriate assessment needed to ensure these new voices break through and are honored.
- Local SVPs vary widely in their capacity to implement primary prevention strategies and process and outcome evaluation. At the same time there has been positive movement toward a higher state of readiness for primary prevention in response to the NJCASA Sexual Violence Prevention Capacity Development Initiative, now underway with the VERA Institute for Justice.
- A number of local SVPs already have existing strong relationships with schools, which will be helpful in strategy implementation.

Workplan Priorities and Task List

Capacity Goals: Improve Funding, Data and System Capacity

Selected strategies will:

- **increase funding available for sexual violence prevention strategies, data collection and system capacity upgrades and minimize negative financial impact on intervention activities.**
- **maximize use of scarce resources by integrating data collection in New Jersey for all issues that have overlapping risk and protective factors.**
- **ascertain and develop clear commitment and capacity of state agencies and communities represented on the SPT for the sexual violence prevention plan and its implementation.**
- **create a coordinated system for data collection and analysis in New Jersey.**
- **increase skill and knowledge level of SVPs in the implementation and assessment of prevention strategies.**

Core Principles: Across all goals

- Capacity building for cultural competency must be embedded in all implementation plans for prevention strategies. All strategies will require a strong sensitivity to the very diverse cultural norms and communities in New Jersey.
- This plan highlights the broad range of prevention strategies required in New Jersey. These strategies and the capacity building they require significantly exceed the resources available for prevention through current funding. Plan emphasis for the first two years is on capacity building and the development of a dedicated funding stream for both intervention and prevention.
- Use of advanced technology is needed for implementation of many of the prevention and capacity building strategies

Task Plan: Capacity Building

Strategy	Year 1 - 2 Tasks	Year 3 - 4 Tasks	Year 5 - 8 Tasks
Increase Prevention, Data Collection and Intervention Funding	<ul style="list-style-type: none"> • NJCASA identifies and solicits private and <u>public</u> funding (\$58,000) for state/county <u>adult</u> baseline data on gender norms. • SPT develops funding model for social norms campaign • SPT develops model for state and local prevention and intervention that allows for discrete local funding for at least 1 FTE for prevention and clear delineation of 	<ul style="list-style-type: none"> • DOW coordinates 75% of public funding for 3-year state/county valid follow-up survey on gender norms. • NJCASA coordinates 25% of private funding for 3-year state/county valid follow-up survey on gender norms. • SPT/DOW develops cooperative funding agreements in place for cross-departmental cooperation and 	<ul style="list-style-type: none"> • DOW coordinates 75% of public funding for 6-year state/county valid follow-up survey on gender norms. • NJCASA coordinates 25% of private funding for 6-year state/county valid follow-up survey on gender norms. • A new, dedicated state level funding stream is passed by

Strategy	Year 1 - 2 Tasks	Year 3 - 4 Tasks	Year 5 - 8 Tasks
	<p>prevention/intervention responsibilities.</p> <ul style="list-style-type: none"> • NJCASA completes research on dedicated funding stream and begins to craft legislation and coordinate legislative support. • SPT/DOW advocates for increasing federal funding support for SV prevention and surveillance. • SPT to identify and engage high profile victim allies in New Jersey to support this plan 	<p>integration on funding and data collection for overlapping risk and protective factors.</p> <ul style="list-style-type: none"> • SPT/DOW and NJCASA advocate for funding models with state and federal funds and foundation support. • NJCASA finalizes sponsors for dedicated funding stream legislation and bill is introduced. • SPT/ GACASV advocate for passage of dedicated funding stream legislation. • SPT advocates for increasing federal funding support for SV prevention and surveillance. 	<p>New Jersey legislature to fund SV prevention and intervention strategies and services, based on need identified in years 1-2.</p> <ul style="list-style-type: none"> • NJCASA advocates for increased private support for use in sexual violence prevention and intervention strategies. • SPT advocates for increasing federal funding support for SV prevention and surveillance.
<p>Increase Commitment and Coordination</p>	<ul style="list-style-type: none"> • SPT members facilitate formal sign off from other state department leadership (DCJ, DCF, DHS, DHSS, DOE, DOC, State Police, DMVA, and DCA) to the plan goals, strategies and advocacy priorities. • SPT identifies liaisons in each state department that currently has responsibility for sexual violence related issues • SPT identifies and documents existing statutory regulations in each partner department related to sexual violence • NJCASA increases local SVP capacity to analyze sexual violence 	<ul style="list-style-type: none"> • SPT coordinates a core group of identified liaisons to share data, improve data collection and pool resources between departments • DOW/GACASV/SOVWA coordinates statewide incidence data collated and shared across partner agencies. 	<ul style="list-style-type: none"> • SPT coordinates streamlined data collection system for state agencies. The data collection system will be integrated and produce: <ul style="list-style-type: none"> • demographic data on perpetrators and victims/survivors • data that tracks cases of perpetration over time including relevant past history • data that demonstrates the

New Jersey State Prevention Plan for Sexual Violence

Strategy	Year 1 - 2 Tasks	Year 3 - 4 Tasks	Year 5 - 8 Tasks
	<ul style="list-style-type: none"> • magnitude data • NJCASA implements state/county survey on gender norms; coordinates with SCBT. • NJCASA integrates baseline survey content with DOE middle school survey • UMDNJ facilitates agreements with local health departments for commitment to plan goals and strategies • NJCASA collaborates with RWJF and local SVPs to adapt SAFE DATES for sexual violence • SPT, state department leadership and other prevention entities commit to including cultural competency in all strategy development and implementation 		<ul style="list-style-type: none"> • effectiveness of strategies • sufficient state, county and major urban area data • data that identifies shared characteristics of perpetrators • optimal use of existing data collection systems (i.e.: add SV module to BRFS, YRBS and other student health surveys)
<p>Increase Local Program Prevention Capacity</p>	<ul style="list-style-type: none"> • Targeted capacity building implemented for bystander, gender equity, and positive social norms marketing through the NJCASA Training Institute. • NJCASA's SVP capacity building project goals are integrated with State Plan goals. • NJCASA develops core competencies for sexual violence prevention staffing and funding based on state goals and strategies, including cultural competency. 	<ul style="list-style-type: none"> • NJCASA develops and implements certification process for sexual violence prevention staff • NJCASA implements targeted capacity building for process and outcome evaluation and use of technology in strategy implementation. • NJCASA develops, coordinates and provides training and capacity building for cultural competency in implementation of strategies 	<ul style="list-style-type: none"> • NJCASA implements ongoing training and capacity development based on progress of State Plan and increased use of varying strategies.

New Jersey State Prevention Plan for Sexual Violence

Strategy	Year 1 - 2 Tasks	Year 3 - 4 Tasks	Year 5 - 8 Tasks
	<ul style="list-style-type: none">• RPE RFP guidelines and funding levels reflect State Plan goals and strategies		

Goal: Decrease Perpetration against Highly Vulnerable Populations

Create and implement institutional and agency strategies that prevent the perpetration of sexual violence against people with developmental disabilities and inmates of correctional facilities. These strategies will:

- **increase supervision of caregivers.**
- **improve screening staff for potential perpetration.**
- **create and implement educational programs for wide range of service recipients, caregivers, and supervisors (organizational, family and peers) on primary prevention of sexual violence.**
- **revise and upgrade existing policies and procedures and expand implementation of prevention standards to a variety of settings and across populations.**

Strategies Selected:

Prison population

Recommended strategy:

- Adopt the Prison Rape Elimination Act standards promulgated by PREA Commission
- Monitor the implementation of the standards
 - Research monitoring models used in other areas such as Court Watch
 - Advocate for state level oversight and monitoring

People with disabilities

Recommended strategies:

- Bystander training for caregivers and people with disabilities
 - Local programs
- Establishment of a central registry of caregivers in institutions and community care settings who have been found to have abused their clients
 - Statewide
- Building grassroots support for legislative changes
 - Local programs and statewide
- Modification of New Jersey Sexual assault laws regarding accountability of caregivers
 - Statewide
- Modify Prison Rape Elimination Act standards in the following areas for implementation in institutional and community care settings for people with disabilities: (statewide)
 - Mandatory reporting of abuse of people with disabilities
 - Protection for staff members who report abuse

- Training around reporting
- Establishment of a zero tolerance policy for sexual relationships between a caregiver and the client
- Collection of data as suggested in federal Crime Victims with Disabilities Act (S 3668)
 - Statewide

Core Principles and Components: These include strategy requirements and New Jersey specific adaptations.

The principles of the Prison Rape Elimination Act (PREA) are the core of the standard for working with vulnerable populations. The principles in PREA include empowering staff and inmates to report abusive behaviors without fear of reprisal, a commitment on behalf of institutions and community care settings to eliminate sexual violence and to deal with incidents of sexual violence in an appropriate and timely manner, and accountability within the institution/community care setting. These principles can be applied to those working with other vulnerable populations, such as those with developmental, mental health and physical disabilities.

Implementation Recommendations:

In New Jersey, we have found that in attempting to create change within the agencies charged with working with people with disabilities and inmates, a top down approach is the most effective method of creating change. Legislative and regulatory changes lead to changes in behavior at the local level. Many of these agencies are accustomed to following many regulations and will make changes only when pushed to do so by way of statute or regulation. However, once the statute or regulation is created, there are actual changes in behavior at the local level.

Task Plan – Vulnerable Populations

Strategy	Year 1 - 2 Tasks	Year 3 - 4 Tasks	Year 5 - 8 Tasks
Advocate for adoption and monitoring of PREA standards in New Jersey prisons and jails	<ul style="list-style-type: none"> • GCASV Legislative Committee work on needed legislation/regulations to adopt PREA standards in New Jersey • Advocate for train the trainer sessions for DOC personnel on PREA standards and SV dynamics (Advocates with select PPEC members) • Provide DOC with technical assistance in development of training curricula to implement 	<ul style="list-style-type: none"> • SPT implementation workgroup to research models for effective monitoring of implementation of standards • GCASV continued advocacy on PREA implementation 	<ul style="list-style-type: none"> • New Jersey Office of Ombudsman and criminal justice system advocates (i.e.: New Jersey Institute for Social Justice) to work with DOC to monitor implementation of regulations and report back to SPT • Consider application of PREA strategies to other disabled populations

New Jersey State Prevention Plan for Sexual Violence

Strategy	Year 1 - 2 Tasks	Year 3 - 4 Tasks	Year 5 - 8 Tasks
	PREA at the institutional level		
Build collaborative relationships with DDD and DMH and community care providers to ensure adaptation and implementation of PREA-like standards and policies	<ul style="list-style-type: none"> • Advocacy for establishment of a central registry of caregivers who have been found to have abused their DD clients (GACASV Legislative Committee) • Advocate for modification of New Jersey consent laws in 2C14 to include focus on caregivers of vulnerable individuals 	<ul style="list-style-type: none"> • SPT to advocate for data collection standards suggested in Federal Crime Victims with Disabilities Bill (S3668) • SPT to adapt PREA standards for the disabled community including: <ul style="list-style-type: none"> • Mandatory reporting • Protection for staff who report abuse • Training around reporting • Zero tolerance for sexual relationships between a caregiver and client 	<ul style="list-style-type: none"> • DDD and DMH to implement and monitor data collection standards • SPT to research how to expand standards and central registry concept in Mental Health field and with other vulnerable populations in institutional and community care settings
Customize and implement select strategies for use with caregivers of vulnerable populations		<ul style="list-style-type: none"> • SPT implementation workgroup to research and assess applicability of bystander strategies for use with caregivers, and consider implementation options • Adapt strategies selected for use with caregivers 	

Goal: Increase Empathy and Attachment

Identify and support delivery systems that would achieve the following: increase parental/caregiver attachment and increase empathy skills in children.

Strategies Selected for Collaboration:

- Strengthening Families (funded by DCF)
- Healthy Families (coordinated through PCANJ)
- I Can Problem Solve, Incredible Years, Second Step, Social Decision Making, Dare to be You (funded under DOE – Drug Free Schools)

Core Principles and Components: These include strategy requirements and New Jersey specific adaptations. In making judgments about which programs to consider recommending, three criteria were used:

- Has the strategy been vetted by a credible source in terms of effectiveness related to the purpose of the goal?
The informational sources used to make this judgment were inclusion in the Matrix of Programs Identified by Federal and Private Agencies of the Center for the Study and Prevention of Violence, and the knowledge and experience of SPT members regarding how the program was being utilized in New Jersey and elsewhere.
- Is the strategy in current use in New Jersey at a level that makes implementation practice credible and accessible?
This criterion became an important pragmatic consideration as SPT members realized that identifying the most rigorously researched programs for implementation was marginally useful if they were without standing in New Jersey because without a program delivery infrastructure to champion it and significant new implementation resources, a new program would have no traction or hope of large scale adoption.
- Did the program rest on grounded theory that was in keeping with the goal?
This criterion emerged as SPT members responsible for reviewing specific programs discussed the relationship between how the program was developed, effectiveness research and the intent of the goal.

Other Considerations:

- Has the strategy been evaluated or is the program evaluation ready (integrate existing evaluation data into future sexual violence evaluation)?
- Prioritize those strategies that have a top down, state level association approach, such as strategies funded through the Department of Children and Families, the Department of Education's Office of Educational Support Services, Office of Drug-Free Schools or coordinated through Prevent Child Abuse New Jersey (PCANJ).

Implementation Recommendations:

- Most of the focus is placed on supporting delivery systems that are already providing attachment and empathy skill building programs and strategies and assisting those agencies with understanding the connection between empathy, attachment and risk and protective factors for sexual violence perpetration.
- This should be mutually supportive for SVPs by creating opportunities for these programs to meet those involved in delivery systems already providing attachment and empathy skill building and to cross train.
- NJCASA will support this collaborative relationship by advocating for and supporting funding for delivery systems already implementing the above strategies and therefore creating a win-win situation for both existing delivery systems and SVPs.

Task Plan: Empathy and Attachment

Strategy	Year 1 - 2 Tasks	Year 3 - 4 Tasks	Year 5 - 8 Tasks
Add sexual violence content and linkages to strategies	<ul style="list-style-type: none"> • DOW to build collaborative relationships with State level funders and implementers to begin discussions on strategy integration based on overlapping risk and protective factors (Rutgers CVAWC) 	<ul style="list-style-type: none"> • DOW facilitates addition of appropriate sexual violence content into targeted strategies 	<ul style="list-style-type: none"> • Evaluate sexual violence content and provider use of content (DOW and SPT) • Continue advocacy and coalition building at state level (DOW)
Advocate for funding and expansion of strategies in New Jersey as part of integrated prevention program	<ul style="list-style-type: none"> • DOW to identify collaborative, cross system, win/win messaging about strategy funding and expansion (GACSV, NJCASA membership, Empathy and Attachment provider/funder systems) • DOW to work with DCF to integrate planning efforts on Strengthening Families with the Sexual Violence Primary Prevention plan 	<ul style="list-style-type: none"> • Identify and use opportunities for cross system advocacy for funding, expansion and recognition of overlapping risk and protective factors 	<ul style="list-style-type: none"> • Continue advocacy and coalition building at state level (DOW)

Goal: Increase Community Connectedness

Increase opportunities for healthy community connectedness for young males (middle, high school and college level) who have been exposed to family violence.

Strategies Selected:

- Collaboration with others who have access to this high risk population. Since the New Jersey Coalition for Battered Women (NJCBW) will soon become part of DELTA Prep, the SPT sees this as an opportunity for collaboration between the two teams on primary prevention initiatives. The SPT will work in partnership to help develop strategies to address community connectedness.
- Identify opportunities for building community connectedness into other goals and strategies

Core Principles and Components: These include strategy requirements and New Jersey specific adaptations.

- Since NJCBW and its member programs may be more readily able to identify young males who have been exposed to family violence, this DELTA Prep organization may be best suited to assist in the development and implementation of a strategy addressing community connectedness.
 - Another consideration is to recommend merging this goal with gender equity through the MOST Clubs, which is a Gender Equity recommended strategy.
 - There are opportunities for articulating the principle of community connectedness across all goals, reinforcing positive social norms.

Implementation Recommendations:

- It was determined that this goal would need longer term research of effective strategies and building of collaborative relationships with those who have direct access to this high risk population. One collaborative relationship that already exists is the one between members of the State Prevention Team and the New Jersey Coalition for Battered Women. In fact, a staff member of the New Jersey Coalition for Battered Women is a member of the State Prevention Team and could help to facilitate collaboration on this goal.

Task Plan: Empathy and Attachment

Strategy	Year 1 - 2 Tasks	Year 3 - 4 Tasks	Year 5 - 8 Tasks
Collaboration with those who have direct access to this high risk population - DV Providers		<ul style="list-style-type: none"> • Research core strategies that can be implemented in cooperation with others who have direct access to this population -(DOW/SPT and DELTA Prep) 	<ul style="list-style-type: none"> • Integrate the work of domestic violence programs into the sexual violence prevention system and evaluation plan

Goal: Increase Gender Equity Norms

Create and market social norms in New Jersey that promote gender equity and respect for women and girls by reducing rigid sexual stereotypes and

Specific Strategies Selected:

- New Mexico Media Literacy Project – Gender Constructions and Body Image
- Positive Social Norms Marketing
- MOST Clubs

Core Principles and Components: These include strategy requirements and New Jersey specific adaptations.

New Mexico Media Literacy

- Participate in 2-4 day training institute
- Combine the Media and Body Image and portions of the Media Literacy Toolbox to create a comprehensive curriculum
- Add extra examples targeted to men, men and women, people of color and people of all sexual orientations
- NMMLP to add evaluation tools based on work in tobacco prevention
- Positive messaging developed locally fed back to state level for possible use in Social Norms Marketing

Social Norms Marketing

- A data driven message and process (strong data collection before, during and after)
- Messaging must be Positive, Inclusive and Empowering (PIE)
- Must use credible message sources for the select population
- Must use multiple message channels that promote contamination
- The message must be a social norm in the language of the target audience
- The primary message jumps out of the media – is most visible
- Dedicated staff to oversee strategy implementation

MOST Clubs

- Dedicated staff to oversee Club
- Background checks on Club facilitators
- Mentoring, parent, Strength Project and Public education campaign components required
- Required Code of Conduct
- Ability to require participant attendance
- Designated safe meeting space
- Completion of training with MCSR
- Financial resources for incentives to participants
- Access to TV/VCR and/or DVD player

Implementation Recommendations:

- It is expected that strategy adaptation, especially where sexual violence content needs to be added or developed, will occur at the state level in the first year to two years prior to local program implementation. Local pilots will be used in early years to test the strategies and make adjustments as needed.
- It is also expected that local SVPs will use the first two years of the plan to transition their current programming to align with the core principles of plan identified strategies or to pilot the plan identified strategies. Local SVPs may continue to implement “foundational” strategies currently in place while making the necessary transition and adaptation to the plan identified strategies.

New Mexico Media Literacy	Social Norms Marketing	MOST Clubs
Local choice to implement and identify local high risk populations (and targeted communities)	Pilot test in urban, suburban and rural areas before widespread implementation	Local choice to implement with middle and high school males

Task Plan

Strategy	Year 1 - 2 Tasks	Year 3 - 4 Tasks	Year 5 - 8 Tasks
Media Literacy \$ = low cost * = relatively easy to implement with a variety of community partners	<ul style="list-style-type: none"> • Work with New Mexico Media Literacy Project to customize toolkits on healthy sexuality and evaluation tools (SPT or NJCASA) • Identify SVPs who wish to implement this strategy (NJCASA) • Provide training to local providers (NJCASA) • Local implementation, testing and adaptation of Media Literacy Toolkit on Gender Constructions in pilot communities (SVP's) • Begin outreach and planning with 	<ul style="list-style-type: none"> • Expanded implementation, testing and adaptation of Media Literacy Toolkit on Gender Constructions in locally targeted communities (SVP's) 	<ul style="list-style-type: none"> • On-going implementation, evaluation and adaptation (SVP's) • Add sites throughout state (SVP's)

New Jersey State Prevention Plan for Sexual Violence

Strategy	Year 1 - 2 Tasks	Year 3 - 4 Tasks	Year 5 - 8 Tasks
	communities selected for strategy piloting (SVP's)		
<p>Positive Social Norms Marketing \$\$\$ = high cost ***=requires relatively high levels of coordination, data capacity and staffing for facilitators and community partnerships</p>	<ul style="list-style-type: none"> • Develop baseline state and regional data on SV social norms, attitudes and evaluation requirements (NJCASA) • Assess funding model required to support start up and expansion (NJCASA and SPT) • Develop statewide sexual violence content and focus for this strategy (NJCASA and SPT) • Identify core requirements and methodology for selection of pilot sites (PPEC) • Develop training requirements to meet capacity building needs of local providers (NJCASA and SPT) • Assist interested local SVPs in adapting current practices/strategies to integrate best practice standards of Positive Social Norms Marketing (NJCASA) 	<ul style="list-style-type: none"> • Conduct training to build local capacity to customize messaging channels for targeted communities (NJCASA) • Use focus groups to test messages in diverse communities and identify most useful local communication channel standards (NJCASA and SVP's) • Implement 3-4 pilot projects (SVP's) • Repeat attitudinal survey bi-annually (NJCASA) 	<ul style="list-style-type: none"> • On-going implementation, evaluation and adaptation • Upgrade collection and review of community data for use in cultural and geographic adaptation in other local communities (SVPs and NJCASA/DOW) • Add sites throughout state • Repeat attitudinal survey bi-annually (NJCASA and SVP's)
<p>MOST Clubs \$\$ = moderate cost ** = requires moderate levels of internal capacity and staffing and coordination for</p>	<ul style="list-style-type: none"> • Work with MCSR to ensure selection for state's participation in strategy (SPT) • Add training to NJCASA Training Institute for local programs that wish to use this strategy 	<ul style="list-style-type: none"> • Implement strategy in select communities (SVP's) • Conduct process evaluation to check for fidelity to core principles and adaptation needs that might arise (SVP's and 	<ul style="list-style-type: none"> • On-going implementation, evaluation and adaptation • Add sites throughout state

New Jersey State Prevention Plan for Sexual Violence

Strategy	Year 1 - 2 Tasks	Year 3 - 4 Tasks	Year 5 - 8 Tasks
community partnerships	(NJCASA) <ul style="list-style-type: none"> • Identify SVPs that wish to choose this strategy (NJCASA) 	NJCASA)	

Goal: Increase Bystander Intervention

Increase bystander intervention along the continuum of sexual violence behaviors among middle school, high school, and college communities.

Specific Strategies Selected:

- Green Dot
- Mentors in Violence Prevention
- SCREAM Theater: Learning To Scream

Core Principles and Components: These include strategy requirements and New Jersey specific adaptations.

1. Strategies need to educate, train, and utilize peer educators or popular opinion leaders (POLS) from the targeted community or school. These peer educators and POLS must receive the CDC – recommended dosage of seven-nine sessions of training. Social norms marketing or other follow-up activities should be used in order for the larger community to get sufficient dosage.
2. Strategies must have administrative, top-down support. Included in this support is education for all key stakeholders and administrators on sexual violence prevention and bystander intervention.
3. Strategies must incorporate a specific component on bystander skill development- how to intervene effectively and safely.
4. Strategies must include a component on sexual violence education, including information on the continuum of sexual violence and what actions constitute prevention.

Implementation Recommendations:

In order to give people a choice of programs with different venues, we are recommending three strategies as ways to implement bystander intervention. We envision that these programs would be implemented based on the core components listed. We also assume that these strategies will be implemented in public, private and parochial schools.

<i>Green Dot</i>	<i>SCREAM Theater, Learning to SCREAM</i>	<i>Mentors in Violence Prevention (MVP)</i>
<p>\$ to \$\$\$ = minimal to high: can be done on any budget</p> <p>***=Need staff to train POLs/PEs and community members, lead follow-up trainings/meetings, and conduct social norm marketing campaign</p>	<p>\$ to \$\$ = minimal to moderate: cost of Learning to Scream is \$150 to \$500. Expense would go up if a SCREAM theater project is implemented.</p> <p>* = Rutgers can be contracted to train POLs/PEs. High capacity would be required if peer educator theater program is implemented.</p>	<p>\$\$ to \$\$\$ = moderate to high: ranges from \$5000 one-time event to \$7500 for train-the-trainer. Expense will go up if MVP program is implemented.</p> <p>*= MVP can be contracted to provide awareness raising programs as a one-time only event. High capacity would be required if peer educator MVP program is implemented.</p>
<ul style="list-style-type: none"> • Pioneered by Dorothy Edwards at the University of Kentucky, Green Dot is a universal bystander intervention program applicable to a wide variety of communities, ages, and educational institutions. • The program is flexible and engaging and can be easily adapted. • This state-to-state strategy has future benefits for cross state evaluation, research, and funding. 	<ul style="list-style-type: none"> • SCREAM (Students Challenging Realities and Educating Against Myths) Theater is an interactive, peer education theater program that addresses issues of violence. • The Learning To SCREAM program helps other groups develop their own peer education theater programs using a Train-the-Trainer model. • Rutgers University is already implementing this strategy in New Jersey and has conducted evaluation of its effectiveness on knowledge, attitudes and behaviors. 	<ul style="list-style-type: none"> • Based out of Northeastern University, the MVP program is focused on empowering students to act as engaged bystanders on issues of violence. • The Train-the-Trainer piece offers the chance to create a group of peers or leaders who are educated on prevention and bystander action. • It has demonstrated success and appeal to various audiences, especially adolescents and all-male groups.

Task Plan – Bystander Strategy

Strategy	Year 1 - 2 Tasks	Year 3 - 4 Tasks	Year 5 - 8 Tasks
<p>Bystander strategies:</p> <ul style="list-style-type: none"> • Green Dot • Mentors in Violence Prevention • Learning to SCREAM 	<ul style="list-style-type: none"> • NJCASA to provide training and capacity building for SVPs) who choose to implement a bystander intervention strategy • NJCASA to offer the opportunity for training for all programs interested in Green Dot • The SPT to customize the listed strategies to ensure that they have sufficient and age appropriate sexual violence content for high school through college age students • The SPT o build collaboration between local sexual violence programs and other providers to maximize access to schools and integrate efforts • The SPT to develop an evaluation plan, in collaboration with Green Dot and other states implementing Green Dot, 	<ul style="list-style-type: none"> • NJCASA to provide training and capacity building for local programs that chose to implement in middle schools, especially in area of choosing POL’s that reflect the diversity of New Jersey • The SPT to assess the effectiveness of implemented bystander programs and make recommendations to SVPs for modification if needed • The SPT to develop marketing strategies to expand prevention efforts beyond SVPs, with a focus on colleges and universities • The SPT to provide technical assistance to other prevention programs in schools, as requested, to align their strategy to CDC definition of primary prevention, add sexual violence content and meet core standards identified by the workgroup • The SPT to customize listed strategies to ensure that they have sufficient and age appropriate sexual violence content for middle school students 	<ul style="list-style-type: none"> • On-going implementation, evaluation and adaptation by the SPT • The SPT will document implementation of bystander strategies in 10% of the total public, private and parochial high schools, middle schools and colleges across the state

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Strategy	Year 1 - 2 Tasks	Year 3 - 4 Tasks	Year 5 - 8 Tasks
		<ul style="list-style-type: none"> The SPT to provide technical assistance to other prevention programs in schools, as requested, to align their strategies to CDC definitions of primary prevention, add sexual violence content and meet core standards identified by the workgroup. 	

APPENDIX A

Governor's Advisory Council Against Sexual Violence Prevention and Public Education Committee

Members and Resource People

CURRENT MEMBERS

Shari Bloomberg, LCSW

Coordinator, Domestic Violence Program
Jewish Family Services of Central NJ
655 Westfield Ave
Elizabeth, NJ 07208
E-mail: sbloomberg@jfscentralnj.com
Phone: 908.352.8375
Fax: 908.352.8858

Tay Bosley, PsyD

Clinician Administration, CSL/PSL Program
UMDNJ-UHC
P.O. Box 863 Whittlesey Rd.
Trenton, NJ 08625-0863
E-mail: bosleyjt@umdnj.edu
Phone: 609.341.3093
Fax: 609.341.9380

Phillip M. Brown, PhD

Director
Center for Character Education, Rutgers University
41 Gordon Road
Piscataway, NJ 08854
E-mail: pmbrown@rci.rutgers.edu
Phone: 732.445.7504
Fax: 732.445.7970

Elizabeth M. Casparian, PhD

Director of Educational Programs
HiTOPS
21 Wiggins Street
Princeton, NJ 08540
E-mail: ecasparian@hitops.org
Phone: 609.683.5155 ext. 234
Fax: 609.683.9507

Judy Chapman

Editor/Founder
Garden State Woman Magazine
PO Box 709
Long Valley, NJ 07853
E-mail: jchapman@gswoman.com

Phone: 908.879.7143
Fax: 908.879.5839

Jacqueline Deitch-Stackhouse, LCSW

Coordinator, Office of Anti-Violence Initiatives
The College of New Jersey
TCNJ - Eickhoff Hall #159
PO Box 7718
Ewing, NJ 08628-0718
E-mail: Deitch@tcnj.edu
Phone: 609.771.2272
Fax: 609.637.5107

Glenn Ferguson, PhD

Deputy CEO/Clinical Services
Ann Klein Forensic Center
PO Box 7717
West Trenton, NJ 08628
E-mail: Glenn.Ferguson@dhs.state.nj.us
Phone: 609.633.0905
Fax: 609.633.0966

Vincent J. Giardina

Supervisor of Investigations
NJ Department of Human Services, Special Response Unit
222 S. Warren St.
P.O. Box 700
Trenton, NJ 08625-0700
E-mail: vince.giardina@dhs.state.nj.us
Phone: 609.777.0865/856.690.5374
Fax: 609.292.6045/856.696.6315

Karen Gillespie

Education Specialist
Prevention First
1405 Highway 35 North
Ocean, NJ 07712
E-mail: KGillespie@PreventionFirst.net
Phone: 732.663.1800 x 267
Fax: 732.663.1698

Jill Giordano

Prevention Coordinator
New Jersey Coalition Against Sexual Assault
2333 Whitehorse Mercerville Rd. Suite J
Trenton, NJ 08619
jgiordano@njcasa.org
<http://www.njcasa.org>
Phone: 609.631.4450 x 202
Fax: 609.631.4453

Mary Giovinazzo

Associate Director
New Jersey Coalition Against Sexual Assault
2333 Whitehorse Mercerville Road, Suite B
Trenton, NJ 08619
E-mail: mgiovinazzo@njcasa.org
Phone: 609.631.4450
Fax: 609.531.4453

Joseph Griffin

Unit Head, Victim Services Unit
NJ State Police
PO Box 7068 River Road
West Trenton, NJ 08081
E-mail: Lpp3780@gw.njsp.org
Phone: 609.452.2601 ext 5905

Vance Hagins

Court Executive
Administrative Office of the Courts
Hughes Justice Complex/Criminal Court
Trenton, NJ 08625
E-mail: Vance.Hagins@judiciary.state.nj.us
Phone: 609-984-5041

Barbara M. Horl

Lobbyist, Governmental Relations Dept.
NJ School Boards Association
28 Buena Place
Red Bank, NJ 07701
E-mail: horlfamily@aol.com combhorl@njsba.org
Phone: 609.278.5225
Fax: 609.394.0753

Maneesha Kelkar

Director
Manavi, Inc.
P.O. Box 3103
New Brunswick, NJ 08901
E-mail: maneesha@manavi.org
Phone: 732.435.1414 ext. 3
Fax: 732.435.1411

Sylvia C. Loumeau, LCSW

Director of Behavioral Health Services
Catholic Charities of the Diocese of Camden
1845 Haddon Ave
Camden, NJ 08103
E-mail: Sylvia.Loumeau@vhsdc.org
Phone: 856.342.4162
Fax: 856.342.4174

Vicki Lunde Rodriguez

RPE and RC&P Program Coordinator
Division on Women
NJ Department of Community Affairs
101 South Broad Street
PO Box 801
Trenton, NJ 08625- 0801
E-mail: vrodriguez@dca.state.nj.us
Phone: 609.984.2016
Fax: 609.633.6821

Phillip T. McCabe, CSW, CAS

Health Educator
UMDNJ - School of Public Health
683 Hoes Lane West
Piscataway, NJ 08854
E-mail: mccabept@umdnj.edu
Phone: 732.235.8229
Fax: 732.235.9460

James A. McCall, PhD

Coordinator, Health and Physical Education
NJ Department of Education
PO Box 500
100 Riverview Executive Plaza
Trenton, NJ 08625
E-mail: james.mccall@doe.state.nj.us
Phone: 609.777.4809
Fax: 609.292.7276

Jennifer L. Miller, LCSW

Director of Marketing
Mental Health Association in New Jersey
88 Pompton Avenue
Verona, NJ 07044
E-mail: jmiller@mhanj.org
Phone: 973.571.4100 ext. 118
Fax: 973.857.1777

Melissa H. Nazario

Rape Care and Prevention Program
Division on Women
NJ Department of Community Affairs
101 South Broad Street
PO Box 801
Trenton, NJ 08625- 0801
E-mail: mnazario@dca.state.nj.us
Phone: 609.633.6308
Fax: 609.633.6821

Peri Nearon

Director, Office on Women's Health
NJ Department of Health and Senior Services
50 East State Street
PO Box 364
Trenton, NJ 08625-0364
E-mail: peri.nearon@doh.state.nj.us
Phone: 609.984.9384
Fax: 609.292.9599

Erin O'Hanlon

Program Supervisor
Atlantic County Women's Center
PO Box 311
Northfield, NJ 08225
E-mail: ecohanlon@aol.com
Phone: 609.646.6767 ext. 655
Fax: 609.645.8877

Regina Podhorin

President
The Leadership Group
83 Beechwood Avenue
Trenton, NJ 08618
E-mail: tlgrpodhorin@comcast.net
Phone: 609.392.4872
Fax: 609.393.4651

Jennifer Schneider, PhD

Director of Research and Quality Improvement
NJ Department of Human Services, Ann Klein Forensic Center, Special Treatment Unit
P.O. Box 905
Avenel, NJ 07001
E-mail: Jennifer.Schneider@dhs.state.nj.us
Phone: 732.499.5393
Fax: 732.499.5440

Pamela Smith Chambers

Training Director
Beyond Diversity Resource Center
8 Montgomery Place
Trenton, NJ 08618
E-mail: pschambers@verizon.net
Phone: 856.235.2664
Fax: 856.235.0827

Andrea Spencer-Linzie

Executive Director

New Jersey Coalition Against Sexual Assault
2333 Whitehorse Mercerville Road, Suite B
Trenton, NJ 08619
E-mail: aspencer-linzie@njcasa.org
Phone: 609.631.4450 ext. 205
Fax: 609.531.4453

James Stores

NJ Department of Children and Families
Division of Prevention and Community Partnerships
P.O. Box 717, 50 E. State Street
Trenton, NJ 08625-0717
Phone: 609.943.4161
E-mail: James.Stores@dcf.state.nj.us

Jane Sweeney

Administrator, Office of Domestic Violence and Family Support Services
NJ Department of Children and Families
Division of Prevention and Community Partnerships
P.O. Box 717, 50 E. State Street
Trenton, NJ 08625-0717
E-mail: Jane.Sweeney@dcf.state.nj.us
jane1223@comcast.net
Phone: 609.984.5539
Fax: 609.777.0341

Carol Vasile

Supervisor, Office on the Prevention of Violence Against Women
Division on Women
NJ Department of Community Affairs
101 South Broad Street
PO Box 801
Trenton, NJ 08625- 0801
E-mail: cvasile@dca.state.nj.us
Phone: 609.633.6812
Fax: 609.633.6821

PAST MEMBERS

Patricia Barahona

Community Outreach Educator
New Jersey Coalition Against Sexual Assault
2333 Whitehorse Mercerville Road, Suite B
Trenton, NJ 08619
E-mail: pbarahona@njcasa.org
Phone: 609.631.4450 ext. 202
Fax: 609.531.4453

Stephanie R. Bush-Baskette, Esq., PhD

Director
Joseph C. Cornwall Center for Metropolitan Studies, Rutgers University
47 Bleeker Street
Newark, NJ 07102

E-mail: Sbushbask@aol.com
Phone: 973.353.1750 ext. 225
Fax: 973.353.1753

Marilyn D. Kinelski

Director of Adolescent Services
Prevention First
1405 Highway 35 North
Ocean, NJ 07712
E-mail: mkinelski@preventionfirst.net
Phone: 732.663.1800 ext. 238
Fax: 732.663.1698

Claire Riley

Supervisor
Cumberland County Sexual Assault Program
2038 Carmel Road
PO Box 808
Millville, NJ 08332
E-mail: claireriley99@hotmail.com
Phone: 856.825.6810 ext. 259

Librada C. Sanchez

Director of the Women's Center
William Paterson University of New Jersey
300 Pompton Road
Wayne, NJ 07470-2103
E-mail: sanchezl193@wpunj.edu
Phone: 973.720.2586
Fax: 973.720.3644

Rose A. Williams

Community Outreach Coordinator
New Jersey Coalition for Battered Women
1670 Whitehorse-Hamilton Square Road
Trenton, NJ 08690-3541
E-mail: williams@njcbw.org
Phone: 609.584.8107
Fax: 609.584.9740

RESOURCE PEOPLE

Michelle Aimone

Coordinator
Sexual Violence Program
Long Beach Island Community Center
Ocean County

Jennifer DaCunha

Community Educator/Volunteer Coord
Sexual Violence Program
SAFE in Hunterdon County

Melissa Decker

Coord of Comm Mobilization & Education
Sexual Violence Program
SAFE in Hunterdon County

Patricia Doebler

Regional Supervisor
New Jersey Child Assault Prevention

Sarah McMahon

Center on Violence Against Women & Children
School of Social Work
Rutgers University

Jennifer Nix

Legislative Director
New Jersey Coalition Against Sexual Assault

Tracy Simmons Hart

Director of Training and Education
New Jersey Coalition Against Sexual Assault

Matt Smircich

Sexual Violence Program
Community Educator
Domestic Abuse and Sexual Assault Intervention Services
Sussex County

Caitlin Stinneford

Coordinator
Sexual Violence Program
Women's Health and Counseling
Somerset County

APPENDIX B

Governor's Advisory Council Against Sexual Violence PREVENTION AND PUBLIC EDUCATION COMMITTEE Member Agreement

The mission of the Prevention and Public Education Committee (PPEC) of the Governor's Advisory Council Against Sexual Violence (GACASV) is to develop and promote a statewide strategic plan that focuses on primary prevention efforts that keep individuals from committing acts of sexual violence. A significant focus of the PPEC through 2008 is to work with the Centers for Disease Control and Prevention (CDC) on the EMPOWER (Enhancing and Making Programs and Outcomes Work to End Rape) Project to build New Jersey's capacity to conduct comprehensive planning, implementation and evaluation of sexual violence prevention efforts. Information about EMPOWER, Empowerment Evaluation and Getting to Outcomes is attached.

Members of the PPEC serve as New Jersey's State Prevention Team (SPT) for the purposes of the CDC's EMPOWER project. By signing this document, PPEC members agree to the responsibilities outlined below.

I. PURPOSE

The purpose of this MOU is to commit to a common vision and mission and to formalize the arrangement being undertaken by the GACASV's PPEC and its members in their role and responsibilities in developing a comprehensive plan to address the primary prevention of sexual violence.

STATEMENT OF SHARED VISION AND MISSION

The undersigned parties share the CDC's Rape Prevention and Education vision of a world free of sexual violence and will work to have society, communities, relationships and individuals support this goal.

The undersigned parties are also committed to the mission of the CDC's Rape Prevention and Education: creating social conditions, systems and environments to prevent sexual violence before it occurs by mobilizing partners, key constituents and communities; by educating adults, youth and children; and by training professionals.

II. COMMITMENT AND RESPONSIBILITIES OF PPEC MEMBERS WITH REGARD TO THE PROJECT

- A. The Member is dedicated to a vision of a world free of sexual violence.
- B. The Member is dedicated to helping shift the focus of prevention and education to primary prevention efforts aimed at keeping individuals from committing acts of violence.
- C. The Member is dedicated to fostering collaborative relationships with diverse communities.
- D. The Member will commit to a minimum two year membership on the PPEC.

- E. The Member will regularly attend monthly 3 to 6 hours meetings that are generally held in Mercer County.
- F. The Member will notify the PPEC chair in advance if unable to participate in a scheduled meeting.
- G. The Member will complete all related tasks, which may include reading, information analysis, and work on special projects.
- H. The Member will participate in the planning, implementation and evaluation capacity-building activities regarding primary prevention of sexual violence in New Jersey. Work will be done within the guidelines and models approved by the CDC for the EMPOWER Project, including Empowerment Evaluation principles within a Getting to Outcomes framework.
- I. The Member will share their expertise and input from your individual background and/or community/constituency to further the goals of the project and the work of the PPEC.
- J. The Member will discuss relevant information from the PPEC with their community or constituency, as appropriate.
- K. The Member will commit to respectful, constructive participation in all PPEC work honoring all participants' diverse and equally important voice.

III. STATEMENT OF CONSENSUS

The PPE Committee and the Member support the contents of this agreement and the roles and responsibilities delineated.

 Vicki Lunde Rodriguez,
 RPE Coordinator, PPEC Chair

 (member)

 Date

 Date

APPENDIX C

COMMON NEW JERSEY RPE ACRONYMS

AG – Attorney General

BRFSS – Behavioral Risk Factor Surveillance System

CDC- Centers for Disease Control and Prevention

CQI – Continuous Quality Improvement

CSA – Child Sexual Abuse

DELTA – Domestic Violence Prevention Enhance and Leadership Through Alliances

DAG – Deputy Attorney General

DCA – Department of Community Affairs (state government)

DCJ – Division of Criminal Justice (state government)

DFSA – Drug Facilitated Sexual Assault

DHS – Department of Human Services (state government)

DHSS – Department of Health and Senior Services (state government)

DL&PS – Department of Law and Public Safety (state government)

DOE – Department of Education (state government)

DOJ – Department of Justice (federal government)

DOW – Division on Women (state government)

DV – Domestic Violence

DVRT – Domestic Violence Response Team

DYFS – Division of Youth and Family Services

EE – Empowerment Evaluation or Empowerment Evaluator

EMPOWER – Enhancing and Making Programs and Outcomes Work to End Rape

GTO – Getting to Outcomes

IPV – Intimate Partner Violence

IPCQ - Individual Prevention Capacity Questionnaire

KABB – Knowledge, Attitudes, Beliefs and Behaviors

LGBTQ – Lesbian, Gay, Bisexual, Transgendered, Queer

MCSR – Men Can Stop Rape

MPR – Mathematica Policy Research

NCIPC – (CDC’s) National Center for Injury Prevention and Control

NJCAP – New Jersey Child Assault Prevention

NJCASA – New Jersey Coalition Against Sexual Assault

NJCBW – New Jersey Coalition for Battered Women

N/R – Needs and Resources

NSVRC – National Sexual Violence Resource Center

OPVAW – Office on the Prevention of Violence Against Women (state government)

PCAR – Pennsylvania Coalition Against Rape

PCADV – Pennsylvania Coalition Against Domestic Violence

PSA – Public Service Announcement

PTSD – Post Traumatic Stress Disorder

RAINN – Rape, Abuse and Incest National Network (national rape hotline)

RPE – Rape Prevention and Education

RTS – Rape Trauma Syndrome

SA – Sexual Assault

SAAM – Sexual Assault Awareness Month

SAFE – Sexual Assault Forensic Examiner

SAFE Kit – Sexual Assault Forensic Evidence kit

SANE – Sexual Assault Nurse Examiner

SART – Sexual Assault Response Team

SCBT – State Capacity Building Team

SCREAM Theater – Students Challenging Realities and Educating Against Myths (Rutgers University’s peer theater project)

SPT – State Prevention Team

SV – Sexual Violence

SVP – Sexual Violence Program (local RPE funded program)

TA – Technical Assistance

Title IX – Federal legislation that requires federally funded educational institutions to have sexual harassment policies

TNCJ – The College of New Jersey

UCR – Uniform Crime Report

VAG – Victim Assistance Grants

VAWA – Violence Against Women Act

VCCB – Victims of Crime Compensation Board

VOCA – Victims of Crime Act

YRBS – Youth Risk Behavior Survey

APPENDIX D

Magnitude of Sexual Violence Data Review

Magnitude Data Source	NJ SV Program Data 1999 - 2006	2005 Latina Immigrant Needs Assessment - IPV	DHS 2005 Monitoring Report on Child Institutional Abuse
What does this data source tell us about magnitude of IPV and/or SV among universal and selected populations?	New cases peaked in 2005. New cases are about 2 times the number of SART/SANE cases but these include sv in prior years who have just disclosed.	Of IPV victims who are Latina Immigrants 53% report sexual assault as part of the IPV. 93% of perpetrators had witnessed or experienced family violence in their childhood.	5% of reported cases of institutional abuse were sexual abuse cases.
What does this data source tell us about risk and protective factors among universal and selected populations?	There is very little descriptive data. 41% of new cases belong to “disparate” populations but there is no breakdown of which populations. Incident reports exceed # of victims which indicates repeat victimization (averaging about 5% of victims) Only about 50% of those who have forensic exams request/receive police accompaniment.	Victims of IPV have a higher risk of SV than the general population. Witnessing or experiencing family violence in childhood is a high risk factor for perpetration in the immigrant community Language barriers, poverty and community isolation experienced by the immigrant population lowers the willingness to ask for help. This includes high levels of economic dependency on the perpetrator and fear of deportation.	There are poor community sanctions in place due to the long delays in investigations and the low rate of crosschecking with the child abuse registry (only 53% of cases were cross checked though it is a requirement for all allegations). Perpetrators can easily hide in this system of care which includes correctional facilities, , treatment facilities, schools, shelters, hospitals, licensed camps, licensed day care and family resource homes.
What does this data source tell us about assets / resources?	Program data collection capacity is very limited and only counting process. Victims are using e-mail increasingly to connect with services	Very low rate of use of health services Disclosure is mainly to girlfriends, mothers, sisters and female neighbors.	The investigation system continues to have problems of timeliness and thoroughness. CARI checks are underutilized.
What are the strengths of this data source?	Multi-year view of magnitude of the problem. Supports findings in SANE data.	Significant levels of detail about both the victim and the perpetrator	Each case in the study is professionally re-evaluated by a team of experts
What are the limitations of this data source (e.g. who was left out, how was data collected)?	Disparate population includes : disabled, race, ethnicity and LGBT but does not breakdown these categories. There is some question about the consistency of the data across programs.	Study covers only Mercer County and all information is through self reporting of victims. The findings may not be generalize-able to the larger Latina population.	-relatively small sample size – only 161 cases audited out of 1613 complaints (10%).
How does the information from this data source compare with other data sources?	With SANE data so we know that advocates are being used by the SARTS. This data shows lifetime incidence and current year disclosure, not one year snapshot of incidents.	Nat Institute of Justice 2005 reports 68% of all IPV victims report Sexual assault of part of their victimization.	Data was compared to prior audit to look for improvements and worsening conditions. Sexual assault percentages were lower than that found in the general population suggesting possible under-reporting.
Could this data source be improved to provide more useful information in the future? If so, how?	Compiling incident report forms would be more useful since it has discrete data on both the victim and perpetrator.	Should be repeated in other counties, especially where there are high concentrations of immigrants.	?
Do we have enough information to write clear problem statements?	Only that year of disclosure does not match year of incidence which supports serious underreporting of the problem. Need longitudinal data that follows cases	Immigrant (especially Latina) sexual violence is seriously under reported and cases have special circumstances that increase the risk factors of isolation and family violence.	Perpetrators of sexual violence are potentially well hidden in institutional setting that care for vulnerable children. Community sanctions are relatively low considering the vulnerability of the children.
If no, what other information do we need?	Incident report data	Other county information	

Magnitude Data Source	2006 Report Office of the Ombudsman for the Institutionalized Elderly	Cost of Sexual Violence	NJ Div. of Civil Rights Sexual Harassment Data 1990 -2007
What does this data source tell us about magnitude of IPV and/or SV among universal and selected populations?	There were only 43 sexual abuse complaints out of total of 6319 for FY 2006	There is no NJ specific data on the cost of sexual violence. All data is national or other states	Reported incidents of sexual harassment have declined considerably since the 1990's
What does this data source tell us about risk and protective factors among universal and selected populations?	For the institutionalized elderly who are <60years of age in a licensed facility the risk of victimization is lower than the general population or there is serious under reporting. The group questioned whether higher levels of supervision and/or cognitive impairment increase/decrease risk/reporting.	n/a	About 25% of cases are withdrawn by the complainant Another 25% are found to have no probable cause.
What does this data source tell us about assets / resources?	The largest number of complaints was in the area of inadequate care plans and involvement of family members. Reporting of complaints by trained staff has increased significantly but is usually related to quality of care, not abuse.	It would be helpful to assign a cost to tax payers for this issue. Hospital costs per diagnosis would be helpful though there is no standardization on the use of diagnosis in cases of sexual violence.	Civil remedies for sexual harassment are difficult to attain/prove
What are the strengths of this data source?	The report is highly detailed and is produced annually	Could help get people to pay attention to the problem	Not much – there is no descriptive data provided on either the victim or perpetrator
What are the limitations of this data source (e.g. who was left out, how was data collected)?	We were not able to tell much about who the perpetrators were in cases of sexual assault.	No NJ data available	See above
How does the information from this data source compare with other data sources?	There are significantly higher incidents of sexual abuse against the disabled in other studies – but those also show lower rates for older adults.		National data on sexual harassment indicate proportionately much higher volumes of cases especially in the military and in schools.
Could this data source be improved to provide more useful information in the future? If so, how?	Perpetration data would be helpful		Need information about alleged victims and perpetrators/perpetration circumstances.
Do we have enough information to write clear problem statements?	No specific problems identified	At this time we cannot capture cost data for sexual violence in NJ	Data publicly available about sexual harassment complaints in NJ suggest serious underreporting.
If no, what other information do we need?			

Magnitude Data Source	2005 UCR Data	One in Ten: Rape in NJ May 2003	Clery Reports: Campus Violence 2001-2005
What does this data source tell us about magnitude of IPV and/or SV among universal and selected populations?	Tells us about aggravated sexual assault cases that were reported. Tells us that reporting is down in 2005	That 1 in 10 adult women in NJ have been victims of one or more completed forcible rapes during their lifetime (over 327,000)	Reporting of SV has increased year to year at 4 year colleges, especially those that have SV services
What does this data source tell us about risk and protective factors among universal and selected populations?	Of those arrested, Blacks (40%) Hispanics (24%) and 25-39 years old (34%), make up a disproportionate number compared to 58% who are white.	Children under 11 are more at risk The extremely poor are more at risk Prior victimization is a risk factor	Not clear – does a congregate setting increase risk? Is reporting still too inconsistent to draw any conclusions
What does this data source tell us about assets / resources?	n/a	N/a	Colleges that have SV services clearly have higher reporting
What are the strengths of this data source?	Regularly collected and reported	Useful for intervention services Does focus on different income levels	Data potentially available for all 2 and 4 year colleges
What are the limitations of this data source (e.g. who was left out, how was data collected)?	No males, only instances that are reported to police Only includes rape definition not full range of sexual assault	Uses forcible rape as definition, not sexual assault Does not count women under 18 Original surveys done in English only Does not include caregiver situations Counts where people lived, not where it occurred Original national surveys are dated	Not yet reliable – inconsistencies in reporting are widespread. The audience for this data is parents and prospective students so under reporting is probable. Off campus data limited to school related facilities, not local community. 2 year colleges have little or no data. Only includes assaults occurring that year, not those reported that year.
How does this information with other data sources?	Very few other data sources in NJ available	Better than UCR in terms of reporting	Provides a targeted snapshot not available from other data sources
Could this data source be improved to provide more useful information in the future? If so, how?	Expand definition to include all aspects of NJ law	Need to do NJ surveys and isolate rural, urban and suburban populations Need both lifetime and last 5 years Need info on perpetrators Do with multiple languages Include male victims and those under 18	Need consistency in reporting across all colleges. Broaden definition of “off campus” incidents to include students assaulted in the local community. Add data on perpetrators – were they students or not?
Do we have enough information for clear problem statements?	No	No	Not yet
If no, what other information do we need?	More data on perpetrators. More data on select populations	Information on attitudes about sexual violence and acts of sexual assault	Who are the “mandated reporters”? Does this include health centers as well as SV center and campus security.

Magnitude Data Source	2004 SAFE Data	Emergency Room Data 2004 & 2005	NJ ARREST Data 1997-2006 DCJ
What does this data source tell us about magnitude of IPV and/or SV among universal and selected populations?	Victim data matches NJ demographics fairly closely, except for Asian population. Either the incidence is lower or the use of SARTS is lower for the Asian population.	ER visits increase in April-August and from 5-11pm. Rates are significantly higher for black and Hispanic population, especially for young children (0-12 and 13-17). Rate/100K is highest for 13-17 year old (120.3). total rate/100K is 27.6	Arrests for child and adult sexual assault/sexual contact decreased in 2003-2006 with a yearly range of 1887-2459 arrests. 98% of those arrested are male with 34% black, 53% white and 12% other (fairly consistent year to year).
What does this data source tell us about risk and protective factors among universal and selected populations?	Risk factors – partying/hanging out significantly increases risk. Victims are more likely to be ages 13-30 with 20-24 years olds having the highest risk. Lack of adult supervision for 13-17 year olds may increase the risk factor. Location, use of drugs/alcohol will also increase risk.	Certain times of day may be higher risk (5-11pm) and certain times of year carry higher risk (April-August). Children/adolescents are at significantly higher risk than adults, especially black children	Those at highest risk of perpetration and arrest are 18-24 years old (24% of arrests) with a significant # and % of juvenile offenders (under 18) being charged as adults (13%).
What does this data source tell us about assets / resources?	The SAFE is sometimes done in hospital ERs and sometimes in outpatient facilities. The data collected by the SANE in each setting is identical.	The SANE program and DOHSS need to integrate data collection and share data. ER data appears only to count those cases where there has been third party billing. Hard to tell the degree of overlap.	Not clear
What are the strengths of this data source?	Victim driven data, does not require crime reporting.	Can provide significant levels of cross analysis by age, race, hospital and county. Includes all ages and sexes of potential victims	Multiple years of data available with core demographics included.
What are the limitations of this data source (e.g. who was left out, how was data collected)?	Doesn't include counties/facilities that don't have actual SARTS up and running. Missing several counties as a result. Incident must have occurred in last 5 days to be counted. Perpetrator data is often missing.	Use of DC-9 (10) codes is inconsistent. Very little use of Child Sexual abuse and Adult Sexual abuse as primary diagnosis. This data misses anyone who is victimized but does not have injuries requiring treatment in the ER.	Only includes those actually arrested
How does the information from this data source compare with other data sources?	Counts a much broader pool of victims and provides more data on each incident.	Not clear exactly how this data correlates with SAFE data – is this a subset of those cases or does it also include cases missed by SAFE (other than 0-12 ages)?	Matches UCR data
Could this data source be improved to provide more useful information in the future? If so, how?	Some data is based on the victim offering information without a particular question being asked, especially alcohol and drug use and relationship of perpetrator to victim.	Integrate with SAFE data to get full picture.	Gives a yearly snapshot but does not follow individual cases to identify what happens in rest of the process.
Do we have enough info?	Yes, especially regarding age and situations that increase risk.	Yes, especially regarding age and race of victims	Possibly regarding age of perpetrators that are arrested.
If no, what other information do we need?	Perpetrator data by county, race, age, situation. Need to be able to correlate this to victim data.	Data on perpetrators/situations.	Would be helpful to know # convicted & sentenced and more details about the circumstances

Magnitude Data Source	BRFSS – 2003 SV Pilot in NJ	NJ Sex Offender Registry (current)	NJ Dept of Corrections – 2004 Sexual Assault Pop
What does this data source tell us about magnitude of IPV and/or SV among universal and selected populations?	Approximately 1 in 10 experience SV in lifetime	Not a lot – tells us where they are likely to reside (by county) and housing accessibility for offenders. Can give some information about the type of assault at different levels of risk.	Only 1,750 individuals in jail for SA crimes in 2004. Considering the length of the jail terms and number of new incidents each year, the incarceration rate is very low
What does this data source tell us about risk and protective factors among universal and selected populations?	Not clear	Not clear	2/3rds of incarcerated are not in mandated treatment. Majority of sex offenders are still in the community. -40% of those incarcerated are black, with majority not sentenced under Sex Offender Act -40% of those incarcerated are white with half sentenced under ACT and receiving mandatory treatment -20% are Hispanic with majority not under the ACT -Individuals from Camden have highest numbers for sentencing under the ACT-twice as much as Essex
What does this data source tell us about assets / resources?	Not clear	Housing availability for offenders concentrated in several counties, mostly with larger urban centers.	Grand jury norms about “believability” of evidence need work.
What are the strengths of this data source?	Includes male victimization	Not much	Gives a good picture of who is in jail for SA – point in time
What are the limitations of this data source (e.g. who was left out, how was data collected)?	Was only a pilot to test the original questions and the sample size was small (686 women and 669 men). Can we get good county level data from a sample this small? NJ does not currently use the SV module when doing the BRFSS. There are plans to add it next year.	Tells us only about those who are eligible for the registry based on risk levels in legislation. Leaves out others who have been convicted of the crime and all those who were never convicted, charged.	Crime categories are confusing – rape and sodomy included, juv assaults may be mixed in with others This is one point in time – does not follow cases nor tell about those not incarcerated
How does the information from this data source compare with other data sources?	Confirms the 1 in 10 lifetime prevalence found in other studies	Currently there are 2,269 people in the registry. Difficult to compare to other data about perpetrators since we know nothing about when/where the crime occurred.	Compared to UCR, SART/SANE and NJ Arrest Data, incarcerations are very low. Age data inconsistent with arrest data but age is not at time of offense – skews higher than arrest data (46% 40-59 years old and only 17% 21-29 years old)
Could this data source be improved to provide more useful information	Questions about implementation: how were the respondents randomized, can the result be weighted by county, what is	No – its uses are highly prescribed by the offender registration laws. Arrest data from DCJ is more useful and	Need information on relationship to victim Need comparison of crime to sentence

in the future? If so, how?	missed by those who are on the DNC registry?	flexible. Might be able to give us some insight into high risk perpetrators but only those convicted	Need clearer crime categories and clarification of offenses against juveniles
Do we have enough information to write clear problem statements?	No	No	Changing jury norms and prejudices about SA may increase conviction rates
If no, what other information do we need?	Respondent demographics that would be available from full BRFS report. Is it administered in different languages? What are the final questions now being used as a result of the pilot.	Population covered is too limited.	Need to hear from Prosecutors about Grand Jury dynamics Need more info on sentencing under the ACT

Magnitude Data Source	NJ Dept of Educ Violence & Vandalism 2004-2005	DOW Incident Reports	PREA – Prison Rape 2004
What does this data source tell us about magnitude of IPV and/or SV among universal and selected populations?	429 reported sexual offenses in 2002-2003 238 reported sexual offenses in 2003-2004 199 reported sexual offenses in 2004-2005	Data not collated at this time. Plans underway to collate data	3.15 allegations of sexual violence per 1000 inmates nationally 42% of allegations were staff sexual misconduct, 37% inmate on inmate, 11% staff sexual harassment, 10% abusive sexual contact
What does this data source tell us about risk and protective factors among universal and selected populations?	Special education students are more likely to be offenders (compared to their % in pop.) Staff victimization is increasing (violence in general)	Has potential to give good information on perpetration context – where, when, circumstances	Youth corrections facilities (both public and private) had higher reporting and substantiation
What does this data source tell us about assets / resources?	Best practices guidelines and training are in the planning stages Funding is available for school based programming Schools are very responsive to state regulation	Local programs have limited data capability	The 2003 Prison rape Elimination Act requires annual reporting and improved data collection
What are the strengths of this data source?	They revised (broadened) the definition of sexual assault in 2003-2004 to match NJ statute	Comprehensive instructions and many useful variables Will include cases that have not been reported to police	Used the CDC definitions of sexual violence so it is comprehensive 100% of state/federal institutions and 10% of local and private were surveyed.
What are the limitations of this data source (e.g. who was left out, how was data collected)?	Comparable to college data, there is strong pressure to underreport. The conditions placed on the definition of harassment, bullying or intimidation could severely limit reporting Some reporting is linked to YRBSS which is impaired by active parental consent regulations. Sexual violence data is often	Has not been collated either by programs or DOW due to limited resources and capability. There are gaps in information – it is not used as a questionnaire but gleaned from survivor or significant others' description of events. Data is not updated – can't find out about subsequent events like court etc.	Appears there is serious underreporting in NJ compared to other states. Institutions are not collecting data in a uniform manner at this time State laws regarding liability of correctional staff?

	lumped with other data and can't be pulled out		
How does the info from this data source compare with other sources?	No other school based reports available for this age group. YRBS data limited in NJ	Potentially more comprehensive that UCR and hospital data Includes cases not reported to police	Waiting for copy of recent in-depth survey of NJ prisons that was done after this report
Could this data source be improved to provide more useful information in the future? If so, how?	More information about perpetration. Need some context on why the #'s are decreasing year to year. Link data to schools with anti-violence programming and those without	Uniformity of reporting is in question. Since the elements are not specifically asked, do advocates guess on some items?	There are plans in place to improve data collection.
Do we have enough information to write clear problem statements?	No	Not yet	
If no, what other information do we need?	Context When did zero tolerance policy come into play in NJ? Need impact of separating out bullying data Need context on why numbers are decreasing	Continuous training to ensure consistency of data Group recommends that data input start from current year and go back as far as possible where there are consistent and important comparable data.	Need more information on the perpetrator and circumstances

Magnitude Data Source	NJ 2005 American Community Survey and National Accessing Safety Initiative	2005 YRBS National Report	NJ Student Health Survey 2005
What does this data source tell us about magnitude of IPV and/or SV among universal and selected populations?	-Disabled women have 4-10X more risk of SA than general pop. -Those with psychiatric problems have 2X more risk than general pop -12.5% of NJ pop has disability	7.5% of youth said they were forced to have sexual intercourse in lifetime 50% of high school youth had at least one sexual encounter while in high school	9.6% of high school youth reported they had sexual contact against their will, in lifetime 44% have had sexual intercourse in their lifetime
What does this data source tell us about risk and protective factors among universal and selected populations?	-97-99% of abusers were people they know or caregivers. The nature of the relationship is critical and much higher than general pop.	27% of black male students have sexual intercourse before age 13 (compared to 6% overall) – this was not consistent with females their age so they must be having sex with older or younger individuals 39% of black male and 21% of Hispanic male students had sex with 4 or more partners in their lifetime (compared to 14% overall) 34% of high school students were sexually active in last 3 months 23% of all students used alcohol or drugs prior to last sexual encounter (white rates the highest, black rates the lowest)	12% of black males and 8.7% of Hispanic males had sex before age 13, compared to 5% overall. 27% of black males had sex with 4 or more partners in lifetime (compared with 12% overall) 33% of high school students were sexually active in last 3 months 21% of all students used alcohol or drugs prior to last sexual encounter (white rates the highest)
What does this data source tell us about assets / resources?	Nothing specific	Overall Youth risk behaviors are decreasing but are still high	Overall Youth risk behaviors are decreasing but are still high
What are the strengths of this data source?	Seems an accurate reflection of community knowledge about NJ disabled community	Significant level of detail in data and year to year comparisons available	Detailed data on youth behavior in middle and high school
What are the limitations of this data source (e.g. who was left out, how was data collected)?	National data only for female victims, no male victimization data Community knowledge says that there are both male and female victims in NJ	-NJ data on sexual behavior is missing -NJ has opt in parental consent so those whose parents don't bother or refuse are missing -Questions about "boasting" behavior – is this a cultural issue for young black males?	Middle schools students were not asked questions on sexual behavior 8% of parents said no to survey (refused) 13% of parents did not respond (to give consent)
How does the information from this source compare with other sources?	Still attempting to access DHS Police data – no response to date	NJ Student Health Survey has similar data – see next column	Similar findings to National data
Could this data source be improved to provide more useful information in the future?	Need NJ specific data	Need NJ data for easy comparison	Middle school data on sexual behavior/attitudes would be helpful to track trends over age

<p>Do we have enough information to write clear problem statements?</p>	<p>Must address power relationship over the disabled, especially caregivers Disabled victims are especially vulnerable – may not even know they are victimized and can't advocate for self</p>	<p>Black males are at high risk of early sexuality, possibly with older adults Need to address potential cultural messages to black males about sexuality (and possibly Hispanic males) Use of alcohol and drugs during sex (whites males and females mostly) is high risk behavior.</p>	<p>Same as national Youth generally engage in serious high risk behaviors – not clear what will/has impacted n this to slightly lower the rates over the years.</p>
<p>If no, what other information do we need?</p>	<p>Comparison of risk factors for those in community settings and those in institutions – need DHS police data</p>		<p>Impact of prevention curricula in schools over the years</p>

APPENDIX E

Summary of Risk & Protective Factor Data Review

Protective Factor	# of studies	Author of Studies	Changeable within 3-5 years with resources available?
Higher absolute levels of female income (and education)	2	Bailey, Eschholz	Need to make the linkage apparent Societal level messaging
Gender equality -economic, employment, legal & political -decreased hostility and increased empathy towards women	7	Baron, Forbes, Pridemore, Stith, Sugarman, Whalley, Yllo	Yes but only the increased empathy and decreased hostility – sexual respect Relationship, Community and societal levels
Social Support (Individual) -family -friends -adult figures in childhood	5	El Bassell, Levandosky, O’Campo, Suzuki, Van Wyck Focus Group Reports (V) APA’s Sexualization of Girls(V)	Yes at the relationship level
Community Connectedness -schools -network of friends -youth groups	5	Blum, Borowsky Focus Group Reports Askew & Ross, 1988; Borowsky, et al., 1997	Yes at the community level
Emotionally healthy -able to regulate emotions, positive self perception	2	Borowsky, Suzuki	Individual and community norming
Pro Social Moral Reasoning -Self- reflective -Internal reasoning -Learning from past experience	2	Carlo, Suzuki Kirkburg – 7 stages of moral development	Yes at the relationship and community level focusing on “ally” behavior – bystander programming
Planning and pursuing goals Academic Success <i>Add incremental thinking and planning</i>	1	Suzuki	Yes, with mentoring type services at the individual and relationship level
Spiritual beliefs	1 1	Suzuki Focus Group Reports	Only 10 cases studied here – not easily changeable but may be an important asset or risk factor.
Healthy sexuality	1	APA – Sexualization of Girls (V)	Yes
Media Literacy – ability to filter/judge messages	1	APA – Sexualization of Girls (V)	Yes through teaching monitoring activities
Attachment/healthy parenting	1	Roberts and Coursol, 1996	Yes

Risk Factor	# of studies	Author of Studies	Changeable within 3-5 years with resources available?
Social isolation, low social support, low community/school attachment, low neighborhood monitoring, high non-intervention norms, low parental monitoring/divorce; neglect: basic emotional needs not cared for	8 (3 victim, 5 perp)	El Bassell, Farris, Curtis, Pridemore, Banyard, Baron, Walton, Browning	Need to be careful of cultural norms
Alcohol/drug use Incapacitation of victim Daily/regular/heavy use by perpetrator Anabolic Steroids	2 5 1 1	Borowsky, et al., 1997; Locke and Mahalik, 2005; Abby et al., 2006; Schwartz & DeKeseredy, 1997; Koss and Gaines, 1993 Corbin, Lisak Brecklin, Carr, Schwartz, Walter, Borowsky; Focus Group Report Report	Does this connect to “Hanging out more than 40 hours per week” ? Is this and/or?
Neighborhood disadvantage, poverty, social disorganization, resource deprivation -low per capita income -high ratio of renters to homeowners -high unemployment	6	Benson, Lunradi, Miles, O’Campo, Pearlman, Van Wyck	No, but needs to be on radar screen at societal level Focus on impact of this – isolation, exposure to violence, lack of alternatives
Witnessing/experiencing family violence	11	Borowsky, Stith; Prentky and Knight, 1993; Dean and Malamuth, 1997; Prentky, Knight, Sims-Knight, Rokous & Cerce, 1989; Knight and Sims-Knight, 2003; Finkelhor et al., 1986; Stalter, et al., 2003; Shaw et al., 1993; Spaccarelli, Bowden, Coatsworth and Kim, 1997; Skuse, Bentovim, Hodges, Stevenson, Andreou, Lanyado, New, Williams and McMillan, 1998; Focus Group Report Report	

Rage/other violent behavior (non-sexual) Antisocial behavior/ delinquency, bullying behavior	4	Blum, Lisak, Schwartz, Sears Dean and Malamuth, 1997; Malamuth, et al., 1991, 1995; Shaw, Campo-Bowen, Applegate, Perez, Antoine, Hart, Lahey, Testa and Devaney, 1993	
Gang membership	1	Borowsky	
“Hanging out” more than 40 hours per week (adolescent)	1	Borowsky	See ? on alcohol/drug use
Income/employment equality of women* -short term? -backlash effect of challenging men’s status	4	Bailey, Eschholz, Whaley, Yllo	*this is also seen as protective factor by some, esp. longer term
Negative, rigid or patriarchic attitudes toward women Hyper-masculinity, rigid sex roles for men, high levels of anger at women	3	Carr, Forbes, Baron Focus Group Reports; Lisak and Roth 1990; Koss and Dinero, 1998; Malamuth, 1986; Malamuth, et al., 1996; Seidman, Marshall, Hudson, and Robertson, 1994; Murnen, Wright and Kaluzny, 2002	Yes
Circulation/use of pornography Exposure to unfiltered, uncensored media messages, sexualized media messages in all forms	5	Baron, Carr Focus Group Reports Check & Malamuth, 1983; Jensen, 1995	This includes print, film, TV, advertising, music videos, music content, reality TV, internet
Emotional inhibition	1	Richardson	
Entitlement Mentality	1	World Health Organization Report on Violence and Health, 2002, Sexual Assault Chapter 6	Individual – must start early
Lack of self-worth, self esteem	1	Borowsky, et al., 1997	
Perceived lack of power	1	Focus Group Report Report	

Lack of Empathy/Attachment/parenting style	8	Prentky, 2003; Dean and Malamuth, 1997; Malamuth, Sockloskie, Koss and Tanaka, 1991; Marchall and Moulden, 2001; Fernandez and Marshall, 2003; Gidycz, Layman, Crothers, Gyles, Dowdall and Matorin, 1997; Lisak and Ivan, 1995; Schewe and O'Donohue, 1993	Yes – but early age Individual level Relationship (parenting)
Promiscuity/impersonal sex/early initiation to sex	7	Abby, Parkhill, BeShears, Cinton-Sherrod, Zawacki, 2006; Malamuth, Linz, Heavey, Barnes,& Acker, 1995; Kanin, 1984; Sarwer, Kalichman, Johnson, Early and Akram, 1993; Malamuth, 1986; Malamuth, et al., 1995 Martinn, Vergeles, Acevedo, Sanchez and Visa, 2005	
Narcissism	2	Malamuth, et al., 1995; Ryan, 2003	
Impulsivity	2	Prentky and Knight, 1991; Malamuth, et al., 1995	
Belief in rape myths	3	Koss, et al., 1985; Lonsway & Fitzgerald, 1994; Malamuth, 1986	Yes
Homophobia	1	Pilkerton and D'Augelli, 1995; Rivers, 2001	See hypermasculinity

APPENDIX F

CONTINUUM OF STATE SEXUAL VIOLENCE PREVENTION SYSTEM CAPACITY

New Jersey
Completed in April 2007

Leadership <i>Those in recognized positions of authority and/or influence around SV prevention in the state</i>	Low	Moderate or Mixed*	High
1. Recognition and established legitimacy of leadership	<ul style="list-style-type: none"> No stable or recognized leadership at state level for SV prevention, OR Those in positions of power or authority lack legitimacy with key SV prevention constituencies 	<ul style="list-style-type: none"> Statewide leadership has established legitimacy across key SV prevention constituencies AND is gaining legitimacy in broader arenas <p style="text-align: center;">X</p>	<ul style="list-style-type: none"> State has strong, recognized, stable leadership for SV prevention, with broad legitimacy across multiple constituencies
2. Leadership style	<ul style="list-style-type: none"> Existing leaders are autocratic and/or do not encourage or foster participation, collaboration 	<ul style="list-style-type: none"> Leaders encourage inclusion, collaboration and democratic participation and demonstrate openness to new ideas <p style="text-align: center;">X</p>	<ul style="list-style-type: none"> Leadership consistently and actively models principles of inclusion, collaboration, and democratic participation, encouraging creativity and continuous learning
3. Leadership values	<ul style="list-style-type: none"> Leadership values are rigid, reflecting narrowly defined constituency No evidence of shared values across leadership spectrum No leadership commitment to principles of primary prevention <p style="text-align: center;">X</p>	<ul style="list-style-type: none"> Leadership values are evolving in response to inclusion of broader and more diverse constituencies Shared values are emerging across the leadership spectrum Leadership commitment to principles of primary prevention apparent <p style="text-align: center;">X</p>	<ul style="list-style-type: none"> Leadership values continuously evolve to incorporate cultural perspectives of broader constituencies Shared values and a common vision for SV prevention are strongly in evidence across the leadership spectrum Leadership exhibits strong and sustained commitment to principles of primary prevention through their action
4. Leadership development	<ul style="list-style-type: none"> No leadership development is evident, or development is limited to small group of select few No effort to reach beyond traditional constituencies to develop new leadership poor Little or no opportunities for younger persons to take on leadership roles <p style="text-align: center;">X</p>	<ul style="list-style-type: none"> Systematic effort to develop new leaders is emerging Emerging efforts to reach beyond traditional constituencies to develop new leaders with new ideas Opportunities for younger persons to take on leadership roles are increasing 	<ul style="list-style-type: none"> Leadership development is systematic, ongoing, continuously evaluated and improved New leadership cadre is emerging, reflecting diverse non-traditional constituencies and new ideas Leadership routinely explores and develops new opportunities for younger persons to take on leadership roles

Strategic Planning <i>Development of statewide strategic objectives and action plans around SV prevention</i>	Low	Moderate or Mixed*	High
5. Process of developing statewide SV prevention strategic objectives	<ul style="list-style-type: none"> • SV planning is reactive, fragmented • SV planning is not focused on primary prevention • SV planning is driven solely by requirements imposed by funding source <p style="text-align: right;">X</p>	<ul style="list-style-type: none"> • Systematic approach to statewide SV planning beginning to be apparent • Focus on primary prevention in SV planning is emerging • Statewide SV planning beginning to be based on evidence, rather than funding requirements alone 	Statewide SV planning is <ul style="list-style-type: none"> • well developed, systematic, and integrated • clearly focused on primary prevention • evidence based
6. Carrying out statewide SV strategic objectives and action plans	<ul style="list-style-type: none"> • No evidence that SV strategic objectives and action plans are being carried out in the state <p style="text-align: center;">X</p>	<ul style="list-style-type: none"> • SV prevention action plans are in the early phases of being carried out across the state, but the level of activity may be inconsistent 	<ul style="list-style-type: none"> • SV prevention action plans are actively being carried out across the state and are continuously evaluated and improved
7. Measuring and evaluating progress	<ul style="list-style-type: none"> • Goals and objectives are not defined and/or are not measurable <p style="text-align: center;">X</p>	<ul style="list-style-type: none"> • Measurable goals and objectives have been (or are being) identified, with early efforts to track progress 	<ul style="list-style-type: none"> • Progress against planning goals and objectives is routinely measured, and evaluation results are fed back into the prevention planning process

Community Focus <i>Understanding and involving statewide SV constituencies and communities</i>	Low	Moderate or Mixed*	High
8. Relationships with SV constituencies and communities across the state	<ul style="list-style-type: none"> SV constituencies or communities are poorly or narrowly identified No efforts to reach out to those who have traditionally lacked voice, power, or representation No effort to reach out to those who have traditionally opted out 	<ul style="list-style-type: none"> Some key SV constituencies and communities are clearly identified and strong relationships are in evidence Efforts to define broader, more diverse statewide constituencies that include those who have traditionally lacked voice, power, or representation are evident Outreach to those who have traditionally opted out are beginning to show some signs of success. <p style="text-align: center;">X</p>	<ul style="list-style-type: none"> Relationships with broad diversity of communities and constituencies are well-established and strong Relationships with those who traditionally lacked voice, power, or representation, or who opted out are well established Ongoing assessments seek to identify new and/or underrepresented communities, given demographic changes in the community
9. Processes and mechanisms for gaining community knowledge and ensuring accountability to the community	<ul style="list-style-type: none"> No mechanisms for gaining community knowledge are in place No mechanisms for determining whether SV system is accountable to constituencies or communities are in place <p style="text-align: center;">X</p>	<ul style="list-style-type: none"> A systematic approach to gaining community knowledge is emerging, including knowledge of those who traditionally lacked voice, power, or representation Systematic approaches to elicit feedback from SV constituencies and communities are beginning to emerge 	<ul style="list-style-type: none"> Mechanisms for keeping community knowledge current are well-established and well integrated into system wide SV prevention planning, implementation, and evaluation Mechanisms for eliciting community feedback and ensuring accountability are well integrated into system side SV prevention planning, implementation, and evaluation
10. Community involvement and ownership in primary SV prevention planning, implementation, and evaluation across the state	<ul style="list-style-type: none"> Little or no evidence of promoting community involvement in SV prevention planning, implementation, and evaluation 	<ul style="list-style-type: none"> Community involvement in and ownership of primary prevention planning and evaluation is measurably growing <p style="text-align: center;">X</p>	<ul style="list-style-type: none"> Broad diversity of communities and constituencies are actively involved in SV prevention planning, implementation, and evaluation and convey a strong sense of ownership through their actions

Human Resources <i>Organizing, developing, and supporting the workforce around SV prevention across the state</i>	Low	Moderate or Mixed*	High
11. Organization of work systems, work teams, work units for SV prevention	<ul style="list-style-type: none"> • Work systems are poorly defined 	<ul style="list-style-type: none"> • Work teams beginning to be well defined <p style="text-align: center;">X</p>	<ul style="list-style-type: none"> • Work systems to support primary prevention planning, implementation, and evaluation are well established demonstrating long-term sustainability
12. Processes and practices for statewide recruitment, hiring, and retention	<ul style="list-style-type: none"> • Recruitment, hiring, and promotion do not reflect core SV constituencies or communities or principles of social justice • Staff turnover is high 	<ul style="list-style-type: none"> • Recruitment, hiring, and promotion involve and acknowledge core SV constituencies and communities and principles of social justice • Rates of retention are improving 	<ul style="list-style-type: none"> • Workforce at all levels reflects broad range of SV and related constituencies and communities, and principles of social justice • Retention is high
13. Training, development, and motivation of workforce	<ul style="list-style-type: none"> • No education or training to support SV prevention planning, implementation, or evaluation 	<ul style="list-style-type: none"> • Education and training are beginning to build individual capacity in SV prevention planning, implementation, and evaluation 	<ul style="list-style-type: none"> • Training and education is responsive to continuing needs of workforce.
14. Work environment and systems of support for SV prevention workforce across the state	<ul style="list-style-type: none"> • Individuals involved in SV prevention are isolated, with no collaboration within or across organizations • Work environments are unsupportive or not conducive to SV prevention planning, implementation, and evaluation 	<ul style="list-style-type: none"> • Collaborative approaches to SV prevention decision-making and problem solving are beginning to emerge, with opportunities for shared learning • Work environments promote shared learning for SV prevention planning, implementation, and evaluation 	<ul style="list-style-type: none"> • Strong collaborative teams and support networks addressing both programmatic needs and emotional needs of workforce are in evidence • Work environments are strongly supportive of primary prevention planning, implementation, and evaluation, with an eye towards long-term sustainability

System Operations <i>Core operational programs, processes, and strategies that achieve results in SV prevention across the state</i>	Low	Moderate or Mixed*	High
15. Alignment of SV programs and statewide strategic objectives	<ul style="list-style-type: none"> SV programs function locally and independently, with no evidence of collaboration or alignment with statewide objectives 	<ul style="list-style-type: none"> Local or community-level SV prevention programs are beginning to define common ground to achieve identified objectives 	<ul style="list-style-type: none"> Local and community-level SV prevention programs, processes and strategies are well aligned with state strategic objectives for SV prevention
16. Public health approach	<ul style="list-style-type: none"> Interventions are (haphazard and) episodic, lacking depth or breadth 	<ul style="list-style-type: none"> Interventions are beginning to be intensive and intentional, addressing multiple levels of the social ecology 	<ul style="list-style-type: none"> Interventions are routinely well designed and intensive, evidence-based, addressing multiple levels of the social ecology; address short- and long-term goals
17. Operational planning, implementation, and evaluation	<ul style="list-style-type: none"> State operational programs do not promote primary prevention and/or demonstrate no systematic approach to SV prevention planning, implementation, and evaluation 	<ul style="list-style-type: none"> State operational programs are beginning to demonstrate systematic approach to primary prevention planning, implementation, and evaluation 	<ul style="list-style-type: none"> State and local SV operational programs are actively engaged in systematic and ongoing program planning, implementation, evaluation, and continuous improvement
18. Sustainability	<ul style="list-style-type: none"> State operational programs have no systematic approach to achieving sustainability of SV prevention efforts 	<ul style="list-style-type: none"> State operational programs are beginning to address sustainability in planning and evaluation efforts 	<ul style="list-style-type: none"> State and local SV operational programs consistently demonstrate that they are sustainable

Information <i>Measurement, analysis, and management of information for knowledge-driven performance</i>	Low	Moderate or Mixed*	High
19. Gathering, analyzing, and managing data	<ul style="list-style-type: none"> Information is anecdotal; no systematic approach to data gathering or information sharing Information technology (IT) systems are primitive or non-existent <p style="text-align: center;">X</p>	<ul style="list-style-type: none"> Information needs are identified, and a systematic approach to data gathering and analysis and information sharing is beginning to take shape IT systems are beginning to support some routine data gathering and analysis functions 	<ul style="list-style-type: none"> A systematic, collaborative, approach to measurement and analysis is evident and well integrated across the SV prevention system IT systems are well developed to support data gathering and analysis and to ensure data quality; IT systems are continuously evaluated, updated, and improved to support system-wide information needs
20. Using data to assess and inform performance	<ul style="list-style-type: none"> No systematic approach to analyzing data to assess needs, inform planning, or evaluate performance <p style="text-align: center;">X</p>	<ul style="list-style-type: none"> Use of data to assess needs, inform planning, or evaluate performance is evident, but may be inconsistent across the SV prevention system 	<ul style="list-style-type: none"> Data is consistently used to assess needs, inform planning, and evaluate performance, and information is routinely shared across the system
21. Data quality and utility	<ul style="list-style-type: none"> Data quality is poor, or little or no utility <p style="text-align: center;">X</p>	<ul style="list-style-type: none"> Systematic efforts are in place to improve data quality and utility 	<ul style="list-style-type: none"> The quality of the data available for SV prevention planning, implementation, and evaluation is continuously evaluated and improved to ensure its utility

Results/Outcomes <i>Achievements demonstrated through performance indicators</i>	Low	Moderate or Mixed*	High
22. Building system capacity	<ul style="list-style-type: none"> No results on system capacity are reported, or results are poor <p style="text-align: center;">X</p>	<ul style="list-style-type: none"> Reported results demonstrate good performance across many dimensions of system capacity Trend data demonstrate improvement across many dimensions of system capacity Benchmarking data indicate good performance in building system capacity, relative to peers 	<ul style="list-style-type: none"> Reported results and trend data demonstrate continuous and/or sustained improvement across all dimensions of system capacity Benchmarking data demonstrate sustained performance, relative to peers, in building and maintaining system capacity
23. Preventing sexual violence: Intermediate outcomes	<ul style="list-style-type: none"> No results on increasing protective factors and/or reducing risk factors are reported, or results are poor <p style="text-align: center;">X</p>	<ul style="list-style-type: none"> Indicators beginning to demonstrate some progress towards increasing protective factors and/or reducing risk factors, although results may be mixed across programs or communities 	<ul style="list-style-type: none"> Indicators demonstrate sustained achievement in increasing protective factors and/or reducing risk factors across communities
24. Preventing sexual violence: Long-term outcomes	<ul style="list-style-type: none"> No results on primary prevention of sexual violence are reported, or results are poor <p style="text-align: center;">X</p>	<ul style="list-style-type: none"> Indicators may be beginning to demonstrate progress toward primary prevention of sexual violence, but improved reporting may make some outcomes look worse 	<ul style="list-style-type: none"> Clear indicators of reduced incidence of first-time SV perpetration and/or victimization

Notes: (as of 4/25/07 when survey completed)

1. Entities in place: GACASV, DOW, EMPOWER, PPEC, NJCASA, Sexual Violence Programs (SVPs).
2. Statutes and regulations are intervention based.
3. GACASV/PPE, DCA commissioner and DOW director – politically appointed.
4. Constituency of PPEC still identifying stakeholders and partners. Much work within networks still based in intervention (ie. SART).
5. Still intervention focused – need to look as to how to switch to prevention.
6. Individuals committed, but unsure of agency level commitment.
7. RPE (DOW) is single federal source of funding (\pm \$1 million for the state -- \pm \$45,000 to each SVP). No state funding for prevention.
8. GACASV, EMPOWER, PPEC, NJCASA. However, there is lack of support from Commissioners and departments for prevention work – most work still centers on intervention.
9. State Capacity Building Team – committed and learning how to do this.
10. There is some conflict between “old guard” concepts regarding intervention and evidence-based prevention models. There are shared values around the desire for prevention, but the vision is not totally clear year. Not enough younger people around the table.
11. Peer groups not present (16-24 years old) either on college level or non-college groups. No systematic development of leadership. Young men not particularly encouraged to participate.
12. Initially work is driven by funding to SVPs. Not enough evidence-based work yet to guide plan.
13. Vision is there, but execution still emerging.
14. No action plan developed yet.
15. Desire to reach out is high and there is recognition of the need to do it early in the process. But, committee has not yet demanded larger inclusion.

16. When plan is in place, community involvement will need to come to the forefront.
17. Focus groups, some community groups represented on committee, but no priority given to community involvement yet. Still largely state level representation.
18. Response based only on PPEC level for GTO 1. Committees are in place but work is not as well defined as we need it to be.
19. N/A at this time.
20. N/A at this time.
21. N/A at this time.
22. Allowing for overall objective of “primary prevention” the local SVPs are beginning to get on board. However, there is very little statewide SV prevention effort – one example may be Rutgers’ *Scream Theater*.
23. Statewide systems are lacking. EONG (SVP community educators) prevention curriculum mostly a “silo” and episodic approach.
24. No systematic approaches exist on operational level.
25. Same as 24 above plus issue of sustainable funding not resolved.
26. Capacity is still low, but recognition there by VAWA advisory, DOW and NJCASA.
27. Little consistent usable data available yet.
28. See #27 above.
29. – 31. No results and outcomes determined yet. Just starting to identify.

APPENDIX G

**Sexual Violence Data Worksheets
New Jersey Capacity, Assets, Resources**

**Data Source: Individual Prevention Capacity Questionnaire (IPCQ)
State Planning Team - Completed 11/2006
N = 23 Of 32 in attendance (out of possible 40)**

What does this data source tell us about magnitude of IPV and/or SV among universal and selected populations?	N/A
What does this data source tell us about risk and protective factors among universal and selected populations?	N/A
What does this data source tell us about assets / resources?	<p>High capacity: good cross section with broad range of experience by participants and variety of spheres of influence</p> <p>High capacity: Program planning and implementation experience</p> <p>High capacity: Access to technology, libraries, networking Groups (F1c, F1e, F1f)</p> <p>Low capacity : lacking people in disabilities field, men’s groups, migrants workers, business</p> <p>Low: Lack of understanding of prevention principles regarding targeted vs global application (E5)</p> <p>Low: Consistently low on culturally specific evaluation (D4, D8, E6)</p> <p>Low: Lack of experience in continuing effort after funding ended (D10)</p> <p>Low: lack of knowledge around rate and repeat victimization (G1a, G2f)</p> <p>Low: Lack of people on SPT with specific job responsibility and/or time in the area of prevention of sexual violence (F1a, F1b) – note: we were surprised that even 48% of respondents replied that they had a job description that Specifically included SV prevention – we question whether respondents had sufficient knowledge at time of questionnaire of what prevention really was and probably responded using “intervention” rather than “prevention” as benchmark</p> <p>Low: Lack of access to data for planning; lack of knowledge on how to review data, lack of professional development opportunities for planning, implementing and evaluating (F1h, F1i, F1j)</p>
What are the strengths of this data source?	Gives a broad range of skills and knowledge levels
What are the limitations of this data source (e.g. who was left out, how was data collected)?	<p>Only half of total pool participated in questionnaire.</p> <p>Lack of certainty that participants were clear on primary prevention definition at time of response.</p> <p>Responses given very early in life of SPT – probably does</p>

	not reflect current capacity one year later More clarity in questions of “evaluation” -- whether of outcomes or activities
How does the information from this data source compare with other data sources?	Only comparison is to SCBT questionnaire (N=5). There is more variance in answers within the SPT, whereas SCBT was more often within range preferred by CDC.
Could this data source be improved to provide more useful information in the future? If so, how?	Follow up survey to determine where group is now would be helpful.
Do we have enough information to write clear problem statements?	Yes
If no, what other information do we need?	Would be good to use the same tool with the Sexual Violence Programs.
Where can we find that information?	

Data Source: IPCQ: State Capacity Building Team

November 2006

N=5

What does this data source tell us about magnitude of IPV and/or SV among universal and selected populations?	N/A
What does this data source tell us about risk and protective factors among universal and selected populations?	N/A
What does this data source tell us about assets / resources?	General, SCBT is high in skills and knowledge necessary for planning, planning and implementation of state prevention plan. This analysis lists only areas of lack of capacity, since all other areas were 80-100% within CDC preferred responses, indicating sufficient capacity. Low: Defining prevention activities (C2, C6, C8 = 3 of 8) Low: Lack of access to data, how to review data, and professional development opportunities to increase skills in planning, implementing, and evaluating
Strengths of this data source?	Broad scope of questions.
What are the limitations of this data source (e.g. who was left out, how was data collected)?	Only 5 respondents, so any single deviation is 20% of total.
How does the information from this data source compare with other data sources?	SCBT has consistently higher agreement with CDC preferred responses than full SCBT.
Could this data source be improved to provide more useful information in the future? If so, how?	
Do we have enough information to	Yes

write clear problem statements?	
If no, what other information do we need?	
Where can we find that information?	

Data Source: Focus Groups

December 2005 – August 2006

N = 90 (eight separate groups: Sexual Violence Advocates = 10; Parents = 22 (2 groups of 11); Educators = 7; Teens = 14; Researchers and Therapists = 18 (2 groups); Offenders = 15)

What does this data source tell us about magnitude of IPV and/or SV among universal and selected populations?	N/A
What does this data source tell us about risk and protective factors among universal and selected populations?	N/A
What does this data source tell us about assets / resources?	<p>Higher capacity/asset:</p> <ul style="list-style-type: none"> • Educators and parents linked Healthy sexuality with SV prevention • Teens saw connection between SV, media, music, internet and showed readiness to learn about SV • Educators and nurses saw that SV occurs across ages • Parents and teens saw influence of several sources on SV and sexuality: media, parents, churches, peers • When prompted, most groups showed a readiness to envision what is necessary for prevention • All groups recognized that social norms are part of issue – the “disease and the cure” <p>Lower capacity/asset/readiness:</p> <ul style="list-style-type: none"> • Parents showed lack of readiness to deal with SV and sexuality with their own children • Generally lack of broad participation of parents in school initiated programs • Parents showed some fear around working on issues that would lead to prevention • Educators lack of readiness/comfort around discussing SV, healthy relationships, sexuality • Administrators noted that it was against the cultural norm to discuss sexuality and especially sexual violence in schools • Educators and school nurses not comfortable and/or trained and/or resistant to talk about SV, especially regarding victimization and perpetration • Seems to be a dual system on SV when it comes to adults and children – are they integrated enough? Are we sending different messages?

	<ul style="list-style-type: none"> • Parents do not see criminal justice system as a credible resource or partner • Across all focus groups there was a lack of knowledge around prevention strategies in use, how they work, what their effectiveness is, and certainly a lack of monitoring and measuring effectiveness • Lack of knowledge around basics of SV – still focused on “stranger danger” • Lack of good curricula • Lack of “room” in schools to adopt new curricula
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What are the strengths of this data source?	Community Knowledge -- parents, teens, educators, offenders as well as researchers and experts
What are the limitations of this data source (e.g. who was left out, how was data collected)?	Expressed statements mainly on intervention of victimization and perpetration, not prevention, so it is unclear how helpful this really is on analysis of prevention capacity. Small number of participants.
How does the information from this data source compare with other data sources?	Correlates to some responses in GACASV survey (July 2004)
Could this data source be improved to provide more useful information in the future? If so, how?	Could use more research on offenders regarding prevention for possible use in determining capacity
Do we have enough information to write clear problem statements?	Some
If no, what other information do we need?	Research Planned Parenthood presentations on sexuality Need to do a mega analysis of existing programs and any evaluation/assessment available on them.
Where can we find that information?	Planned Parenthood; possibly DOE for curricula already existing in schools.

**Data Source: Governor’s Advisory Council Against Sexual Violence (GACASV) Survey
Complete July 21, 2004
N = 8 (out of 30 members)**

What does this data source tell us about magnitude of IPV and/or SV among universal and selected populations?	N/A briefly mentions higher incidences in developmentally disabled population
What does this data source tell us about risk and protective factors among universal and selected populations?	N/A
What does this data source tell us about assets / resources?	Responders have already thought about this topic Several responders showed clear understanding of Prevention
What are the strengths of this data source?	Some specific information regarding perpetration, trafficking, people with disabilities, curricula, programs, possible partners and programs Evaluative information on pages 9-10
What are the limitations of this data	limited # of responses (8 of 30)

source (e.g. who was left out, how was data collected)?	<p>answers are very subjective</p> <p>no #s to reflect how many people responded with the same information – only broad narratives</p> <p>questions were not based on capacity</p> <p>questions not specific to primary prevention</p> <p>this source is of very limited value</p>
How does the information from this data source compare with other data sources?	<p>- similar to phone survey list for who's doing prevention</p> <p>- could compare to IPCQ of SCBT & SPT, but questions are vastly different and quantitative data for GACASV survey is missing</p>
Could this data source be improved to provide more useful information in the future? If so, how?	<p>- need more description on entities & programs listed</p> <p>- need composite info on responses</p> <p>- add emphasis on primary prevention</p>
Do we have enough information to write clear problem statements?	<p>- limited responses</p> <p>- topics focused on risk reduction and awareness</p> <p>- need to improve evaluation efforts</p>
If no, what other information do we need?	<p>- need evaluative / research data on programs or entities for effectiveness – don't know the value of the programs</p> <p>- ask more of the GACASV regarding primary prevention and the Public Health Approach</p>
Where can we find that information?	- look to the programs and CDC for evaluation information

Data Source: Summary of Prevention Activities: RPE Funded Programs by Sexual Violence Program Agencies for 2006
N = 23 (21 counties, Rutgers, NJCASA)

What does this data source tell us about magnitude of IPV and/or SV among universal and selected populations?	None
What does this data source tell us about risk and protective factors among universal and selected populations?	None
What does this data source tell us about assets / resources?	<ol style="list-style-type: none"> 1. Lists educational activities 2. Lists relationships in community already established. 3. available \$ through RPE; & total spent on outreach (not sure on constituency of data reported on full budget) 4. 23 entities already doing prevent work in SV 5. breadth of media usage 6. staff hrs/wk 7. # of staff on outreach 8. subject matters
What are the strengths of this data source?	<ol style="list-style-type: none"> 1. info across the state 2. basic snapshot 3. constituencies by grade level 4. subject matter
What are the limitations of this data	1. inconsistency regarding budget data – full data

source (e.g. who was left out, how was data collected)?	<p>or just related to RPE \$</p> <ol style="list-style-type: none"> 2. definition of prevention work Is inconsistent 3. frequency of media use is not known 4. subject area definitions? Inconsistency 5. no frequency of presentation or # presented to – no stats on volume
How does the information from this data source compare with other data sources?	<p>Similar to RPE survey Consistently inconsistent</p>
Could this data source be improved to provide more useful information in the future? If so, how?	<ol style="list-style-type: none"> 1. Included volume & frequency 2. specific to prevention vs. awareness 3. clarify staff reporting 4. cross for age level and subjects 5. specific curricula 6. DEFINITIONS

Do we have enough information to write clear problem statements?	<p>No – reliability of data – staff #, hrs, volume/frequency Yes – re: prevention funding available</p>
If no, what other information do we need?	<p>Cultural competency and language capacity of staff, Historical underserved communities - to or about those communities & what age levels</p>
Where can we find that information?	<p>Sexual Violence Programs (SVPs)</p>

Data Source: Local RPE Programs (SVPs): Resource/Capacity Questionnaire
Distributed November 20, 2006; completed March 14, 2006
N = 22 (out of possible 23 – includes NJCASA response)

What does this data source tell us about magnitude of IPV and/or SV among universal and selected populations?	<p>N/A</p>
What does this data source tell us about risk and protective factors among universal and selected populations?	<p>N/A</p>
What does this data source tell us about assets / resources?	<p># of programs funded to do Prevention Work (23) 20 of 22 respondents got funding from DOW (RPE)</p>
What are the strengths of this data source?	<p>Shows what kind of prevention activities are undertaken: 21 General public/classroom presentations 16 training of related professionals (educators and social Service – 6) 14 specialized training in drug facilitated sexual violence 12 use of research-based curricula (various age levels)</p> <p>Shows other collaborating organizations: 16 schools 9 houses of worship; police or courts; hospitals or health Care providers</p>

What are the limitations of this data source (e.g. who was left out, how was data collected)?	Many answers don't seem consistent with questions asked Confusion in answers regarding what primary prevention is Confusion how to answer "dosage" question Doesn't indicate overall agency work on prevention
How does the information from this data source compare with other data sources?	Responses to funding question could have been on prevention and/or entire agency – answers seemed inconsistent to other known data sources (DOW) – some sources cited are clearly for intervention work (VAG) Further comparison needs to be made with DOW survey of prevention activities.
Could this data source be improved to provide more useful information in the future? If so, how?	Needs more clarification of primary prevention definition being used Q #13 – needs clarification as to what level agencies are functioning and where they hope to be and what they really need to reach their goals Not sure at this point how we can co-validate this data Do not know who filled out questionnaire, what position they held, and whether they were filling out for full agency or only sub-program

Do we have enough information to write clear problem statements?	No – only that we needed more concise data based on shared and clear definition of prevention, dosage, funding, etc.
If no, what other information do we need?	What other programs in catchment area are doing SV prevention (schools) Who filled out the survey Outcomes (specific) – positive and negative On funding (Q#5): how much, how often in the last 5 years and that was used ONLY for prevention Strengths and weaknesses of programs implemented Need to clarify if staffing indicated in Q#2 represents paid and/or volunteer and how many are specifically for prevention – data presented here does not match other known data sources (DOW)
Where can we find that information?	DOW information and survey Local school listings/ DOE

Data Source: Phone Interviews with Other Prevention Organizations (focused on pages 16-24)

August 2006

N = 17

What does this data source tell us about magnitude of IPV and/or SV among universal and selected populations?	N/A
What does this data source tell us about risk and protective factors among universal and selected populations?	N/A
What does this data source tell us about assets / resources?	<ul style="list-style-type: none"> • 17 organizations in NJ doing prevention work in other fields • School access is possible

	<ul style="list-style-type: none"> • Larger coalitions of organizations working through state • Research exists on effectiveness of programs in other fields • Some evidence based plans with higher dosage in use in other fields • State agencies (other than DCA/DOW) funding prevention efforts in other fields • Some fields have already developed outcomes measures • Some prevention organizations and/or coalitions have access to parents and youth • Prevention system in NJ is fairly isolated and not connected • All organizations expressed interest in collaborating/partnering in SA prevention and willingness to be called back
What are the strengths of this data source?	<ul style="list-style-type: none"> • Variety of organizations and networks surveyed
What are the limitations of this data source (e.g. who was left out, how was data collected)?	<ul style="list-style-type: none"> • Small interview pool • Close-ended questions • Lack of quantitative data • Specific source of information is not identified (such as name of person and position within agency) • Unable to discern whether definition of prevention is equivalent to definition used in SA field • Interpretation of answers difficult given vague and/or sparse answers • No specific data on outcomes, just indication that it exists • Some groups visibly missing: NJCBW, NJCASA, Planned Parenthood, ATSA, HighTops, Dept of Health
How does the information from this data source compare with other data sources?	<ul style="list-style-type: none"> • No point of comparison with other data sources reviewed • General lack of understanding of prevention of SA
Could this data source be improved to provide more useful information in the future? If so, how?	<ul style="list-style-type: none"> • Use fuller definition of prevention rather than “primary prevention” term that seems to confuse people • Use open ended questions • Include specific questions on outcomes and effectiveness and tools used to measure same • Inquire about specific sources of funding and at what levels • Inquire about what their prevention “message” is and use of media and other outlets to convey their message • Inquire about their activity on state-wide bases – type; dosage; outcome • Be intention about covering all geographic areas in state, including urban, suburban, rural breakdown • Identify source of information and position with

	organization/network
Do we have enough information to write clear problem statements?	<ul style="list-style-type: none"> • There is a lack of specific data in this source – it provides only a broad brush overview that organizations exist in the state doing prevention in other areas – difficult to develop problem statements on this basis
If no, what other information do we need?	<ul style="list-style-type: none"> • Funding sources, amount and for what use • # of people reached through programs broken down by demographics • Any specific populations reached and/or targeted • Dosage and duration of programs • Outcomes measures and effectiveness of programs, especially over long term • Current partnerships • How far is their reach -- geographically • What kind of advocacy and/or policy work do they engage in
Where can we find that information?	<ul style="list-style-type: none"> • Internet/websites • Annual reports • Direct interviews • Dept of Health • Prevention Networks

Data Source: Rose Williams, Outreach Coordinator of New Jersey Coalition for Battered Women April 2007
N = 29 (member programs of NJCBW)

What does this data source tell us about magnitude of IPV and/or SV among universal and selected populations?	N/A
What does this data source tell us about risk and protective factors among universal and selected populations?	N/A
What does this data source tell us about assets / resources?	<ul style="list-style-type: none"> • 29 DV program members of NJCBW • # of presentations on DV in the state • # of people reached through presentations • Categories of organizations/people reached • Types of media used to present information (oral, newspaper, publications, etc)
What are the strengths of this data source?	<ul style="list-style-type: none"> • Gives general look at out many people are reached in a year by NJCBW educational programs: 143,127 people through 3,400 presentation
What are the limitations of this data source (e.g. who was left out, how was data collected)?	<ul style="list-style-type: none"> • Informal data collection • No correlation of numbers reached by specific organizations • No outcomes given

How does the information from this data source compare with other data sources?	We reviewed no other data that was specific to DV presentations
Could this data source be improved to provide more useful information in the future? If so, how?	<ul style="list-style-type: none"> • Would be useful to analyze full data set • Questions on dosage, duration, outcomes • Questions on whether “prevention” was intent of presentation or merely awareness/information sharing
Do we have enough information to write clear problem statements?	No
If no, what other information do we need?	See above
Where can we find that information?	NJCBW

APPENDIX H

**Prevention and Public Education Committee
of the
Governor's Advisory Council Against Sexual Violence**

Preventing Sexual Violence – Report on Stakeholder Input

(Summary of Focus Groups)

September 19, 2007

**Preventing Sexual Violence – Report on Stakeholder Input
(Summary of Focus Groups)**

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Introduction & Methodology

The Prevention and Public Education Committee (PPEC) of the Governor's Advisory Council Against Sexual Violence, in an effort to address its key goals, initiated a focus group project in the spring of 2005. The project was designed to bring together groups of key stakeholders in a facilitated discussion around several carefully framed questions regarding the prevention of sexual violence (see Appendix I). The results would inform the PPEC's work in developing a statewide plan for the primary prevention of sexual violence in New Jersey and subsequent strategies designed to prevent perpetration of these crimes.

PPEC began by adopting the Centers for Disease Control and Prevention's (CDC) definition of primary prevention efforts as being approaches and interventions that take place before sexual violence has occurred to prevent initial perpetration or victimization. PPEC's aim was to develop and promote a statewide strategic plan based on the CDC's Public Health Approach to sexual violence prevention that focused on efforts that keep individuals from committing acts of sexual violence. This focus on primary prevention presented a challenge to some focus group participants whose familiarity with the issue of sexual violence was centered historically on sexual violence awareness and risk reduction efforts directed at potential victims.

In order to frame the questions to be asked at each focus group, the project design also called for initial interviews with experts in the field of sexual violence. Dr. Jackson Tay Bosley and Dr. Kathryn Hall were selected as the experts to be interviewed based upon their reputations in the field and the fact that each had a depth of experience in establishing a therapeutic community and/or providing therapy to both perpetrators and victims of sexual violence. Dr. Elizabeth Paul, Acting Vice President for Student Affairs at the College of New Jersey, was also interviewed separately when it was determined by PPEC that her experience and research would add perspective specifically with respect to college age youth, an important cohort in primary prevention efforts.

PPEC then determined that the following stakeholders would be asked to participate in a focus group for that particular constituency (see chart below for description of groups and topics covered):

- Parents
- Researchers and Therapists
- Educators
- Rape Care Advocates
- Offenders
- Teens

Efforts were made to organize a focus group with sexual assault survivors. However, PPEC was unable to locate a group of survivors with whom a focus group could be conducted. It was decided that efforts would be made again at a later point in the planning process to include the voice of survivors.

At the start of each focus group session, ground rules were established to ensure stakeholders that remarks made during the discussion would never be attributed to any individual. Rather, the aggregate data gathered would be recounted in a summary report that would constitute the

content from which the final report would be drawn. The notes of each of the focus groups were taken by PPEC members.

In all, ninety (90) people participated in eight (8) focus groups. The groups were held in various locations around the state to ensure diversity in race/ethnicity, gender and geographic location, and to encourage people with an interest and expertise in this subject to participate.

Focus Group Overview

Group	Date	Attendees	Question Topics
<p>Rape Care Advocates – multiple representatives from local Sexual Assault Programs in Bergen, Cumberland, Monmouth and Ocean counties</p> <p>(Held in Hazlet, NJ)</p>	4/28/06	10	<p>Current prevention activities and effectiveness</p> <p>Receptivity of schools</p> <p>Obstacles to prevention</p> <p>Risk factors</p> <p>Motivational factors</p> <p>Cultural, racial/ethnic or socio-economic factors for targeting prevention strategies</p>
<p>Parents – Two groups - one suburban, one urban</p> <p>(Held in Maple Shade, NJ and Camden, NJ)</p>	<p>2/27/06 (Maple Shade)</p> <p>8/25/06 (Camden)</p>	<p>11</p> <p>11 (10 females, 1 male)</p>	<p>Knowledge about sexual violence</p> <p>Outside influences on youth</p> <p>Methods to enlist participation of parents, schools & community in prevention</p> <p>Awareness of current school based efforts</p> <p>Effective methods to reach youth</p>
<p>Educators – including a school nurse, community college counselor, school administrator, high school teacher, NJ Dept. of Education Nurse Coordinator and Rutgers victim services counselor</p> <p>(Held in Trenton, NJ)</p>	6/12/06	7	<p>Role of schools in prevention</p> <p>Resources needed by educators</p>
<p>Teens Bridgeton Community Alliance- Youth to Youth Program participants and leaders</p> <p>(Held in Vineland, NJ)</p>	8/29/06	14 teens, 2 adults	<p>Current knowledge and questions about preventing sexual violence</p> <p>Outside influences on youth that promote sexual violence</p> <p>Effective ways to reach youth</p> <p>Awareness of current prevention efforts</p> <p>Risk factors</p> <p>Teen & parent involvement in prevention</p>
<p>Researchers & Therapists - Two groups of individuals who either conducted or compiled research on the topic. The groups also included practitioners with</p>	<p>12/29/05 (Trenton)</p> <p>12/30/05 (New Brunswick)</p>	<p>11</p> <p>7</p>	<p>Leading causes of sexual violence</p> <p>Risk factors</p> <p>Motivational factors</p> <p>Effective prevention strategies</p> <p>Key elements of statewide plan</p> <p>What public needs to know</p>

Group	Date	Attendees	Question Topics
extensive experience (Held in Trenton, NJ and New Brunswick, NJ)			
Offenders - offenses included voyeurism, lewdness, stalking, rape, child sexual assault, robbery, kidnapping, use of weapons (Held with currently incarcerated offenders at the Adult Diagnostic & Treatment Center, Avenel, NJ)	3/28/06	15 offenders, 1 ADTC Therapist, 1 ADTC Administrator	Factors that contributed to their behavior Requests for help and types of previous interventions What might have prevented this behavior What should the public know Roles of schools, parents, community in prevention Effective treatment to prevent recidivism

Expert Interviews

The following notes were taken from interviews conducted between September 2005 and March 2006 by Judith Hain, a consultant to the Prevention and Public Education Committee (PPEC) of the NJ Governor's Advisory Council Against Sexual Violence (GACASV). Interviews were held with two therapists who specialize in the treatment of sex offenders and sexual assault victims, and one researcher who specializes in adolescent sexual behavior.

The therapists were asked about primary risk factors for perpetration, primary motivational factors and effective strategies for prevention. The researcher was asked about youth attitudes towards sex, effective methods to reach youth on prevention of sexual violence and key elements of an effective statewide plan for prevention.

Experts:

Jackson Tay Bosley, Psy.D.

Jackson Tay Bosley, Psy.D. is currently a Clinical Administrator for the University of Medicine and Dentistry of New Jersey (UMDNJ) developing a statewide program for adult sex offenders under parole supervision for life. He is also the current President of the New Jersey Association for the Treatment of Sexual Abusers (NJATSA), which is the primary professional organization of sexual offense treatment providers in New Jersey. Dr. Tay Bosley specializes in the development, implementation and evaluation of structured sex offender treatment programs for adults and adolescents.

This interview occurred at his previous job as Program Director for the Juvenile Sexual Offense Treatment Services, in the New Jersey Training School for Boys, Jamesburg, NJ.

Kathryn S.K. Hall, Ph.D.

Dr. Hall is a licensed clinical psychologist practicing in Princeton, NJ. She is also a member in good standing in the American Psychological Association; the International Academy of Sex Research; the Society for Sex Therapy and Research; the Association of Sex Educators, Counselors and Therapists; the International Society for the Prevention of Child Abuse and Neglect; and the American Professional Society on the Abuse of Children. She serves on the Special Classification Review Board, appointed by the Governor to oversee the clinical progress of convicted sex offenders in the state of New Jersey. Dr. Hall has been a frequent consultant to lawyers and the courts on sexual violence related matters.

Elizabeth (Beth) Paul, Ph.D.

Elizabeth (Beth) Paul is the Interim Provost and Vice President for Academic Affairs at the College of New Jersey since 1992. She served as the Chair of the Department of Psychology from 2003-2005 and as Interim Vice President for Student Life in 2005-2006. Dr. Paul's psychological research focuses on relational challenges of late adolescence and young adulthood including risky sexual experiences. Her recent work on "hookups" – youths' spontaneous and anonymous sexual experiences, was featured in a *Newsweek* article and on the *Today Show*. She

is currently writing a book on youth sexuality and has developed a Healthy Relationships Initiative in Trenton, NJ to support youth making healthy sexual and social choices.

Summary of Interviews:

Jackson Tay Bosley, Psy.D.

Clinical Administrator, University of Medicine and Dentistry of New Jersey
President, New Jersey Association for the Treatment of Sexual Abusers

(This interview occurred at his previous job as Program Director for the Juvenile Sexual Offense Treatment Services, in the New Jersey Training School for Boys, Jamesburg, NJ.)

Summary of Interview - September 22, 2005.

Commonly seen risk factors seen in this setting:

Growing up in an environment where:

- There is little or no respect for other people
- Poverty and crime are rampant
- Basic information about sexuality is lacking
- Bullying behaviors are tolerated/condoned
- “Getting over” on people is accepted
- Getting unhealthy messages around sexuality is the norm

Within the population at the New Jersey Training School, there is a low rate of repeat criminal sexual behavior, but a high rate of non-sexual criminal behavior. Only a minority of that population has been sexually abused and only a minority appear to have sexual attraction to specifically deviant activities/partners (violence or pre-pubertal partners). In these cases, the behavior is often based on opportunistic exploitation of weaker individuals.

Common characteristics of perpetrators in this setting:

Perpetrators:

- Don’t care about the welfare of others
- Feel that exploiting a weaker person is okay
- Assume that “if I feel bad, why should I care about anyone else?”
- Many are beginning to show overtly antisocial tendencies (with adolescents it is sometimes difficult to determine sociopathy/psychopathy because adolescents are more concerned about themselves anyway)
- Have no internal compass
- Internalize a specific type of negative male socialization where “getting over” on a another person is important; success at any price is prized and caring about other people is seen as a weakness
- Show little ability to inhibit impulsive, antisocial behaviors or emotions

Dr. Bosley spoke also about the impact of Megan’s Law on sexual violence. He pointed out that the law in New Jersey makes little distinction between adults and children. It can result in a

juvenile being labeled a sex offender for life. This *can* cause the developing juvenile, who is searching to find their place in society, to assume and/or struggle with this very negative label. The developing identity issue is very important for youth, and this label complicates their ability to become a functioning member of society. Under state law, offenses that could best be described as “butt grabbing” in school can constitute a Megan’s Law offense, punishable by lifetime registration. A problem with the law is that it sometimes does not make the kinds of delineations necessary to distinguish the unpleasant and offensive from the much more serious behaviors that warrant criminal sanction.

Dr. Bosley also spoke of the need to consider unintended consequences of our acts (both individual behaviors, and legislation). Many of his colleagues have also noted that “pleading out” the sexual aspects of a crime might be legally just (to avoid the overly severe consequences of Megan's Law), but paradoxically eliminate the kinds of leverage necessary to mandate offenders into treatment. Youth are sent to Jamesburg for something else and aren't mandated to go through therapy, and most will not go through therapy for sexual perpetration voluntarily. Dr. Bosley pointed out that as a result of this he was losing access to a good number of youth who would have seriously benefited from the program.

Most effective methods/strategies for prevention:

In talking about prevention, Dr. Bosley made several points. First, he talked about the need for increased work in the community to educate families about the need for children to have appropriate supervision and education. Circumstances such as leaving a troubled young boy/man in positions of responsibility over vulnerable younger children can contribute to incidents of sexual exploitation. When fashioning a message to be effective with these young men, it is critical to select a spokesperson who will have “street cred(ibility).” Rock stars, rappers, sports heroes, etc. are preferred. Further, educating young people about the laws could sensitize youth to the issue (i.e., age of consent, etc.).

Dr. Bosley also addressed the issue of impulsivity in sexual assault and pointed out that some perpetrators do, in fact, engage in planning. In treatment, the Relapse Prevention Safety Plan identifies the feelings/thoughts/behaviors that indicate the youth is moving toward another assault (High Risk Factors) and gives the youth alternative behaviors to avoid future sexually victimizing behaviors.

When asked about the point of greatest impact to reduce the incidence of sexual violence, Dr. Bosley said that primary prevention efforts must begin in the schools. The message to everyone is that “women are people too.” He also suggested that education around the courtship process to give young men more socially acceptable skills in this area would be helpful. Different cultural standards must always be kept in mind when addressing these issues. Key to reducing the potential for sexual violence from Dr. Bosley’s point of view is to address, reduce and/or eradicate exploitative/bullying behavior as it can be a precursor to sexual violence. He also highlighted how powerful the use of language can be in creating a negative, disrespectful atmosphere around women such as calling women “bitches.”

Once juveniles are in the system, treatment is provided and is a very effective in reducing further incidence of sexual violence by using a variety of treatment techniques including cognitive

behavioral therapy. Dr. Bosley also described tools and techniques that “humanize” the experience of sexual violence victims, including a training video he made for his doctoral dissertation and bringing in survivors to describe the negative effects of their victimizing experiences.

The greatest statistical risk factor for victimization is being female (a sad fact according to Dr. Bosley). The messages that need to be sent to victims are that it is not their fault, that they are not damaged goods, and that they did not bring it on themselves in any way. Offenders must take responsibility for their hurtful behaviors, and learn to feel and show respect for others.

The general public needs to be educated about the fact that sexual violence does exist, that young children need to be supervised, and that most sexual offenders can learn to control their behavior. A small minority of offenders does not, or cannot, control this kind of behavior, and need the strict controls of Megan’s Law. However, with treatment most offenders will not revert to the offending behavior.

Kathryn S.K. Hall, Ph.D.

Licensed Clinical Psychologist, Princeton, NJ
Member, Special Classification Review Board

Summary of Interview - September 12, 2005

Primary risk factors associated with perpetrators:

- A history of abuse and/or neglect, not necessarily of a sexual nature
- A history of domestic violence (witnessing, engaging in,,)
- Alcohol/drugs and/or anger (all tend to dis-inhibit this behavior)
- Lack of resources such a someone to talk to
- Lack of coping skills
- Disassociation from their behavior as an offender (rationalizing and minimizing their behavior)
- Violation of boundaries (some boundary has been crossed for them, or they know someone who has offended, or they learn that a potential victim has been abused before)

Motivational factors, common characteristics of perpetrators:

- Sex is a powerful drug that offenders use to make themselves feel better. When sexual gratification is combined with violence, these are strong motivators.
- Underlying motivators for perpetrators are negative feelings about one’s self, one’s masculinity, and about women, which may range from just not understanding women to actually vilifying women (exemplified by such beliefs as: “Women only care about material things”; “She’s so stuck on herself she would not go out with me”; “If I can have sex with her once, then she will see how good I am and want me.” Adolescent sex offenders notably portray women as sexual objects.

There are many myths associated with sexual assault. With respect to the myth that it is an impulsive act, Dr. Hall explained that even though the act is often seen as impulsive, offenders

generally struggle with their tendencies toward sexual violence for some time. Further, they tend to plan their activities in ways that they are often reluctant to admit, even to themselves. They may start at the lower end of the spectrum such as exposing themselves in public, and as their boundaries grow wider, escalate into more serious acts of sexual violence.

Perpetrators of sexual assault against strangers often have a history of “breaking and entering” which, at some point, results in their engaging in a sexual assault while on the premises. They may in fact be practicing for engaging in an assault or hoping to find a victim during a burglary. They may also engage in “criminal trespass” where they “case” a particular house and/or follow a potential victim for some time before actually attacking.

They often demonstrate more violence than is actually necessary to carry out the crime. The violence is fueled by the motivators set forth above. Offenders will often tell themselves that they are just fantasizing and that they will never act on their fantasies, but the more they think about it, the less their desires seem abhorrent to them. The internet is also important here, as many offenders can find websites that feed their fantasies or encourage their rationalizations for criminal sexual behavior. This dis-inhibits their acting on these desires.

Ironically, because sexual offenders and particularly child molesters are seen as the “lowest of the low” and will do anything to avoid even acknowledging to themselves that they may have this problem, it is exceedingly difficult to get these offenders into treatment unless they have had some interaction with the legal system. This may come from many sources such as being caught at work or by viewing pornography on the Internet. Ironically, many rapists are caught because they call the victim the following day to ask for a date. In any case, Dr. Hall prefers treating offenders who have a legal obligation to enter therapy because they are required to stick with it and have motivation to improve.

Most effective methods/strategies for prevention:

Perpetrators are often in therapy for other things. Given that, if the therapist does not specifically ask about sexual violence, the perpetrator will not offer such information. Therefore, psychologists should be prompted as part of their protocol to ask questions about the client’s relationship to women and whether it includes instances of sexual violence. The therapist should also ask about whether the client has any anger management issues, rape fantasies and or other fantasies about sexual violence. In this way, perpetrators and potential perpetrators might come to the attention of health care providers much earlier in the progression. This is important if any of the following risk factors are present: domestic violence, a personal history of abuse, a family history of abuse of a sibling, a history of petty crime, engaging in sexual harassment at work , spending excessive time on internet pornography especially if it relates to rape, child molestation etc.

Dr. Hall expanded on her earlier point that there is also great shame in knowing oneself to be a perpetrator of sexual violence. Her recommendation was to establish a “hotline” which a person could call when he/she was fantasizing about sexual violence or find they are exhibiting threshold behaviors to committing such an act. Having a trained professional at the other end of the line could help extinguish the potential to act out at that time and perhaps lead someone into therapy. Anonymity would encourage many to utilize such a service.

When asked about risk factors associated with victims, Dr. Hall mentioned that:

- anyone who had previously been a victim was “at risk” again
- there is often a lack of good judgment (a history of victimization damages not only the ability to trust one’s judgment about others, but also damages trust in oneself and one’s own ability to judge personal safety or that of one’s children especially as they don’t want to hurt the feelings of others)
- there is a sense of denial that it can happen to me even though it may have happened already
- poverty contributes in a multitude of ways.

First regarding poverty, the parents of children of poverty are, because of the circumstances of their lives, not as able to watch over their children as those more financially fortunate can. Secondly, those in poverty are often victims of unemployment, which may introduce potential use of drugs/alcohol making them more vulnerable. Finally, women in poverty are often struggling with so many issues they may turn a blind eye to warning signs that they or their children may be victimized by sexual violence. Lack of good quality and affordable child care places many children at risk, as do the policy of housing children in motels where many transient people also stay.

In identifying potential messages to be used for protecting potential victims, Dr. Hall mentioned a number of approaches:

- If you have a funny feeling about a situation you are in, do something about it or get away as quickly as you can.
- Do not be afraid to make a fuss.
- Care enough about yourself and act accordingly.
- People instinctively sense danger. Trust your own judgment and don’t talk yourself out of what you are feeling.

In terms of prevention, Dr. Hall offered that girls are more likely to be victimized at home; boys are more likely to be victimized outside the home. This is important information for parents in looking for warning signs.

Speaking about child molesters in particular, Dr. Hall stated that their *modus operandi* is to look for children who are needy, who look neglected and then work to earn their trust while isolating them from others. Given these factors, there is opportunity to make it more difficult for a child molester to perpetrate his crime, and there is more opportunity to intervene if you see any of the warning signs. However, these individuals often blend into the general community and often look quite respectable. This is in stark contrast to the image we have of child molesters as monsters. They are often respected people in positions of authority. Parents should assess the situation as well as the people to whom they entrust their children. People should trust their own judgment regarding the appropriateness of any situation and not rely on published websites regarding Megan’s Law lists to feel secure. Children should be taught to be assertive and to disclose any weird feelings they may have.

Elizabeth (Beth) Paul, Ph.D.

Interim Provost and Vice President for Academic Affairs, College of New Jersey
Researcher & Author, Youth Sexuality

Summary of Interview - March 20, 2006

What are the attitudes/behaviors of today's youth as they relate to sexuality/sexual violence?

Dr. Paul described today's youth as experiencing a significant challenge in establishing an intimate relationship and relating in an intimate way. They are "petrified" about emotional intimacy in peer to peer relationships, even if they do experience healthy familial relationships at home.

She talked about how casual sex is now more the norm for today's youth within the context of the quest for instant gratification so common in today's culture. She also made the telling point that when young people engage in casual sex, they do not even experience it as victimization.

Dr Paul pointed out that today's youth are constantly bombarded with sexual images and messages, yet parents and other adults are loath to talk about sex. In today's culture, sex and relationships are synonymous. While this is problematic in and of itself, the situation is exacerbated by the fact that much of our efforts are directed toward eliminating the sex but we refuse or are unable to talk about relationships.

A key point made by Dr. Paul was that males do not experience these factors differently than females. Young men report experiencing pressure from their partners and society at large to engage in sex. Because they are males, they feel even more inhibited about owning their confused or bad feelings about sexual behavior and activity. They and today's young women therefore carry a lot of emotional pain which they have no place to process. They live with significant unexamined issues which affect their attitudes and behaviors. All of today's youth need gender socialization. That is the common ground.

In her work in the urban areas, Dr. Paul also found that there were fewer differences based upon socio-economic status when dealing with issues of sexual violence than might otherwise be expected or predicted. While the descriptions of events might be different, the phenomena, issues and feelings were all the same. Dr. Paul concluded that the human condition is the common denominator when it comes to sexual violence.

While sexual activity increases when young men and women reach college because of the freedom inherent in that situation, sexual activity is also common in high school and even earlier. In the heightened awareness of homosexuality in today's culture, the pressure often begins in middle school where young people experience the need to demonstrate to their parents that they are not gay.

Children are already also aware that who they date is taken as a reflection on their parents' status in some way. Dr. Paul also talked about how parents often engage in heterosexual pair bonding behavior with their very young children by talking about how cute they are together and how

maybe they will get married some day. In all these ways, coupled with the lack of constructive dialogue about sexuality, Dr. Paul indicated that we are creating an impossible situation for our young people.

The schools, while having the potential to address many of these issues, have been forced through budgetary restraints to eliminate the educational resources previously available to work with kids on sexual issues.

Further, there is a distinct lack of public discourse about what constitutes a good relationship. Dr. Paul added that technology has operated as a counterforce to building good relationships in our society.

What are effective means of reaching today's youth to enhance primary prevention of sexual violence?

There are significant competing interests compelling the attention of today's youth so a key issue is how to attract and hold their attention. In addressing how to get a message to today's youth, according to Dr. Paul, "Just talk to them. They will talk back."

While we hope to achieve the final goal of eliminating victimization in sexual behavior, Dr. Paul addressed a healthy mid-point goal which would be achieved if people didn't feel as if they had to keep their feelings hidden. If all people could be encouraged to feel and express how they themselves have been victimized, we would be on our way to establishing a more healthy context in which to raise our children. According to Dr. Paul, for many parents, not addressing the issues surrounding healthy sexuality with their children is a way to avoid their own pain. Dr. Paul also talked about how the preponderance of psychological resources is currently crisis-oriented. She advocated for more preventative and educational use of psychological resources in all areas of community life when working with children and their families.

What would be elements of an effective statewide plan?

Going forward and recommending elements of an effective statewide plan for primary prevention of sexual violence, Dr. Paul stressed several things. First, we should use powerful tools like "My Space" and "Facebook" to influence youth in a positive way.

Further, there is a critical need for additional psychological resources to be available to children and their families. These resources should provide a place to be with one's feelings, build capacity in people to expand upon what they already know and help develop the emotional tools to deal with life in our culture.

The role of gender, an exploration of emotional complexity and the understanding that things are not all good or all bad are critical issues that must be addressed. In closing, Dr. Paul offered that rather than being fearful of the confusion and juxtaposed feelings in today's youth, we should use this as an "entry point" for communicating about the emotional and psychological issues facing them.

Focus Group Summaries by Topic

Risk & Motivating Factors

Researchers & Therapists, Rape Care Advocates and Offenders were asked about their perception of primary risk and motivating factors in sexual violence. The following responses were identified most often across all groups (note: not in any priority order):

Risk factors for offending included:

- early trauma or abuse in family (both being directly abused and witnessing abuse)
- low self esteem/feeling of inadequacy (offenders noted specifically feeling disrespected, rejected, abandoned, isolated or depressed)
- substance abuse
- premature exposure to sexually explicit materials
- secrecy about sex
- lack of anger or impulse control
- lack of empathy
- lack of a positive male role model
- rigid or distorted gender/sex roles
- perceptions that sex equals power and is a way to get power back when feeling inadequate,
- a sense of entitlement
- no safe place to disclose early (impact of Megan's Law, punished for early disclosure, disclosure seen as sign of weakness, no access to services)
- lack of accountability

Risk factors for victimization:

- those perceived as vulnerable (homeless, developmentally disabled, children who can't refuse, those not adequately supervised)

Risk Factors Identified by Specific Groups:

Incarcerated Offenders in Treatment:

Each member of the offender's focus group told their own story about what factors contributed to their own behavior that resulted in incarceration and treatment. While some of the details varied by person, there was a very strong set of themes that were part of every story. These themes included:

- Sexual and physical abuse as a child
- Abandonment (either by mother or father)
- Use of alcohol/drugs
- The culture, community and friends reinforced the offending behavior and rigid gender roles (being a real male equates with strength and power, being a female equates with weakness/passivity).

Researchers/Therapists:

This group's responses mirrored that of the offenders with several additional risk factors including:

- Media messages that link sex and violence
- A strong sense of entitlement in relationships/marriage
- Family member/acquaintance sexual assault seriously underreported supporting the myth of "stranger danger" which obscures the much higher risk of being raped by a family member or acquaintance

Rape Care Advocates:

The discussion in this group was around the risk factors of witnessing domestic violence in the home, substance abuse, lack of accountability in judicial systems and vulnerability of unsupervised children. They also focused on especially vulnerable populations including the homeless and the developmentally disabled.

Current & Required Knowledge about Sexual Violence

Teens and parents were asked what they currently knew about sexual violence and what they would like to know.

Current Knowledge:

Response to the question about what they currently know was sparse (usually one person answers for each item) and included:

- Most assaults are committed by family members or acquaintances
- Anyone can be raped at any age
- Sexual violence takes many forms
- Sexual violence impacts all aspects of the victim's life, for the rest of her life
- There is a fear of telling

Teens, parents, educators, offenders and researchers/therapists were also asked what they would like to know or feel the public needs to know about sexual violence. Responses included:

Would like to know:

Teens:

- Reasons people commit sexual violence and to understand what motivates them
- What is included in the definition of sexual violence?
- How to identify people who commit sexual violence as well as who they choose as targets

Parents:

- Need real statistics on the problem
- Need to know about services to get help
- Need access to information about sexual predators who reside in the community
- How to discuss sexual violence and sexuality with their children

The public needs to know:

Educators

- What healthy and unhealthy relationships look like

- What consent really means
- That sexual violence happens to men also
- Parents need to know how to discuss sexual violence and sexuality with their children
- For so long we have made women responsible for their own safety. Males need to participate in providing protection

Parents

- Parents need to know that sexual predators exist in the home
- Must get beyond small town mentality that “it doesn’t happen in our community”
- Parents need to know to believe their children when they disclose abuse

Researchers/therapists

- Other safety issues (fire safety, bike safety) are discussed without traumatizing children. We can just as easily address staying safe from sexual violence. Research suggests that it does not harm children to discuss sexual violence.
- A majority of advertisements are sexualized
- Children who have been abused are more likely to be re-abused
- Parents should believe their children when they disclose abuse
- There is a dramatic increase in the reporting of younger and younger perpetrators and victims. 40% of child victims of sexual violence are under the age of 6 and reports of teen perpetrations are increasing (teens who perpetrate tend to have younger victims).

Offenders (select responses)

- We all must be able to talk about sexual violence and not keep secrets.
- Offenders or potential offenders need to see themselves as valuable before they can see the other person (potential victim) as valuable.
- The reason victims are chosen has nothing to do with the victim. Instead it has everything to do with the mind and heart of the sex offender. Sexual assault is all about the sex offender and his issues.
- Sexual perpetrators must see women, intimacy and relationships differently. We must challenge beliefs learned at an early age.
- Sex offenders, post treatment, should be able to live together to support each other and hold each other accountable. We know when someone is getting close to re-offending.
- All offenders are very different and there are many more who are never caught. The public needs to differentiate between different types of offenders and avoid stereotypes.
- There must be follow-up services for offenders when they are released into the community. They need the same support when they get out that they had while incarcerated. They also need jobs, housing and transportation so they do not feel isolated. If offenders are condemned at the door, why bother releasing them?
- Teachers, school nurses and DYFS give up too easily. They need to recognize that perpetrators will manipulate and minimize in order to not be found out. Caseworkers need to persist and not close the case too quickly.
- People should follow their gut instinct. Follow your gut instinct that something is not right.

Outside Influences on Youth

Parents and teens were asked about outside influences on youth today that promote sexual violence and how best to get messages to youth about preventing sexual violence.

Teens - Priority influences on youth:

- Music is the biggest influence on youth in promoting sexual violence and can also be a strong vehicle for prevention messages.
- Youth spend more time with teachers and peers than with their own families.
- Television, movies and video games send inappropriate messages that children then act out.

Parents – Priority influences on youth:

- Videos, television and music lyrics are bad influences on youth violence.
- Internet use, especially www.myspace.com, is the source of youth messages about sex and violence.
- Kids have a tremendous influence on each other – peer pressure about females not having the right to say no is pervasive. Peer support for saying no (and having that respected) could be a positive influence also.
- Fathers “high-five” their sons for having sex and send the message that early sex is accepted/applauded.
- Police assume the victim provoked the rapist and this message gets transferred to the community and to youth.
- Churches and community leaders might have a positive influence on teens but parents feel they have the greatest impact.

Current Prevention Efforts

All focus groups were asked about their knowledge of current prevention strategies (especially in schools) and how effective these strategies are at preventing sexual violence. There appeared to be a general consensus that there are very limited prevention strategies in use today and that consistency of approaches and effectiveness are not being monitored or measured. Specific responses included:

- Current prevention efforts only address “stranger danger.” They do not address violence by people they know, which is the majority of cases.
- There are few good school curricula in use on this topic.
- Informal discussion work better than presentations. Visual tools like skits have a real impact. They are direct, “in your face” and get everyone involved. Peer to peer programs are also seen as more effective strategies than presentations.
- The topic of relationships is part of every grade level in the Core Curriculum Content Standards. However, implementation is left to each district and depends on a school’s/teacher’s comfort with the topic. Generally sexual violence is taught in health or physical education classes and there is no monitoring on how this is taught.
- Participants in both of the parent focus groups discussed potential prevention strategies for the community and schools, but did not cite any current activities that they knew about. Some specifically noted that parents often don’t know what is being done in the schools.
- The organization *Stop It Now!* was created with the specific purpose of targeting undetected offenders so they have a safe place to self-report into treatment versus incarceration. Since the implementation of Megan’s Law this approach has been stymied

- Rape Care Programs reported some efforts to bring information into schools, especially as part of the health curriculum. These were mostly short term efforts aimed at middle and high school students. One longer term effort is the *Expect Respect* 24 week curriculum used in Cumberland County. None of the efforts mentioned appeared to reach all students of a particular age or grade level.
- Child Abuse Prevention (CAP) programs were mentioned as having curricula on sexual violence for elementary school children.
- *Character Counts* was mentioned as a values program in schools that addresses issues of violence generally.

Obstacles to Working with/in Schools

Educators and Rape Care Programs were asked about obstacles to working with schools on prevention. There was general agreement on the major obstacles:

- The core curriculum standards leave little room for extra or new activities. Whatever is the hot issue of the moment tends to be the focus. One issue will be dropped to make room for another.
- There is still resistance from community members for discussing sexual violence with children.
- Teachers/counselors/nurses are not comfortable or trained, and some are even resistant, to speak about sexual violence. There is even more discomfort about children who might disclose either victimization or an urge to offend.
- Funding for prevention is being cut or is very limited.
- There is a mentality and attitude that sexual violence doesn't happen here (in this community). This is also true for colleges that are resistant to acknowledge that this is a problem on their campus. School policies (i.e: policies on sexual harassment, bullying, holding perpetrators accountable) must be created or strengthened and actually enforced.
- There are 612 school districts in the state of New Jersey, each with "home rule" about deciding exactly what goes into the curriculum.
- Whatever is taught in school can be contradicted by what is happening at home or in the community. School based programs will never be enough to prevent sexual violence if the community and parents do not take some responsibility for these issues.

Enlisting Participation of Parents

Both parent groups and the youth group were asked about how to enlist the participation of parents in prevention activities. Responses were extremely mixed with most of the discussion in one group centered on the serious difficulty of getting parent involvement on most topics. There was some discussion of making parental participation mandatory when offering training/education on sexual violence within schools. The other parent group discussed the need for school involvement as primary.

Youth talked about getting parents the information they need to discuss issues of sexual violence with their children and ensuring that the discussion occurs in a safe, comfortable environment (no yelling and good active listening skills needed).

Primary Prevention Strategies for the Future

All groups were asked about what components they would include in any effective state prevention plan. Responses were varied and numerous with several key similarities including:

- It will take a team of people to effectively do prevention work. Active participation of legislators, educators, parents, community leaders, judges, policy makers, professionals in the field of sexual violence and the media are needed to bring expertise from many perspectives into the process and enhance buy-in. As one focus group participant mentioned: “It will take a village to do prevention work – a team with a vested interest to move mountains”.
- A multi-dimensional, on-going, cross-cultural, repetitive education/awareness effort that includes a focus on acquaintance and interfamilial sexual abuse is required. Any prevention effort must counteract the very strong media messages now being portrayed through music, television and the internet. Prevention messages should both dispel common myths and provide positive alternatives.
- Development of both effective curriculum for use in schools and resources for parents to use at home are needed. It will not be enough to work on prevention in the schools when communities are not supportive of this effort and might reject or contradict the norm changes that are being taught. School based programs should include informal discussions, peer to peer interactions and hands-on activities in addition to formal presentations.
- Support early identification of those at particular risk for becoming sex offenders or in the early stages of exhibiting such behaviors so they can receive treatment and support before such behavior is demonstrated and/or escalates. Creating safe spaces for individuals to get help early on can help break the cycle. This can include special hotlines, training of school staff to be responsive and creating an environment where early disclosure is de-stigmatized and results in appropriate intervention.
- Develop methods and messages that will effect a culture/norm change which eliminates bullying, equating power with sex, glorifying unhealthy sexual images/messages and which promotes healthy relationships and respect. Key to this is ensuring that these methods and messages have adequate buy-in from men and local communities. Building alliances with men and communities was mentioned repeatedly.
- Any prevention strategy must take into account the needs of special populations and cultures. The most vulnerable must get the messages in a customized way. This includes but is not limited to the developmentally disabled, special needs students and the homeless.

Consultant Conclusion/Key Findings

Judith Hain

Consultant to the Prevention and Public Education Committee
of the
NJ Governor's Advisory Council Against Sexual Violence

This summary, in total, offers the PPEC significant substance to inform its efforts toward creating a statewide plan for the primary prevention of sexual violence and related public information messages. The key findings which emerged are as follows:

- Directing and holding focus group participants' attention on primary prevention, even just trying to focus on prevention per se, was an extremely difficult task. As a society, we are more comfortable attending to and treating the outcomes of sexual violence. Shifting the focus of policy makers and eventually the general public toward primary prevention will take a concerted and consistent effort and will likely need to involve considerable educational efforts before progress may be made.
- Understanding the risk factors and motivators for the perpetration of sexual violence can help us develop an effective plan for primary prevention. Such a plan would allow us to intervene at a sufficiently early point with effective therapy to eliminate the propensity to commit acts of sexual violence. The plan could also allow us to interrupt a potential perpetrator's behavior leading to an act of sexual violence when such behavior were observed and identified.
- The majority of sexual violence is perpetrated by persons who are known to the victim, yet the focus of most media attention and, therefore, advice given to children is based upon the danger posed to them by "monstrous" strangers. Further, the vast majority of those who might perpetrate or have perpetrated sexual violence can be managed through appropriate therapeutic efforts. Only a smallest percentage, the compulsive/repetitive offenders, are unlikely ever to respond to therapeutic efforts. Even these offenders, however, do respond positively to therapy.
- The consistent emphasis in all focus groups on the essential role of schools in primary prevention efforts creates a significant dynamic tension when viewed in the real context of the reluctance of many, and opposition of some, to allow the schools to engage our youth in education related to sexuality and sexual behavior. One approach emerging from the focus group discussions, which might result in positive outcomes, is to take an incremental path, starting in schools where the environment is more receptive, building on successes and expanding into more schools. Some suggested using the more generic anti-bullying program as a way in which to deal with some of the underlying issues relative to sexual violence. This would naturally take a significant amount of time. A more radical approach would require school, governmental and community leaders to embrace the goal of primary prevention as their own and to create an enforceable, legal mandate to implement effective curricula in all schools in all grades. Significant resources would need to be directed to such an effort and the political implications of such an approach would likely be enormous.
- Effective efforts to prevent reoccurrence of sexual violence, based upon what we learned from experts, researchers/therapists and offenders, are actually counter to the policy

directions taken to date. Legislation like Megan's Law was criticized as keeping many victims from disclosing the acts perpetrated against them for fear of breaking up their families and enhances the likelihood of recidivism because supports requisite to successful reintegration into society are not only lacking but assertively denied the offender.

- Poverty provides fertile ground for the existence of sexual violence although the incidence of sexual violence in all socio-economic groups is well documented. A comprehensive approach to eradicating sexual violence would have to take into account the particular vulnerability of those living in poverty.
- The experience of sexual violence for those in urban areas is, at root, no different than the experience of those living in suburbia or rural communities. Further, the experience of young boys/men is more similar to than different from young women with respect to the societal pressures and confusion about relationships, sexuality and sexual behavior.
- The existence of sexual violence in the community of persons who are developmentally disabled must be a significant consideration in any statewide plan for the primary prevention of sexual violence.
- The most potent voice to communicate messages about sexual violence is the media, particularly through music. Technology plays a significant role in creating vulnerability and exposure to sexual violence.
- The issue of male accountability is one that received minimal attention in the focus group discussions, but must be a significant factor in any plan to eliminate sexual violence.

Sexual violence is a significant problem that knows no boundaries in terms of age, socio-economic, gender, and/or race/ethnicity. As is true for most complex social issues, the primary prevention of sexual violence would involve courageous leadership, an informed public, development and implementation of effective programs, a comprehensive approach, and an infusion of financial and other resources. The focus group participants and experts we interviewed indicate that the key to eliminating sexual violence is educating children and families about what constitutes a healthy relationship and then providing the context and support for the development of healthy relationships. Therefore, if there were sufficient will to move forward in the development and implementation of a statewide plan, the necessary components would likely touch on, and significantly positively impact other troubling social issues that unduly burden public attention and resources. The resulting synergy would make such an effort more cost-effective than policy makers might initially envision. In the extreme, a concerted and comprehensive effort at the primary prevention of sexual violence could even help create more stable families, healthier children, a more positive outcome in public education, and a more productive workforce. Framed in this way, the public at large and policy makers in particular, might find it difficult to turn away from the opportunity presented through the work of this invaluable committee.

Appendix I – Focus Group Questions

Rape Care Advocates

1. In your experience, what obstacles exist to the primary prevention of sexual violence: What are effective intervention strategies to overcome these obstacles?
2. To the extent that you have provided educational workshops/material to prevention sexual violence, have you been able to measure their effectiveness and what has been their impact based upon anecdotal observation/information?
3. If you were asked to develop an effective statewide plan for the primary prevention of sexual violence, what components would it include?
4. Are there cultural, racial/ethnic and/or socio-economic differences that must be taken into account when engaging in primary prevention? What are they and how do we effectively address them?
5. Is there anything else we should know?

Researchers & Therapists

1. In your professional judgment, what are the leading causes of sexual violence? Can/should they be ranked in terms of significance?
2. Who is most at risk to become a perpetrator/victim of sexual violence? Does this vary at all with respect to socio-economic and/or racial/ethnic background or age?
3. What are the key motivators to commit acts of sexual violence?
4. Are you aware of any effective intervention strategies to prevent the commission of sexual violence? At what point should they be undertaken to enhance their effectiveness? Are there different strategies based upon socio-economic and/or racial/ethnic background and/or age?
5. If you were asked to develop an effective statewide plan for primary prevention of sexual violence, what components would it include and how would you rank them in order of importance?
6. What do you think the public needs to learn/know in order to effectively participate in primary prevention efforts?
7. What other groups do you think we should meet with in this kind of forum to inform our statewide plan?
8. Is there anything else you think we need to know?

Offenders

1. As you look back on your life, can you share with us some of the factors that you believe have contributed to the behavior which resulted in your incarceration at Avenel?
2. At the earliest point in time that you can identify the start of those behaviors, did you reach out to anyone for help and, if so, who and what help did you receive?
3. As you look back on your experience, is there anything that might have prevented you from engaging in these behaviors? What would it have been?
4. As the Committee develops a Statewide plan for the elimination of sexual violence, what advice would you give the Committee in terms of:
 - information you believe the public should have with respect to sexual violence

- what role the schools, parents, religious organizations, community organizations, governmental bodies and others should play to stop sexual violence before it begins
- how offenders should be treated so as to prevent recidivism
- effective strategies and methods to keep individuals from committing acts of sexual violence

Parents & Teens

1. As we develop our Statewide Plan, it would be very helpful to understand what information (young people) or (parents/adults) in the community already have about sexual violence and what you would like to know about sexual violence so that you can effectively participate in eliminating it.
2. What are the outside influences in the lives of today's youth which seem to promote sexual violence and how do we address those influences and/or use them to our advantage in preventing sexual violence?
3. What do you think are effective ways to reach today's youth with important messages? What speaks to (your) or (their) hearts and what do we need to know about today's youth in order to develop a plan that effectively impacts them?
4. What do you think would help today's youth refrain from committing acts of sexual violence?
5. Are you aware of any efforts already being made in the school district and/or the community to educate young people about sexual violence and/or to help prevent it? What are they and what, if anything, do (children/students) or (your friends and associates) report about those efforts?
6. Are there ways in which you would like to participate in the overall effort to eradicate sexual violence?
7. How do we enlist the cooperation of parents in addressing this issue from a prevention perspective?

Educators

1. What role, if any, could/should the schools play with respect to the primary prevention of sexual violence? Does this need to be modified in order to work with special needs students?
2. What resources, if any, would need to be forthcoming in order for educators to effectively participate in the primary prevention of sexual violence?
3. What are the existing obstacles to educators participating in the primary prevention of sexual violence and how would you propose that we eliminate those obstacles?
4. If you were asked to develop an effective statewide plan for the primary prevention of sexual violence, what components would it include?
5. What do you think the public needs to learn/know in order to effectively participate in primary prevention efforts?
6. Is there anything else you think we need to know?

APPENDIX I

Strategy Sources

PREVENTION INSTITUTE

<http://www.preventioninstitute.org/creatingSAFEenvironments.html>

This report provides an overview of promising violence prevention initiatives across the nation, with special focus on the primary prevention of violence affecting youth and adult intimate partner violence. Specific attention is given to initiatives directed at particularly vulnerable populations, including racial/ethnic groups, immigrants, low-income populations, girls and women, and others

Preventing Drug Abuse Among Children and Adolescents: A Research Based Guide

<http://www.nida.nih.gov/Prevention/examples.html>

The National Institute on Drug Abuse (NIDA) provides a list of research based prevention strategies.

SAMHSA

<http://www.nrepp.samhsa.gov/>

NREPP is a searchable database of interventions for the prevention and treatment of mental and substance use disorders. SAMHSA has developed this resource to help people, agencies, and organizations implement programs and practices in their communities.

Drug Strategies

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

Drug Strategies is a non-profit research institute that promotes more effective approaches to the nation's drug problems and supports private and public initiatives that reduce the demand for drugs through prevention, treatment and law enforcement.

PreventionNet

<http://www.preventionnet.com>

The focus of *PreventionNet* is accurate information on drug abuse prevention programs for which there is credible scientific evidence of effectiveness. Through the *PreventionNet* website, information concerning the most effective prevention programs currently available is provided in a brief and straightforward way.

Network for Dissemination of Curriculum Infusion - Northeastern Illinois University

<http://www.neiu.edu/~k12pac/resources.htm>

Funded by the Fund for Improvement of Postsecondary Education (FIPSE), U.S. Department of Education, The Network for Dissemination of Curriculum Infusion trains College of Education faculty to prepare future teachers in a Curriculum Infusion (CI) methodology. Through CI methodology real life issues including substance abuse, violence, HIV/AIDS, bullying, and social ostracism are substituted for some existing content consistent with class learning objectives and state standards. Future teachers involve students as active learners, engaged in critically analyzing problems. They gain greater understanding of racial and cultural diversity

and learn to incorporate into CI lesson plans current research on the most effective ways to reach students to foster resiliency and support individual and community prevention.

[Center for Effective Collaboration and Practice](http://cecp.air.org)

<http://cecp.air.org>

Check out our extensive collection of web [links](#) related to emotional and behavioral problems in such areas as education, families, mental health, juvenile justice, child welfare, early intervention, school safety, and legislation.

OJJDP Model Program Guide

<http://www.dsgonline.com/mpg2.5/search.htm>

The MPG contains summary information (program description, evaluation design, research findings, references, and contact information) on evidence-based delinquency prevention and intervention programs. Programs are categorized into exemplary, effective, and promising, based on a set of methodological criteria and the strength of the findings. The MPG database can be queried through the three methods described.

BLUEPRINTS FOR VIOLENCE PREVENTION -Center for the Study and Prevention of Violence

<http://www.colorado.edu/cspv/blueprints/>

This database contains a national listing of violence prevention, intervention, and treatment programs. There are several databases on this website so click the “home” button to find others as needed.

Best Practices of Youth Violence Prevention: A Sourcebook for Community Action

<http://www.cdc.gov/ncipc/dvp/bestpractices/chapter2a.pdf>

There are listings of strategies at the end of each section. You will need to review them and use web addresses to find more information.

These programs are drawn from real-world experiences of professionals and advocates who have successfully worked to prevent violence among children and adolescents. As a CDC publication, the sourcebook also documents the science behind each best practice and offers a comprehensive directory of resources for more information about programs that have used these practices.

CDC HIV/AIDS Prevention Strategies

<http://www.cdc.gov/hiv/topics/research/prs/evidence-based-interventions.htm>

The evidence-based interventions, listed in this *Updated Compendium*, have been identified by PRS through a series of [efficacy reviews](#). The current ongoing PRS efficacy review process has identified and catalogued evidence-based interventions as either [best-evidence](#), or [promising-evidence](#).

Resource Center for Adolescent Pregnancy Prevention

<http://www.etr.org/recapp/programs/index.htm>

ReCAPP provides practical tools and information to effectively reduce sexual risk-taking behaviors. For each curriculum we provide: an overview of the curriculum, a discussion of unique features, a description of the theoretical framework, program costs and training information, and an evaluation fact sheet. All these curricula have been rigorously evaluated and

have shown impact on sexual risk-taking behavior. We do not rank the curricula by effectiveness, but present the evaluators' findings.

MyStrength.org - Standing Strong for Today's Youth

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

CALCASA has adapted the Strength Campaign for California. Originally developed by Washington DC's Men Can Stop Rape, the campaign currently appears in communities across the nation, Puerto Rico and more than 20 countries. We created this site to help you as a **Man of Strength**, so you can learn about other young men like yourself who are living a life based on equality, caring and respect. Here at **MyStrength.org**, you are an ally in taking action in your community to stop rape.

Prevent Connect Article on Strategies

<http://www.preventconnect.org/articles/lee%202007%20Sexual%20Violence%20Prevention.pdf>

This article highlights the foundations of effective sexual violence prevention that draw from both the feminist movement and from research based approaches in field such as public health. Examples of prevention programs include The Student Connections Club in Harrisonburg, VA, Washington Middle School Project in Washington State, and the California Coalition Against Sexual Assault's [MyStrength Campaign](#).

NSVRC (National Sexual Violence Research Center)

<http://www.nsvrc.org/selectedresources/searchresults.aspx?TopicId=42>

Prevention resources including studies of prevention strategies in the field. The links here take you to other resources available.

National Violence Against Women Prevention Center

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

Has research articles and other general resources on prevention. Some of the articles include references to strategies (see VAW Publications).

APPENDIX J

Primary Prevention & Education Committee Gender Equality + Media Literacy Workgroup Strategy Vetting List Updated 6/25/08

*Guide for Identifying Workgroup Goal: Media Literacy (ML) / Gender Equality (GE)

Strategy to Vet	Workgroup Goal	Reviewer	Yes / No	Due Date
1) Men's Roles and Responsibilities in Ending Gender-Based Violence This listserv provides an international virtual seminar series focusing on men, masculinity and violence. http://www.un-instraw.org/mensroles/	GE	Tay Barbara	Yes	5/21/08 7/17/08
2) Mentors in Violence Prevention Program This is a website for The Mentors in Violence Prevention (MVP) Program, founded in 1993, by Jackson Katz at Northeastern University's Center for the Study of Sport in Society (CSSS). http://www.ncasports.org/mvpcurriculum.htm	ML / GE	Tay Janet	Yes	5/21/08 7/17/08
3) SAMHSA NREPP is a searchable database of interventions for the prevention and treatment of mental and substance use disorders. http://www.nrepp.samhsa.gov/		Tay Vicki	Yes	5/21/08 7/17/08
4) My Strength Campaign The campaign centers on the theme of "My Strength is Not for Hurting," and is designed for men http://www.MyStrength.org	ML / GE	Shari Jennifer	Yes	5/21/08 7/17/08
5) Men Can Stop Rape Men Can Stop Rape empowers male youth and the institutions that serve them to work as allies with women in preventing rape and other forms of men's violence. http://www.mencanstoprape.org	GE	Patty Michelle	Yes	5/21/08 7/17/08
6) Higher Education Center A Social Norms Approach to Preventing Binge Drinking http://www.higheredcenter.org/pubs/socnorms.html		Patty Trish	Yes	5/21/08 7/17/08
7) The New Mexico Media Literacy Project	ML	Jennifer	Yes	6/24/08

NMMLP provides media literacy CD-ROMS, videos and curricula that are used in thousands of schools, worldwide. http://www.nmmlp.org		Patty		7/17/08
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Strategy to Vet	Workgroup Goal	Reviewer	Yes/No	Due Date
8) National HIV Testing Mobilization Campaign http://www.aids.gov/takecontrol/	ML	Patty Rose	Yes	6/24/08 7/17/08
9) What will it Take? Illinois / Advocacy & Action (community mobilization strategy)	ML	Michelle Shari	Yes	6/24/08 7/17/08
10) Mothers Against Drunk Driving (MADD)	ML	Barbara Pamela	Yes	6/24/08 7/17/08
11) PreventionNet The focus of PreventionNet is accurate information on drug abuse prevention programs for which there is credible scientific evidence of effectiveness. http://www.preventionnet.com (Project Star)	ML	Vicki Tay	Yes	5/21/08 7/17/08
12) Teen CAP curriculum Started as a grassroots program	GE	Trish D.	Yes	6/24/08
13) About Face A website to develop personal activism and media literacy around images of girls and women in the media. http://www.About-face.org	ML / GE	Pamela	Maybe	5/21/08
14) Equity Online The WEEA Center is a national project that promotes bias-free education. http://www.edc.org/WomensEquity/about.htm	GE	Pamela	Maybe	5/21/08
15) Time to Talk ...the conversation starts here from Dads and Daughters website	ML	Michelle	Maybe	6/24/08
16) Media Wise National Institute on Media and Family	ML	Michelle	Maybe	6/24/08
17) Say Yes to No Grassroots Campaign / healthy self-relying kids	ML	Michelle	Maybe	6/24/08
18) CandleInc.org Reality toward drug prevention program (awareness program)		Barbara	Maybe	6/24/08
19) Peace Learning Center Interactive learning tools		Barbara	Maybe	6/24/08

Strategy to Vet	Workgroup Goal	Reviewer	Yes/ No	Due Date
20) Prevention First		Barbara	Check out	6/24/08
21) Harvard School of Public Health		Barbara	Check out	6/24/08
22) Alcoholics Anonymous		Barbara	Check out	6/24/08
23) Child Help.org		Barbara	Check out	6/24/08
24) Media Watch Challenging racism, sexism, and violence in the media through education and action. http://www.mediawatch.com	ML	TBA		TBA
25) Minnesota Center Against Violence and Abuse Electronic Clearinghouse Resources for health care providers and social workers who work with issues of incest domestic violence, and other women's issues. http://www.mincava.umn.edu/health.asp	GE	TBA		TBA
26) The Violence Against Women Online Resource Center This site provides law, criminal justice, advocacy, and social service professionals with up to date information on interventions to stop violence against women. http://www.vaw.umn.edu	GE	TBA		TBA
27) Susan B. Coleman Breast Cancer Awareness		TBA		TBA
28) Race for the Cure		TBA		TBA
29) Truth.org		TBA		TBA
30) Red Dress Campaign		TBA		TBA
31) Students Against Drunk Driving (SADD)		TBA		TBA

Strategy to Vet	Workgroup Goal	Reviewer	Yes/ No	Due Date
32) Prevent Connect Article on Strategies This article highlights the foundations of effective sexual violence prevention that draw from both the feminist movement and from research based approaches in field such as public health. http://www.preventconnect.org/articles/lee%202007%20Sexual%20Violence%20Prevention.pdf		Shari	Follow-up	5/21/08
33) Prevention Institute This report provides an overview of promising violence prevention initiatives across the nation, with special focus on the primary prevention of violence affecting youth and adult intimate partner violence. http://www.preventioninstitute.org/creatingsafeenvironments.html	GE	Pamela	Follow-up	5/21/08
34) Adbusters Media Foundation & Magazine Produces spoof ads, uncommercials, and media critiques in an attempt to ‘clean up advertising and consumerism’s polluting effects on the mental and physical environment.’ http://www.adbusters.org	ML	Rose	Follow-up	5/21/08
35) Action Coalition for Media Education (ACME) ACME is an international coalition of teachers, media producers, researchers, and reformers dedicated to supporting independent media literacy, education, media production and democratic media reform. http://www.acmecoalition.org	ML	Rose	Follow-up	5/21/08
36) End Abuse (rose mentioned looking into this)		Rose	Follow-up	5/21/08
37) Western Massachusetts Gender Equity Center: Media Literacy Curriculum (9-12) This webpage from the W.Mass Gender Equality center offers a high school curriculum focusing on gender issues and media literacy skills. http://www.genderequality.org/medialit/contents.html#units	ML / GE	Vicki	Not found	5/21/08
38) Men Against Sexual Violence The Men Against Sexual Violence (MASV) initiative that began in July of 2001 with the ambitious goal to gather pledge support from one million of Pennsylvania’s male residents has quickly grown in only three short years to take on a life of its own. http://www.menagainstsexualviolence.org/	GE	Shari	No	5/21/08

Strategy to Vet	Workgroup Goal	Reviewer	Yes/ No	Due Date
39) The Center for Media Literacy This website provides other media literacy links, an on-line catalog of resources for parents and educators, and seminar/workshops for professional development. http://www.medialit.org	ML	Michelle	No	6/24/08
40) Media-L A listserv open to teachers, administrators, media-professionals, researchers and other with an active involvement in projects or issues related to media literacy. http://www.ithaca.edu/looksharp/resources/media-l.html	ML	Michelle	No	6/24/08
41) Dads and Daughters This is the site for Dads and Daughters, a grassroots org committed to providing resources to empower and engage fathers in their daughters' lives and in the struggle for gender equality. http://www.dadsanddaughters.org/links.htm	GE	Michelle	No	6/24/08
42) Family Violence Prevention Fund (FVPPF)	ML / GE	Barbara	No	6/24/08
43) Just Think An organization devoted to teaching young people to understand the words and images in media and to think for themselves http://www.justthink.org	ML	Barbara	No	5/21/08
44) Media Awareness Network: Study on How Music Videos Enforce Stereotypes http://www.media-awareness.ca/eng/news/news/two/video.htm	ML	Barbara	No	5/21/08
45) Children Now: Boys to Men: Messages About Masculinity A study conducted on the messages sent by mainstream entertainment media to young men and boys in the United States about what it means "to be a man". http://www.childrennow.org/media/boystomen/report-media.html	ML	Vicki	No	5/21/08

APPENDIX K

*List of all of the Strategies Reviewed
by the
Empathy, Attachment and Community Connectedness Workgroup*

- *Strengthening Families*
- *Healthy Families America*
- *I Can Problem Solve*
- *Second Step*
- *The Incredible Years*
- *Dare to be You*
- *Social Decision Making/Problem Solving*
- *Maternal-Child Health Consortium*
- *Infant Mental Health Institute*
- *Parent Child Development Centers*
- *National Fatherhood Initiative*
- *Family Foundation Program for Incarcerated Mothers*
- *Headstart*
- *Big Brother/Big Sister*
- *Parents Anonymous*
- *Perry Preschool Project*
- *Parents as Teachers*
- *National Fatherhood Initiative*

*denotes recommended strategies detailed below

EMPATHY, ATTACHMENT AND COMMUNITY CONNECTEDNESS WORKING GROUP

Promising Programs

Increase empathy skills in young children and increase parental/caregiver attachment in targeted communities. Targeted children will be more able to accurately recognize and respond to others feelings and emotions. Targeted parents/other caregivers and children will display culturally appropriate bonding and attachment.

PROGRAM	TARGET POPULATION	COMPONENTS	RESEARCH	ORGANIZATIONAL CAPACITY IN NJ
<p><u>Healthy Families America</u> (HFA)</p> <p>www.healthyfamiliesamerica.org/research/index.shtml</p>	<p>New and expectant parents who are facing "stressors" such as: low income, single- parent, substance abuse, domestic violence.</p>	<p>Components: HFA includes screening and assessment for families in need as well as the provision of in-home visitation services, both pre and post natal. HFA programs are based on a set of 12 "critical elements" that are based on research and guide all of their programs and include standards for service initiation, services provided, and staff qualifications and expectations. Those core components under the content of Healthy Families programs include the</p>	<p>The research conducted on HFA is quite impressive and includes over 30 studies and a network of 50 evaluators. The consistent outcomes that have been found in the evaluation include the following, with #1 and #5 being especially related to attachment:</p> <ul style="list-style-type: none"> * Reducing child maltreatment; * Ensuring healthy child development; * Encouraging school readiness; * Promoting family self-sufficiency; and 	<p>Current organizational capacity: The program is currently implemented in 35 states including NJ. Within NJ, there are 25 HFA sites and they are coordinated through Prevent Child Abuse NJ.</p>

PROGRAM	TARGET POPULATION	COMPONENTS	RESEARCH	ORGANIZATIONAL CAPACITY IN NJ
		<p>following:</p> <p>a. Offer intensive services (at least once a week)</p> <p>b. Services should be culturally competent</p> <p>c. Services focus on supporting the parent as well as supporting parent-child interaction and child development.</p> <p>d. Families should be linked with medical provider and other services as needed.</p>	<p>* Demonstrating positive parenting</p> <p>Their identification of attachment as a goal for HFA is clearly stated. The evidenced-based rationale for the program includes the belief that offering services prenatally or at birth "Helps promote parent-child bonding and attachment, a process that begins even before birth" (from HFA critical elements document)</p>	
<p><u>I Can Problem Solve (ICPS)</u></p> <p>http://guide.helpingamericasyouth.gov/programdetail.cfm?id=342</p>	<p>Although the program is appropriate for all children, it is especially effective for young (age 4-5), poor, and urban students who may be at highest risk for behavioral dysfunctions and interpersonal maladjustment.</p>	<p>ICPS is a school-based intervention that trains children in thinking styles that enhance social adjustment and prosocial behavior and decrease impulsivity and inhibition (shyness).</p> <ul style="list-style-type: none"> • Generating a variety of solutions to 	<p>ICPS has been evaluated extensively over the past 20 years. An evaluation of ICPS that included nursery and kindergarten students revealed significant benefits for intervention students. Immediately following and one year after the</p>	<p>Catholic Charities is using this program in its School Based Family Support Program. It is being employed in about 2-3 schools in and around Camden. It has been used in Passaic, Wayne as well; additional information on NJ organizational</p>

PROGRAM	TARGET POPULATION	COMPONENTS	RESEARCH	ORGANIZATIONAL CAPACITY IN NJ
		<p>interpersonal problems,</p> <ul style="list-style-type: none"> • Considering the consequences of these solutions, and • Recognizing thoughts, feelings, and motives that generate problem situations. <p>Small groups of 6-10 children receive training for approximately 3 months. The intervention begins with 10-12 lessons teaching students basic skills and problem-solving language. The next 20 lessons focus on identifying one's own feelings and becoming sensitive to others' emotions. Students learn to recognize people's feelings in problem situations and realize that they can influence others' responses.</p> <p>The last 15 lessons utilize</p>	<p>program ended, ICPS children, compared to control students, demonstrated:</p> <ul style="list-style-type: none"> • Less impulsive and inhibited classroom behavior, and • Better problem-solving skills. <p>A five-year study including inner-city, low income children in nursery school and kindergarten demonstrated that intervention children, compared to control students, had:</p> <ul style="list-style-type: none"> • Improved classroom behavior and problem-solving skills, even 3-4 years after the program. <p>A replication with fifth</p>	<p>capacity is needed.</p>

PROGRAM	TARGET POPULATION	COMPONENTS	RESEARCH	ORGANIZATIONAL CAPACITY IN NJ
		<p>role-playing games and dialogue to promote problem-solving skills. Students generate solutions to hypothetical problem situations and consider the possible consequences to their decisions.</p>	<p>and sixth grade students found that ICPS children, compared to a control group, demonstrated:</p> <ul style="list-style-type: none"> • More positive, prosocial behaviors; • Healthier relationships with peers; and • Better problem-solving skills. 	
<p><u>Strengthening Families through Early Care and Education</u> www.strengtheningfamilies.net/ www.state.nj.us/dcf/prevention/childhood/strengthening.htm</p>	<p>The target group is children and their families, reached through existing community-based and school-based early childhood programs.</p>	<p>Early Care and Education Centers can play a prominent role in building 5 identified protective factors among the families they serve: parental resilience, social connections, knowledge of child development, support in times of need, and social/emotional competence of children. Through seven key strategies, centers can become well positioned to</p>	<p>The research behind the five Protective Factors are the foundation of the Strengthening Families approach. Extensive research supports the common-sense notion that when these Protective Factors are present and robust in a family, the likelihood of child abuse and neglect diminish (Strengthening Families website.)</p>	<p>Implementing Strengthening Families is a significant new initiative of the DCF. There are currently 5 pilot projects in each county attached to Headstart sites and independent early childhood centers in Abbott districts. The plan is to increase the # to 8 (168 sites) by 2009.</p>

PROGRAM	TARGET POPULATION	COMPONENTS	RESEARCH	ORGANIZATIONAL CAPACITY IN NJ
		<p>help families build these protective factors that have proven to be effective in preventing child abuse and neglect.</p> <ol style="list-style-type: none"> 1. Facilitate friendships and mutual support 2. Strengthen parenting 3. Respond to family crises 4. Link families to services and opportunities 5. Value and support parents 6. Facilitate the social and emotional development of children 7. Observe and respond to early warning signs of child abuse or neglect 		
<p><u>Second Step</u> http://www.cfchildren.org/programs/ssp/overview/</p>	<p>There are two programs : one targets preschool and kindergarten and the second one targets grades 1 -5.</p>	<p>The first program provides lessons and activities that teach essential social skills such as problem solving, emotion management, impulse control and empathy. The program for grades 1-5 teaches similar</p>	<p>This is a research-based program that is listed as effective in the <i>Blueprints Matrix</i> from 12 different rating sources.</p>	<p>Organized locally in NJ; unknown how many sites</p>

PROGRAM	TARGET POPULATION	COMPONENTS	RESEARCH	ORGANIZATIONAL CAPACITY IN NJ
		essential social skills such as empathy, emotion management, problem solving and cooperation.		
<p><u>The Incredible Years</u> http://www.incrediblyears.com/</p>	<p>This program is targeted toward 2 to 12 year olds and their parents and teachers</p>	<p>Guided by developmental theory on the role of multiple interacting risk and protective factors. The program focuses on the following outcomes: positive and nurturing parenting, child positive behaviors, social competence, and school readiness skills, parent bonding and involvement with teacher and school</p>	<p>Research based and part of SAMHSA’s National Registry of Evidence – based Programs and Practices. It is also noted as one of the 11 model programs of the <i>Blueprints for Violence Prevention</i>.</p>	<p>Organized locally in NJ; unknown how many sites</p>
<p><u>Dare To Be You</u> http://www.colostate.edu/Depts/CoopExt/DTBY/</p>	<p>This program is targeted to preschool and K-2 and Middle School with the following: family based classes; youth based programs; training for community youth, workers and teachers; training for peer counselors/peer educators</p>	<p>Empathy development, esteem for self and others, role modeling and responsibility and social skills</p>	<p>Evaluated including the inclusion of control groups.</p>	<p>Organized locally in NJ; unknown how many sites</p>
<p><u>Social Decision</u></p>	<p>This program targets K-8</p>	<p>Identifying feelings in self</p>	<p>Four major evaluation</p>	<p>Training and</p>

PROGRAM	TARGET POPULATION	COMPONENTS	RESEARCH	ORGANIZATIONAL CAPACITY IN NJ
<p><u>Making/Problem Solving (SDM/PS)</u></p> <p>www.umdnj.edu/spsweb</p>	<p>grade students in regular and special education in diverse settings. Evaluation studies include a wide range of student groups and nationalities and have taken place in rural, suburban and urban settings.</p>	<p>and in others, managing emotions, effective communication skills, improving social awareness and problem solving/decision making and conflict resolution skills. The program is designed to combine training in specific skills with ongoing infused opportunities to practice and apply the skills within a wide range of academic, discipline and real life situations. A strength of this model is the focus on training teachers to infuse the practice of skills within the academic curriculum as an “add in” rather than an “add-on”. The goal is to provide students with multiple and varied opportunities to practice skills with multiple year exposure to help students internalize skills to a point that they</p>	<p>studies have been conducted in 1986, 1991, 1997 and 2007 in addition to a wide range of in-house evaluations and dissertation studies. In 1986 results showed that students were better at managing feelings and coping with stressors and adjusting to the transition to middle school than matched controls. In 1991, a longitudinal study found that in high school, students participating in the program in elementary and middle school showed higher levels of social competence, emotional regulation, positive pro-social behaviors and decreased anti-social, self destructive and socially disordered behavior than controls. Controls</p>	<p>consultation services provided through the Behavioral Research and Training Institute of the University of Medicine and Dentistry of New Jersey and the Social Problem Solving Lab at The Center for Applied and Professional Psychology at Rutgers University. Training can also be provided by a number of certified trainers both within NJ, nationally and internationally. All of the validation studies were conducted in New Jersey. Several New Jersey schools that have been implementing for years serve as flagship sites for new districts and serve as examples for institutionalizing and sustaining programming by aligning with</p>

PROGRAM	TARGET POPULATION	COMPONENTS	RESEARCH	ORGANIZATIONAL CAPACITY IN NJ
		<p>are accessible and transferable to real life emotional and social situations. Teacher behavior, coordinated support systems and parent training and involvement activities are provided. The program aims to develop empathy and social emotional competencies by teaching children to identify, understand and regulate emotions in self and in others, communicate effectively and make healthy life choices beginning at an early age and continued through the transition to middle school.</p>	<p>scored significantly higher in physical aggression, drug/alcohol, vandalism and poor peer relationships and negative self identity. In 1997, students trained in SDM/PS in five school districts made significant/substantial gains in interpersonal sensitivity, problem analysis and planning skills as compared with controls. In 2007, student in an urban and a suburban school district obtained significant increases, as compared with controls in connectedness and positive school relationships, increased school engagement, decreases in aggressive and delinquent behaviors including a</p>	<p>educational mandates and local needs.</p>

PROGRAM	TARGET POPULATION	COMPONENTS	RESEARCH	ORGANIZATIONAL CAPACITY IN NJ
			<p>decrease in the frequency and acceptance of verbal and physical aggression and teasing.</p> <p>This model has been designated as a “Select” program for Social Emotional Learning in an extensive evaluation and review conducted by the Collaborative for Academic Learning (CASEL) and the Office of Safe and Drug Free Schools, U.S. Department of Education; received the prestigious Lela Rowland Prevention Award by the National Mental Health Association, and was designated as an Exemplary Program by The U.S. Department of Education, National Diffusion Network.</p>	

APPENDIX M

**NJ PPEC/SPT Strategy Review Worksheet – Bystander
Comparative Matrix of Strategies**

Goal: Increase by-stander intervention by middle school and college age students in high risk social groupings/situations (including but not limited to fraternities and sports teams). This includes increasing interventions by those who surround the high risk youth including caregivers, teachers, friends and other community supporters.

<i>Criteria</i>	<i>Strategy 1: TCNJ's Bystander Intervention</i>	<i>Strategy 2: UNH's Bringing in the Bystander</i>	<i>Strategy 3: NJCAP/ Teen CAP Curriculum</i>
Is this a standalone strategy or part of a larger program? Name the whole program here, as applicable. You may need to complete multiple forms if multiple strategies are relevant.	Larger program: 1) Peer Education (SAVE) 2) Bystander Intervention curriculum and brochures 3) Administrative support (OAVI & Exec.)	Larger program: 1) Peer Education 2) Bystander curriculum (90-minutes and 3 sessions) and outreach campaign 3) Booster sessions	Strategy is part of a larger program. Created in 1984, Teen CAP is one of five curricula based on the original Elementary CAP program, a comprehensive primary prevention education program developed in 1978. NJ CAP is a program of ICAP (International Center for Assault Prevention) and serves as the model for CAP programs in the USA and around the world http://www.internationalcap.org/programs_teen.html With regard to bystander intervention, the role of peer support and influence (both positive and negative), and skills and strategies for handling difficult situations and seeking help are infused throughout the curriculum.

<i>Criteria</i>	<i>Strategy 1: TCNJ's Bystander Intervention</i>	<i>Strategy 2: UNH's Bringing in the Bystander</i>	<i>Strategy 3: NJCAP/ Teen CAP Curriculum</i>
What risk factor(s) or protective factors does this address?	Increase bystander intervention Increase ally behavior Increase pro-social moral reasoning	Increase bystander intervention Increase ally behavior Increase pro-social moral reasoning	Protective: pro-social moral reasoning, bystander intervention, ally behavior, social support, emotional health, healthy sexuality, self-esteem. Risk: stereotyped gender and sex roles, sexual harassment, bullying, family and dating violence, early sexual behavior, male entitlement, lack of empathy, pornography.
Is this strategy generally consistent with the goal and RPE Theory of Change: Yes - research further No – review complete	Yes	Yes	Yes, in that the program is comprehensive in its approach and addresses a number of risk and protective factors at multiple levels of the social ecology.
<u>Comprehensive</u> : Strategies should include multiple components and affect multiple settings (levels of the ecological model) to address a wide range of risk and protective factors of the target problem.	Multiple components (PEs, curriculum, administrative support) and affect multiple settings (Greeks, athletes, student organizations, and residents)	Multiple components (PEs, curriculum, outreach campaign)	Includes individual, relational, and community components via workshops for school staff, parents, community members and students. Targets a number of risk and protective factors as listed above.

<i>Criteria – Adherence to Prevention Principles</i>	<i>Strategy 1: TCNJ’s Bystander Intervention</i>	<i>Strategy 2: UNH’s Bringing in the Bystander</i>	<i>Strategy 3: NJCAP/ Teen CAP Curriculum</i>
<p>Sufficient Dosage: Participants need to be exposed to enough of the activity for it to have an effect. Research shows that at least 7-9 “doses” are needed to affect changes in attitudes and behaviors. (More if high risk)</p>	<p>No. This is a one-hour program, reinforced by conversations with coaches and fellow athletes, residences, Greeks.</p> <p>The Bystander Intervention program is one aspect of a series of programs provided by the PEs, community awareness through OAVI, policy and procedural support throughout the institution, and curricular infusion in a Gender & Violence course/concentration.</p>	<p>Yes. There are two versions of the program, one 90-minute condensed version and one 3-session 4.5 hour version. Additionally, booster sessions are available, but it is unclear what they cover, who is reached and for what length of time.</p>	<p>Teen CAP student workshops are completed over 3 separate days, with a Review Time period offered each day. The program builds upon the Early Childhood and Elementary CAP programs and ideally, students will have participated in these programs prior to having Teen CAP.</p>
<p>Positive Relationships: Programs should foster strong, stable, positive relationships between children/youth and adults, youth and youth, adults and adults.</p>	<p>The program encourages teamwork, positive relations, and sticking up for one another between peers.</p>	<p>The program encourages positive relations (inappropriate behaviors and empathy for survivors), and sticking up for one another between peers.</p>	<p>Teen CAP facilitators are trained to foster an atmosphere of mutual respect during classroom workshops. Males and females are separated on Days 2 and 3 of the 3-part workshop series in order to facilitate more comfortable and honest discussion of sensitive topics. Adult workshops emphasize the importance of open communication with teens. Student workshops emphasize “telling a trusted adult.”</p>

<i>Criteria – Adherence to Prevention Principles</i>	<i>Strategy 1: TCNJ’s Bystander Intervention</i>	<i>Strategy 2: UNH’s Bringing in the Bystander</i>	<i>Strategy 3: NJCAP/ Teen CAP Curriculum</i>
<u>Socio-Culturally Relevant:</u> Programs should be tailored to fit within cultural beliefs and practices of specific groups as well as local community norms.	Tailored to be inclusive of various genders, sexual orientations, and racial / ethnic / religious groups	Tailored to be inclusive of various genders with relevant community scenarios.	All CAP curricula are based on a philosophy of human rights and empowerment. Curricula are updated and revised as needed in order to address changes and issues surrounding societal attitudes and norms.
<u>Outcome Evaluation:</u> A systematic outcome evaluation process is necessary to determine whether a program or strategy worked.	Minimal. One 4-6 month Post-test with control and experimental group is underway.	Yes. Systematic evaluation has taken place. See above for details. More evaluation documentation is in press.	Data for each NJ CAP County project is submitted to the NJ CAP Regional Training Center (RTC). This data is reviewed and collated and submitted to the funding agency via quarterly reports. CAP must meet or exceed target objectives specified in the annual contract with the funding agent.
<u>Well-Trained Staff:</u> Programs need to be implemented by staff members who are sensitive, competent, and have received sufficient training, support, and supervision.	Program is implemented by PEs after 24-hours of training on fundamental IPV issues, weekly meetings, and close oversight of OAVI Coordinator, experienced in the field and LCSW	Program is implemented by PEs after training, with supervision by UNH professionals.	Teen Cap workshops are implemented only by CAP trained prevention specialists. CAP trained and certified facilitators for 21 CAP County Projects, plus Newark. All CAP facilitators receive on-going training and supervision. All CAP facilitators must be re-certified every 3 years.

<i>Criteria</i>	<i>Strategy 4: Expect Respect</i>	<i>Strategy 5: Know More to Say No More</i>	<i>Strategy 6: Safer Choices</i>
Is this a standalone strategy or part of a larger program? Name the whole program here, as applicable. You may need to complete multiple forms if multiple strategies are relevant.	Larger program: School based program for preventing teen dating violence and promoting healthy relationships. Includes: a) support group for students at risk b) team leadership training c) school wide strategies	Larger program	Larger program that has 5 components: 1. School Organization 2. Curriculum and Staff Development 3. Peer Resources and School Environment 4. Parent Education 5. School Community Linkages #2 strategy assessed here
What risk factor(s) or protective factors does this address?	Risk factor: having witnessed family violence Protective factor: increase pro-social moral reasoning	- Increase knowledge and skill around healthy relationships - Increase skill on breaking up safely (pro social moral reasoning)	Protective: Pro-social moral reasoning; Healthy sexuality Risk: early sexual behavior
Is this strategy generally consistent with the goal and RPE Theory of Change: Yes - research further No – review complete	Yes	Yes and no	Yes
<u>Comprehensive</u> : Strategies should include multiple components and affect multiple settings (levels of the ecological model) to address a wide range of risk and protective factors of the target problem.	3 components of larger program addresses individual, relational, and institutional levels		Includes both individual and relational components This particular strategy limited to the classroom, but larger program includes school, parents, and community. Address at least 3 risk/protective factors directly

<i>Criteria – Adherence to Prevention Principles</i>	<i>Strategy 4: Expect Respect</i>	<i>Strategy 5: Know More to Say No More</i>	<i>Strategy 6: Safer Choices</i>
<u>Sufficient Dosage:</u> Participants need to be exposed to enough of the activity for it to have an effect. Research shows that at least 7-9 “doses” are needed to affect changes in attitudes and behaviors. (More if high risk)	<ul style="list-style-type: none"> - 24 sessions for support group - 8 sessions of leadership training - On-going activities for school climate change 		20 sessions over 2 years – 10 each year for 9 th and 10 th graders
<u>Positive Relationships:</u> Programs should foster strong, stable, positive relationships between children/youth and adults, youth and youth, adults and adults.	<ul style="list-style-type: none"> - Students and teachers/staff involved - student led awareness groups - student/adult relationships fostered - peer to peer support 		Curriculum includes communication and making one’s own choices. Fosters stronger relationships between youth peers.
<u>Socio-Culturally Relevant:</u> Programs should be tailored to fit within cultural beliefs and practices of specific groups as well as local community norms.	No info on this		Outcomes were positive for African American, Hispanic, and white youth, both male and females, with greater impact on males and Hispanic and white youth.
<u>Outcome Evaluation:</u> A systematic outcome evaluation process is necessary to determine whether a program or strategy worked.	<ul style="list-style-type: none"> - Includes school needs assessment - pre and post tests for students - tracking of school policy and climate change 		Includes rigorous outcome evaluation up to 31 months after baseline. Strategy has been evaluated to be evidence-based.
<u>Well-Trained Staff:</u> Programs need to be implemented by staff members who are sensitive, competent, and have received sufficient training, support, and			Teacher training is included in the curriculum strategy.

supervision.			
<i>Criteria</i>	<i>Strategy 7: Scream Theater – Learning to Scream</i>	<i>Strategy 8: MVP</i>	<i>Strategy 9: Green Dot</i>
<p>Is this a standalone strategy or part of a larger program? Name the whole program here, as applicable. You may need to complete multiple forms if multiple strategies are relevant.</p>	<p>Three part program:</p> <ul style="list-style-type: none"> • Scream Theater – Student activity • Scream Athletes – same as above but specifically for and by athletes • Learning to Scream – Peer Educator Training <p>Focus is on college students and at risk groups (athletes & fraternities)</p> <p>High schools presentations are also done and technical assistance given in how to start a peer education program at that level.</p>	<p>Stand - alone strategy – Mentors in Violence Prevention</p>	<p>Stand alone strategy in use in Kentucky Current focus is on college age students and administrators Strategy is being customized for boarder community use</p>

<i>Criteria</i>	<i>Strategy 7: Scream Theater – Learning to Scream</i>	<i>Strategy 8: MVP</i>	<i>Strategy 9: Green Dot</i>
What risk factor(s) or protective factors does this address?	Increase bystander intervention Increase ally behavior Decrease rape myths	Increase bystander intervention Increase knowledge about sexual violence Decrease rape myths	Increase bystander intervention Increase ally behavior
Is this strategy generally consistent with the goal and RPE Theory of Change: Yes - research further No – review complete	Yes	Yes, not specified but would fit	Yes, designed to fit the Theory model, especially Diffusion of Innovation
<u>Comprehensive</u> : Strategies should include multiple components and affect multiple settings (levels of the ecological model) to address a wide range of risk and protective factors of the target problem.	Multiple components (PEs, curriculum, administrative support) and affect multiple settings (Greeks, athletes, student organizations, and residents)	MVP presents sexual violence as a community issue. It challenges students to look at their own relationships and their communities, such as an athletic team.	The model targets all community members as potential bystanders. Sees self as a social movement, individual behavior change strategy, and community norms strategy

<i>Criteria – Adherence to Prevention Principles</i>	<i>Strategy 7: Scream Theater – Learning to Scream</i>	<i>Strategy 8: MVP</i>	<i>Strategy 9: Green Dot</i>
<u>Sufficient Dosage:</u> Participants need to be exposed to enough of the activity for it to have an effect. Research shows that at least 7-9 “doses” are needed to affect changes in attitudes and behaviors. (More if high risk)	Theatre is one shot but peer educators get training every other week during school year	Can vary from one shot awareness raising workshops to comprehensive train the trainers	Peer educator program meets these guidelines. One shot sessions used for general public
<u>Positive Relationships:</u> Programs should foster strong, stable, positive relationships between children/youth and adults, youth and youth, adults and adults.	Relationships are fostered among peer educators in conjunction with staff. Resources are provided at the end of each presentation encouraging students to reach out to adults for further assistance.	Students are encouraged to work with responsible, trusted adults such as coaches, teachers and mentors	Targets socially influential individuals– from educators to politicians, from healthcare providers to business owners, from media to non-profits. , influencing new norms in their sphere of influence.

<i>Criteria – Adherence to Prevention Principles</i>	<i>Strategy 7: Scream Theater – Learning to Scream</i>	<i>Strategy 8: MVP</i>	<i>Strategy 9: Green Dot</i>
<u>Socio-Culturally Relevant:</u> Programs should be tailored to fit within cultural beliefs and practices of specific groups as well as local community norms.	Attempts to match race of participants and peer educators, various ages, languages and scenarios are customized for the audience as possible	Program includes facilitated discussion about what particular barriers or strengths exist within the community	Intervention suggestions are customized by group/community
<u>Outcome Evaluation:</u> A systematic outcome evaluation process is necessary to determine whether a program or strategy worked.	Evaluations conducted after each performance. Research process currently underway using 1000 pre/post surveys measuring rape myths and bystander attitudes and behaviors	Unclear Internal, non-published evaluation shows positive results (available on website)	College program at University is currently being researched. Evaluation data based on other similar strategies.
<u>Well-Trained Staff:</u> Programs need to be implemented by staff members who are sensitive, competent, and have received sufficient training, support, and supervision.	Peer educators must undergo training and meet bi-weekly for further education Supervised by a Master’s level professional Program includes guest speakers, discussion and interactive learning opportunities	Facilitators well trained and many are former athletes Curriculum includes interactive activities, discussions and role playing. There is a written guide that accompanies the training	Customized Training Institute available for implementers. Curriculum available at college level

APPENDIX N

Workgroup Notes -Vulnerable Populations May 21, 2008

Attending: Melissa N., Tracy S.H., Peri N., Regina P.,

1. Strategy & Research Review To Date:

My Strength Campaign (Tracy) –a men’s campaign that is more of a media and gender equity strategy that is a better fit for the other workgroup

Project Northland (Vance)– comprehensive youth addictions program that includes parental, teacher and peer component. Caregiver education portions may be applicable if we cannot find others since it does focus on increased screening and supervision.

Prison Rape Elimination Act (Jennifer & Melissa)– NJ grant info and draft federal standards. Comment period for the standards has just begun and comments are due by July 7th. The standards appear extremely comprehensive and match our goal perfectly since they have both a prevention and intervention focus. Once approved by the U.S. Attorney General they would need to be implemented in NJ.

Gave update from Jennifer S. about 2004 PREA grant to NJ. NJ Dept. of Corrections has done research and training using the grant. Traci is the NJCASA representative to the PREA advisory group in NJ but has not received any notice of meetings since attending training in 2007. See below for follow-up actions.

2000 Study on Sexual Abuse Prevention Interventions for Individuals with Disabilities (Regina) – The study was a literature review of strategies existing in 1999. All the strategies were risk awareness and training of disabled individuals on how to say “no”. The bottom line was that these programs did have evidence of increasing knowledge but there was not evidence that it changed behaviors.

Blueprints – MultiSystem Therapy (Melissa)– a juvenile offender program that was individually based and not comprehensive. No further work is needed.

Disability Conference Materials – Melissa attended a conference where Beverly Frantz from The Institute on Disability at Temple was the speaker (Vince also referred the group to her). Much of her presentation was focused teaching healthy sexuality to disabled individuals both as potential victims and unintentional offenders (inappropriate sexual gestures/actions). We may want to ask Dr. Frantz to speak at a future meeting. Melissa e-mailed her for more info on her programs.

SIECUS (Melissa)– we went through a SIECUS report and identified a potential strategy that is used by the Queens Occupational Training Center on Healthy Sexuality. Melissa will follow up to find out more.

2. Issues for Discussion

The following issues arose from the strategy and research review:

a. To what degree will we focus on prevention efforts with potential victims?
There was concern that both the disabled and prison population are dis-empowered and vulnerable so teaching them to reduce risk has limited value. Work with potential victims should be a piece of any comprehensive prevention program but is only a small part of responding to this goal. The majority of the work should focus on caregiver and institutional strategies that prevent perpetration.

b. Under what circumstances should we identify specific strategies to suggest rather than coordination with existing strategies?

The work being done with PREA is pretty far along and may need us to have a strategy of collaboration rather than come up with other ideas for strategies. The NJ Dept. of Corrections has access to much larger pools of funding for this work than is available in the RPE/CDC system. The timing is good to make sure the SV system is at the table in this work.

This may also hold true for work with the Disabilities field. We need to know what is already in place before we recommend other new strategies.

c. Do we include the learning disabled population in our definition of disabled?
The group felt that the needs of the LD community should be taken into account in all the goals and is not a targeted focus of our goal. The highest rate of risk is in the institutional population, not the school based population.

d. Is the institutionalized elderly a priority for us?

The data we reviewed showed that the magnitude of sexual violence was not high in these settings. This could be from underreporting or from a stronger focus on other issues like medical abuse or neglect.

3. Next Steps

The group agreed to the following actions:

A. Workgroup to Review & Comment on PREA Standards

- Regina will send out the draft standards/protocol for the full workgroup to review. We will use the June meeting to collate the comments and prepare a response. Peri will check with the Governor's Advisory Council Executive Committee to ensure that we have the authority to submit comments as a workgroup. An alternative is for NJCASA to submit the comments for the workgroup.
- Jennifer will continue to speak with Dept. of Corrections contact to get more info on results of 2004 PREA grant to NJ.
- Tracy will contact DOC to find out the status of the PREA Advisory Group

B. Melissa will follow up with DDD contact to check on current practices in institutions, group homes and for caregiver training.

C. Melissa will research the Disability Pride Project out of Seattle Wash. She has requested more info from them since it appears to be a comprehensive strategy.

D. Peri will review the Wisconsin project that was found in the research.

E. Tracy will review the Promoting Violence Free Relationships: Disabilities Services Project from the list.

APPENDIX O

VIOLENCE IN THE DISABILITY COMMUNITY – STRATEGIES REVIEWED

Promoting Violence-Free Relationships: Disability Services ASAP

<http://ici.umn.edu/products/impact/133/prof2.html>

Understanding Caregiver Abuse as Domestic Violence: Systemic Change in Wisconsin

<http://ici.umn.edu/products/impact/133/prof1.html>

Elder Abuse Speaker's Kit (pdf)

<http://www.mincava.umn.edu/categories/912?type=8>

An Evidence-Based Review of Sexual Assault Preventive Intervention Programs

<http://www.ncjrs.org/pdffiles1/nij/grants/207262.pdf>

The Disability Pride Project

<http://www.cara-seattle.org/disabled.html>

APPENDIX P

Strategy Vetting Process Discussion Notes – 7/30/08 SCBT Members & Workgroup Representatives

Key Issues Regarding Strategy Selection

- The strategy vetting process is very labor intensive and there are concerns being expressed about time requirements and expertise required to do this work. We do not want people to get disheartened, disillusioned or disinterested in this important work.
- All the EMPOWER states are required to go through this process and it appears wasteful not to take advantage of the work being done by others. This was meant to be a collaborative process across states and we should look for efficiencies from this collaboration whenever possible.
- In the long run there will need to be a strong case made for CDC investments in research in sexual violence prevention strategies and there is a window of opportunity for strategic decision making where we consider multi-state efforts and/or each state “going deep” in one area. This is especially true since we are all dealing with similar goals and risk/protective factors.
- Do we have too many prevention goals considering the degree of capacity building required in the next 5-8 years. Should we focus in only one or two areas for actual prevention strategies and use the time to increase collaborations/community capacity?

The Work Ahead – CDC Requirements for the Planning Process (Through December 2008)

Step 3 Results – Strategy Vetting (Workgroups & PPEC)

- Selection of key strategies for each final goal area
 - Must have at least one strategy for a universal goal and one for a select population goal
 - Must identify the core components of any selected strategy required for fidelity (what parts of the strategy are not adaptable or it could lose its effectiveness?)
 - Must identify state level versus local strategies and have a mix of both
 - Need to consider integrating strategies into a comprehensive program across the various levels of the social ecology (individual, relationship, community, society)

Step 4 Results – Adaptation (Workgroups & PPEC)

- Create a plan for adapting the strategies for use in NJ
 - What must we take into consideration that will make any strategy effective for the broadest cross section of people?
 - How will we decide on these adaptations (pilot programming in key areas, getting community input etc.)

Step 5 Results – Capacity Needs (Workgroups & PPEC)

- Identify capacity needs and a plan to build the needed capacity to implement the selected strategies
 - What needs to be in place in order to implement these strategies well?
 - Who should be responsible for implementing each strategy or coordinating the implementation? (or what are the criteria for selecting those responsible?)
 - What partnerships/buy-in/collaborators do we need to do this work?

Step 6 Results – The Plan Timetable & Logic Models (EE/SCBT & PPEC)

- Create system and goal logic models that tie together the results of Steps 1-5 and shows links between the steps in decision making.
- Develop a 5-8 year timetable for implementation of prevention strategies and capacity building strategies

Recommendations

- Workgroups should be reminded that they are not expected to make the “perfect” choice, just an informed choice. We do not want to get into “analysis paralysis”, especially when there is limited time and energy available. We also need to recognize that we are breaking new ground and there are no “perfect” choices available. The evaluation phase of the process will help us make mid-course corrections if needed.
- It would be beneficial to invite the other EMPOWER states to come share their strategy decisions so we can make best use of a broader knowledge base. There is significant overlap in our work and we can possibly save time and effort by sharing the workload.
- The September PPEC meeting is a good time to invite other states to present so our Workgroups can benefit from this information in a timely fashion. We will set aside time that day to break into workgroups and consider how their work can help us make decisions.
- It is worth considering revising our goals or in prioritizing which goals needs a new state/local strategy and which need state/local collaboration/capacity building. We may also want to consider whether NJ should invest more heavily in just one or two goal areas or team up with other states to jointly select strategies/core components that are more likely to attract funding for high level research.

APPENDIX Q

New Jersey Strategy Descriptions **VNERABLE POPULATIONS STRATEGY**

PREA – Prison Rape Elimination Act

http://www.justdetention.org/pdf/PREA_Update_June_2008.pdf

<http://www.sheriffs.org/about/prea.asp>

The Prison Rape Elimination Act (PREA) of 2003 is a Federal law established to address the elimination and prevention of sexual assault and rape in correctional systems. PREA applies to all federal, state, and local prisons, jails, police lock-ups, private facilities, and community settings such as residential facilities. The major provisions of PREA are to:

- Develop standards for detection, prevention, reduction, and punishment of prison rape
- Collect and disseminate information on the incidence of prison rape
- Award grants and technical assistance to help state governments implement the Act

PREA seeks to insure that jails and other correctional settings protect inmates from sexual assault, sexual harassment, “consensual sex” with employees, and inmate-inmate sexual assault. These violations affect security and staff safety, and pose long-term risks to inmates and staff inside jails, and to the public when victimized inmates are released into the community. PREA requires jails to keep data regarding inmate-inmate sexual assaults, nonconsensual sexual acts, and staff sexual misconduct

On May 5, 2008, the National Prison Rape Elimination Commission (NPREC) released a draft of its “Standards for the Prevention, Detection, Response, and Monitoring of Sexual Abuse in Adult Prisons and Jails.” At the end of the public comment period, the NPREC will review all comments it has received and revise the standards. The final version will be submitted by the NPREC to the Attorney General in early 2009. The Attorney General will have one year to publish a final rule adopting the national standards. Once the standards are adopted, all corrections systems will be required to comply with them. The Attorney General will establish procedures to ensure compliance, and reduce by five percent the discretionary grants of states that fail to adhere to the standards.

CENTRAL REGISTRY

http://www.njleg.state.nj.us/2008/Bills/S3000/2516_I1.HTM

Currently, identical bills for a central registry are in both houses of the NJ Legislature. These bills apply to caregivers employed by the Department of Human Service (DHS) or caregivers employed by agencies contracted by DHS to provide services to people with developmental disabilities. It does not include the Division of Mental Health and their service recipients. People found responsible for committing acts of abuse, neglect or exploitation against a service recipient as defined by DHS would be placed on this

registry. In practice, this determination is made based on a preponderance of evidence. A criminal conviction would not be necessary. The investigations would be completed by units such as DHS's Special Response Unit and investigative units at developmental centers (Incident Response Teams).

According to the language in these bills:

“This act establishes a Central Registry of Offenders against Individuals with Developmental Disabilities in the Department of Human Services to prevent offenders against individuals with developmental disabilities from further employment in positions working with individuals with developmental disabilities.”

If this law is passed, regulations would be developed which may create further requirements to be placed on the registry, such as restricting the acts justifying placement on the registry to the more serious abuse, neglect and exploitation and the establishment of a review panel to determine whether there is clear and convincing evidence in the case.

Access to the registry would be restricted to employers and DHS staff, similar to the child abuse registry. It would not be a public record.

The bill also describes due process to appeal the decision to be placed on the registry and the ability to be removed from the registry if certain conditions are met.

AMENDMENT to N.J.S.A. 2C:14 – NEW JERSEY'S SEXUAL ASSAULT STATUTE

The wording of this law fails to adequately protect individuals with significant developmental disabilities living and/working in supervised community settings. People in these settings have been declared eligible for services under the Division of Developmental Disabilities according to guidelines requiring “substantial functional limitations” as defined in NJ statute (Title 30). These individuals are subject to the “supervisory or disciplinary power” (as defined in 2C:14) of their caregivers in the same way as people living in institutions or correctional facilities. However, under the current law, when a person with developmental disabilities in a community setting is sexually victimized by a caregiver, it can only be called sexual assault if the victim meets the severe criteria defined in 2C:14 for a person who is “mentally defective” or “mentally incapacitated.” Otherwise, the sexual act is considered consensual under the NJ criminal code. The Department of Human Services would not consider the same act to be consensual but would describe it as sexual abuse.

According to the current law, “An actor is guilty of sexual assault if he commits an act of sexual penetration with another person under any one of the following circumstances:

“The victim is on probation or parole, or is detained in a hospital, prison or other institution and the actor has supervisory or disciplinary power over the victim by virtue of the actor's legal, professional or occupational status.” Or, “The victim is at least 16 but less than 18 years old and: The actor has supervisory or disciplinary power of any nature or in any capacity over the victim”

The law also stipulates, “An actor is guilty of aggravated sexual assault if he commits an act of sexual penetration with another person under any one of the following circumstances: The victim is one whom the actor knew or should have known was physically helpless, mentally defective or mentally incapacitated.”

The law defines “mentally defective” and “mentally deficient as follows:

“Mentally defective” means that condition in which a person suffers from a mental disease or defect which renders that person temporarily or permanently incapable of understanding the nature of his conduct, including, but not limited to, being incapable of providing consent;

“Mentally incapacitated” means that condition in which a person is rendered temporarily incapable of understanding or controlling his conduct due to the influence of a narcotic, anesthetic, intoxicant, or other substance administered to that person without his prior knowledge or consent, or due to any other act committed upon that person which rendered that person incapable of appraising or controlling his conduct;

APPENDIX R

EMPATHY & ATTACHMENT STRATEGIES (Currently in use in NJ and targeted for collaboration)

Strengthening Families

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

The Strengthening Families Program (SFP) is a nationally and internationally recognized parenting and family strengthening program for high-risk families. SFP is an evidence-based family skills training program found to significantly reduce problem behaviors, delinquency, and alcohol and drug abuse in children and to improve social competencies and school performance. Child maltreatment also decreases as parents strengthen bonds with their children and learn more effective parenting skills.

SFP was developed and found effective on a National Institute on Drug Abuse (NIDA) research grant in the early 1980s. More than 15 subsequent independent replications have found similar positive results with families in many different ethnic groups. Both culturally adapted versions and the core version of SFP have been found effective with African-American, Hispanic, Asian, Pacific Islander, and First Nations families.

The original SFP for high-risk families with children ages 6 to 11 years (SFP6-11) was joined in the early 1990's by a shorter 7-session version for low-risk families with pre- and early teens (SFP10-14). SFP6-11 has now been joined by 14-session versions for high-risk families with both younger children (SFP3-5) and early teens (SFP12-16).

Health Families America

http://www.healthyfamiliesamerica.org/about_us/index.shtml

Healthy Families America is a national program model designed to help expectant and new parents get their children off to a healthy start. Families participate **voluntarily** in the program and receive home visiting and referrals from trained staff. By providing services to overburdened families, Healthy Families America fits into the continuum of services provided to families in many communities.

The program was launched in 1992 by [Prevent Child Abuse America](#) (formerly known as the National Committee to Prevent Child Abuse) in partnership with [Ronald McDonald House Charities](#) and was designed to promote positive parenting, enhance child health and development and prevent child abuse and neglect. The [Freddie Mac Foundation](#) has also been instrumental in supporting ongoing development of the program.

Initially, Healthy Families America drew largely from existing research, knowledge and experiences of the Hawaii Healthy Start program. Healthy Families America is built on a set of 12 research-based critical elements that provide a benchmark in which quality is

measured. [Learn more about evidence-based rationale for the critical elements.](#) As Healthy Families America has continued to evolve, we have incorporated examples of good practice from evaluations of a growing number of communities and prevention models. To date, Healthy Families America exists in over 440 communities in the United States and Canada. 90% of all the families who are invited to participate in the program accept services.

I Can Problem Solve

<http://www.sharingsuccess.org/code/ptw/profiles/es68.htm>

I Can Problem Solve (ICPS), is a school-based primary prevention program that offers practical skills for helping children learn how to think through and resolve everyday conflicts. Through games and exercises, children learn interpersonal cognitive problem-solving skills including the ability to a) identify a problem, b) recognize thoughts, feelings, and motives that generate interpersonal problem situations, c) generate alternative solutions to problems, and d) consider the consequences of these solutions. Based on more than 3 decades of research, ICPS has proven effective in reducing and preventing antisocial and socially withdrawn behaviors, and in promoting positive, prosocial behaviors and peer relations. It has been successfully implemented with children ages 4 through 12, and is especially effective for young, poor, and urban students who may be at highest risk for behavioral problems and interpersonal maladjustment. ICPS is implemented through daily 20-minute lessons spanning approximately 3-4 months. During the lessons, teachers use various techniques, including games, didactic discussion, role-playing, and group interaction to teach children communication and problem solving-skills and the thought processes necessary for good decision-making. In addition to the formal lessons/games, teachers use a problem-solving style of talk—ICPS Dialoguing— when real problems arise to help children apply their newly acquired problem-solving skills in real life. ICPS also includes suggestions for integrating interpersonal concepts into the academic curriculum. ICPS can be easily adapted for use by counselors, school psychologists, or other support personnel who see individual high-risk children. The program also has a stand-alone parent component, *Raising a Thinking Child*, which is available in Spanish and English. This component, which shows parents how to use the ICPS program at home, was selected as an exemplary juvenile delinquency prevention program by the U.S. Office of Juvenile Justice and Delinquency Prevention.

Second Step

<http://www.cfchildren.org/programs/ssp/overview/>

The award-winning SECOND STEP violence prevention program integrates social and emotional learning with academics. Kids from preschool through Grade 8 learn and practice vital social skills, such as empathy, emotion management, problem solving, and cooperation. These essential life skills help students in the classroom, on the playground, and at home.

The SECOND STEP program is research-based and approved for funding on [many](#)

[federal agency lists](#). Educators using the program report reductions in discipline referrals, improvement in their school climate, heightened feelings of inclusiveness and respect, and an increase in the sense of confidence and responsibility in their students.

The Incredible Years

<http://www.incredibleyears.com/>

The Incredible Years Parents, Teachers, and Children Training Series has two long-range goals. The first goal is to develop comprehensive treatment programs for young children with early onset conduct problems. The second goal is the development of cost-effective, community-based, universal prevention programs that all families and teachers of young children can use to promote social competence and to prevent children from developing conduct problems in the first place.

The purpose of the series is to prevent delinquency, drug abuse, and violence. The short-term goals of the series are to:

Reduce conduct problems in children:

- Decrease negative behaviors and noncompliance with parents at home.
- Decrease peer aggression and disruptive behaviors in the classroom.

Promote social, emotional, and academic competence in children:

- Increase children's social skills.
- Increase children's understanding of feelings.
- Increase children's conflict management skills and decrease negative attributions.
- Increase academic engagement, school readiness, and cooperation with teachers.

Dare To Be You

<http://www.colostate.edu/Depts/CoopExt/DTBY/>

The DARE to be You program (DTBY) is a research based multi-level prevention program. It was selected as one of the first national replication prevention programs and is now on the National Registry for Effective Prevention Programs. It builds on the strengths of youth and develops individual assets in youth, families, schools, and community organizations. Focus principals include:

D Decision-making and problem solving

A Assertive communication skills, social skills

R Responsibility and Role Modeling

E Efficacy, Esteem for self and others, Empathy Development

DARE to be You (**DTBY**) is unique in providing training components and materials for all levels of the community which influence youth. Each of these components has undergone 5 to 20 years of research comparing participants with control groups.

Family-based classes

- DTBY for Preschool Families (NREPP)
- DTBY Bridges for Families with Youth in K-2 and their Teachers
- DTBY Care to Wait for Families with Middle School Youth (with a sexual decision-making/abstinence component)

Youth-based programs

- School curriculum for school or after-school programs and other youth organizations

Training for community youth workers and teachers

Social Decision Making/Problem Solving

http://www.findyouthinfo.gov/cf_pages/programdetail.cfm?id=677

The Social Decision Making and Problem Solving Program (SDM) is a social and emotional learning program that assists students in acquiring social and decision-making skills and in developing their ability to effectively use those skills in real-life, with the aim of preventing violence, substance abuse, and related problem behavior. It is a primary prevention program conceptually rooted in research from public health, child development, clinical psychology, cognitive sciences, and organizational and community psychology. The program provides a framework in which students have the ability to learn, reinforce, and practice applying skills necessary to develop social competence. SDM is intended for use with all students (regular and special education) in kindergarten through eighth grade, regardless of ability level, ethnic group, or socioeconomic level. The program has been successfully implemented in urban, suburban, and rural settings nationwide.

SDM is designed to become a strategic part of the teaching process, affecting behavior, academic learning, and the socioemotional life of the school setting. The formal lessons are most effectively taught in at least one classroom session per week (two for special education students), but the SDM approach permeates teaching across several content areas. Because the program provides a foundation of prosocial, critical thinking and life-skills learning for all students, it is often a useful structure for organizing existing school programs. In many sites, social decision-making has been incorporated into a school's annual plans for student learning objectives.

APPENDIX S

GENDER EQUITY STRATEGIES

New Mexico Media Literacy Project

http://www.nmmlp.org/what_we_do/index.html

The Media Literacy Toolbox (\$99) provides a complete introduction to media literacy concepts, skills and applications. It's an interactive DVD-ROM containing over 100 selected media examples – television commercials, magazine ads, excerpts from TV and radio shows, newspaper and magazine articles and other media messages. The disc also includes over 30 printable activity and discussion guides you can use to lead a conversation or teach a class using the media examples on the disc. The activity and discussion guides teach basic media literacy concepts and skills, like the “language of persuasion” and how to deconstruct a media message. They examine media messages about body image, alcohol, tobacco, race, class, aging, and other topics, and illustrate new marketing techniques, like stealth marketing and viral marketing. *Media Literacy Toolbox* looks “beyond the frame” and investigates our media system and the power of Big Media, independent media, media justice and media activism.

While it can be used for individual study, *Media Literacy Toolbox* is designed to be used in classrooms, community groups and other group settings to:

- Teach basic media literacy concepts to people of any age
- Learn how to “deconstruct” media messages
- Understand our changing media system and current media issues
- Access ideas and resources for making your own media
- Discover ways to improve our media environment

The Media & Body Image (\$49) is a multimedia educational resource on media literacy and body image. It can help you improve your ability to access, analyze, evaluate, and produce media messages, and to become an active participant in our media culture.

Media & Body Image is not a movie on a disc. It's an interactive DVD-ROM containing 38 different media examples and printable presentation guides and handouts.

While it can be used for individual study, *Media & Body Image* has been designed to be used in classrooms, community groups, and other group settings to:

- Teach media literacy concepts on the topic of body image to people of any age
- Learn how to “deconstruct” media messages
- Access ideas and resources for making your own media
- Discover ways to improve our body image and our media environment

MOST Clubs

[http://www.mencanstoprape.org/info-url2696/info-url_list.htm?section=Men%20of%20Strength%20\(MOST\)%20Clubs](http://www.mencanstoprape.org/info-url2696/info-url_list.htm?section=Men%20of%20Strength%20(MOST)%20Clubs)

Since 2000, the Men of Strength (MOST) Club — the premier primary prevention program begun by Men Can Stop Rape, Inc. (MCSR)* for male youth in the country — has provided high school age young men with a structured and supportive space to learn about healthy masculinity and men’s role in prevention of violence against women, and to redefine male strength. Each year-long, 16-session Club also introduces participants to social justice activism by building members’ ability to translate their learning into community leadership through a Community of Strength Project that culminates the Club meetings. Participants can continue involvement beyond graduation from the Club through membership on the Men of Strength Advisory Board.

A mentoring component, commitment of trained facilitators, use of a comprehensive curriculum and outcomes evaluation are key features of all MOST Clubs. Use of this prevention strategy requires completion of an application process and approval of MCSR. Facilitator training and evaluation are conducted by MCSR.

In 2006 and 2008 MOST Clubs were adapted for college age men and middle school age boys, respectively. MOST Clubs currently exist in more than 50 locations in the District of Columbia, California (through CALCASA), Maryland, New York, North Carolina, Pennsylvania, and Ohio. An evaluation study funded by the Center for Disease Control and Prevention in 2004 noted that MOST Club participants were more likely to intervene as bystanders when exposed to incidences of violence against women.

*(Men Can Stop Rape, Inc. (MCSR) is an international organization that mobilizes men to use their strength for creating cultures free from violence, especially men’s violence against women.)

Positive Social Norms Marketing

<http://www.socialnormsresources.org/pdf/Guidebook.pdf>

The social norms approach to prevention is founded upon the belief that individuals incorrectly perceive that the attitudes or behaviors of others are different from their own; when in reality they are similar. This may lead individuals to adjust their behavior to that of the majority by adhering to the perceived norms. A positive social norms approach “markets” accurate information and positive group norms about a social issue to affect widespread behavior change.

A Guide to Marketing Social Norms for Health Promotion in Schools and Communities is intended as a comprehensive, step-by-step manual for those who are interested in using the social norms approach to address school-age and community-wide issues. Inspired by the positive impact that numerous colleges and universities have had promoting student health using this approach, a number of high schools and communities have begun to

implement their own social norms projects. Frequently focused on preventing adolescent alcohol and tobacco use, the initial success of these efforts strongly suggests that the number of school and community-based interventions will continue to grow in the coming years. Given that, it is important that those working to implement their own social norms projects have the tools and knowledge to do so effectively, and with fidelity to the model. This guidebook provides community members, school administrators and staff, or health promotion professionals both the theoretical and practical information necessary to conduct an effective project

The social norms approach has become one of the most talked about health promotion strategies in recent years. Known primarily for its application to college student drinking, it has become an increasingly popular topic among community and high school substance abuse prevention specialists who are looking for an evidence-based alternative to ineffective intervention strategies, or to supplement strategies with limited impact.

The growing appeal of social norms is due largely to two related phenomena. First, many of the usual strategies designed to address the problem behaviors in adolescent and young adult populations have been largely ineffective, leading many professionals to look for other options. Second, there is a growing movement in the prevention field toward evidence-based evaluation, a requirement that dramatically contrasts the ineffectiveness of past methods with the impressive data emerging from various interventions using the social norms approach. It is likely this strategy will have positive results when applied to the prevention of sexual violence.

APPENDIX T

BYSTANDER STRATEGIES

Green Dot

<http://www.uky.edu/StudentAffairs/VIPCenter/greenDot.html>

The Green Dot primary prevention initiative is a new way of thinking about and doing prevention. Green Dot is about culture change - harnessing the power of individual choices to shift our current norms. It was designed by integrating some of the best research on social change, diffusion of innovation, communication, persuasion, bystander intervention, and perpetrator patterns into a program that makes practical sense.

GreenDOT began at the University of Kentucky and was the project of Dorothy Edwards, director of the university's Violence Intervention and Prevention Center.

“Visualize for a moment that unforgettable image of small red-dots spreading across a computer generated map of the United States, symbolizing the spread of some terrible epidemic – with each tiny red dot representing an individual case. With disturbing speed, the three or four single dots multiply and spread until the whole map emits a red glow comprised of a zillion tiny dots.

Now imagine for a moment a map of UK. Each red dot on this map represents an act of violence against women (physical assault, sexual assault or stalking) – or a choice to tolerate, justify or perpetuate this violence. A red dot is a rape – a red dot is a hit – a red dot is a threat – a red dot is a “blame the victim” statement – a red dot is an individual choice to do nothing in the face of a high risk situation. Violence against women at the University of Kentucky is not a huge, solid mass that can simply be removed with one swift action or policy. Rather, it is the accumulation of individual decisions, moments, values, and actions made by the students, staff, faculty and administration of our university. It’s hard to know exactly how many red dots are on our map at any given moment – but we do know there have been enough red dots to create a culture that sustains a rate of 36.5% of women becoming victims of physical assault and/or sexual assault and/or stalking while they are students at UK.

Now imagine adding a green dot in the middle of all those red dots on our UK map. Imagine that a green dot is any behavior, choice, word, or attitude that promotes safety for women and communicates utter intolerance for violence. A green dot is pulling our friend out of a high risk situation – a green dot is responding to a victim blaming statement with words of support – a green dot is volunteering a few hours at the Violence Intervention and Prevention Center – a green dot is attending a MAVAR@UK meeting – a green dot is bringing a safety program to your group. A green dot is simply your individual choice at any given moment to make our campus safer.

How many green dots will it take to begin reducing violence against women on our campus? How many of us need to add 2 or 3 or 7 or 50 dots to this map to begin to make

a difference and begin to outshine and displace those red dots? We cannot know the exact number, but we do know this: if most of us choose inaction – if most of us choose to close our eyes to this issue – if most of us choose apathy and indifference – then the red dots stand! If we do not begin replacing moments of violence and victim blaming with moments of support and safety, then we will surely continue to have more than 1 in 3 women become victims of violence. That is not OK. That must not be OK with any of us.”

Mentors in Violence Prevention

<http://www.jacksonkatz.com/mvp.html>

The Mentors in Violence Prevention (MVP) Model is a gender violence, bullying, and school violence prevention approach that encourages young men and women from all socioeconomic, racial and ethnic backgrounds to take on leadership roles in their schools and communities. The training is focused on an innovative "bystander" model that empowers each student to take an active role in promoting a positive school climate. The heart of the training consists of role-plays intended to allow students to construct and practice viable options in response to incidents of harassment, abuse, or violence before, during, or after the fact. Students learn that there is not simply "one way" to confront violence, but that each individual can learn valuable skills to build their personal resolve and to act when faced with difficult or threatening life situations.

The *MVP Model* originated in 1993 with the creation of the Mentors in Violence Prevention Program at Northeastern University's Center for the Study of Sport in Society. With initial funding from the U.S. Department of Education, the multiracial MVP Program was designed to train male college and high school student-athletes and other student leaders to use their status to speak out against rape, battering, sexual harassment, gay-bashing, and all forms of sexist abuse and violence. A female component was added in the second year with the complementary principle of training female student-athletes and others to be leaders on these issues.

Why the initial focus on working with student-athletes? Ever since battered women's programs and rape crisis centers established their first educational or "youth outreach" initiatives in the schools in the 1970's, one of the key challenges they have faced is the apathy, defensiveness – and sometimes outright hostility – of male athletic directors, coaches, and student-athletes. While men and young men in the school-based athletic subculture have hardly been unique in their reluctance to embrace gender violence prevention education, they typically occupy a privileged position in school culture, and particularly in male peer culture. As such, male student-athletes – especially in popular team sports such as football, basketball, hockey, baseball, wrestling, and soccer – tend to have enormous clout when it comes to establishing or maintaining traditional masculine norms. Their support or lack of support for prevention efforts can make or break them.

For the past decade, the *MVP Model* has been utilized by the parent MVP Program at Northeastern University, as well as by dozens of other schools and school systems in

Massachusetts, Iowa, Colorado, Washington, and elsewhere. It has been implemented in hundreds of educational settings with diverse school-based populations of boys and girls, men and women, working together and in single-sex formats. It is important to note that although it began in the sports culture, and retains some sports terminology, by the mid-1990's MVP had moved from a near-exclusive focus on the athletic world to general populations of high school and college students, and other institutional settings.

SCREAM Theatre: Learning to Scream – Rutgers University
<http://sexualassault.rutgers.edu/screamlearning.htm>

SCREAM (Students Challenging Realities and Educating Against Myths) Theater is a peer education, interactive, improvisational student group that educates audiences about issues of interpersonal violence including sexual assault, dating violence, stalking, bullying and harassment. Learning to SCREAM is a theater workshop that teaches peer educators how to institute a theater program for their own school or organization. By demonstrating basic scenarios and allowing educators to participate in the improvisational theater process, SCREAM leaders aid other schools and organizations in developing peer educational theater presentations for their educational purposes.

The "Learning to SCREAM" format begins with the presentation of a typical SCREAM scenario. After the processing takes place, the audience gets a chance to participate in the theater process. Short improvisational exercises demonstrate how to begin creating scenes and are also used to make the actors comfortable in front of a large audience. The "Learning to SCREAM" program facilitates the educational process. Rutgers University will tailor the program to meet the needs of the peer educators.

In addition to the Learning to SCREAM workshop, a 45 page manual entitled Learning to SCREAM: A Guide for Developing Peer Educational Theater Programs provides a step-by-step description of how to create and maintain a peer-interactive theater program. Included in this manual is background information on campus sexual violence, peer education and using theater for education, the process used by SCREAM Theater including creating a skit, training sessions for students, running rehearsals, and considering theater tips, and information on creating an ongoing program including training on the issues and theater, developing a group identity, and creating a student staff.

APPENDIX U



2333 Whitehorse Mercerville Rd
Suite J
Trenton, NJ 08619
Ph: 609.631.4450
Fax: 609.631.4453
www.njcasa.org

May 8, 2009

Karen S. Lang, MSW
Public Health Advisor
Centers for Disease Control and Prevention
NCIPC - Division of Violence Prevention
4770 Buford Hwy., NE, MS F-63
Atlanta, GA 30341-3717

Dear Ms. Lang,

The New Jersey Coalition Against Sexual Assault (NJCASA) supports the New Jersey Sexual Violence Prevention Plan being submitted by the Division on Women and the Prevention and Public Education Committee (PPEC) of the Governor's Advisory Council Against Sexual Violence. NJCASA staff members, including myself, have been actively involved in the development of the plan as members of the State Planning and State Capacity Building Teams, workgroups, and as resource people. The process for developing the plan has been thoughtful, inclusive, challenging, and comprehensive. It is exciting to see it come together at this point as a program of strategies that address general and specific populations across the social ecological model.

The plan submitted certainly represents the work of many stakeholders and future partners. I believe it strikes a good balance between continuing to increase the State's capacity and actual implementation of prevention strategies. It is indeed ambitious, but NJCASA believes it is ultimately do-able over the long-term, with some strategies already underway.

NJCASA had already committed to:

- Continued participation on the SPT and SCBT
- Spearheading the acquisition of additional funding for and implementing the state-wide baseline survey on gender norms;
- Providing ongoing prevention capacity development support and technical assistance for the Sexual Violence Programs and others through NJCASA's Training Institute;
- Overseeing the implementation of the plan on both local and state levels;
- Researching, developing, and advocating through legislation a dedicated funding stream in NJ for sexual violence prevention and intervention;
- Providing one full-time staff member dedicated to prevention in addition the prevention work of the Executive Director and Associate Director;

It is energizing to see the fruit of the SPT's work over the last two and half years. NJCASA looks forward to continuing the partnership and working to prevent sexual violence as outlined in the state plan.

Sincerely,

A handwritten signature in black ink that reads 'Andrea L. Spencer-Linzie'.

Andrea L. Spencer-Linzie
Executive Director

STATEWIDE SEXUAL VIOLENCE HOTLINE **1.800.601.7200**

May 8, 2009

Karen S. Lang, MSW
Public Health Advisor
Centers for Disease Control and Prevention
NCIPC - Division of Violence Prevention
4770 Buford Hwy., NE, MS F-63
Atlanta, Georgia 30341-3717

Dear Ms. Lang,

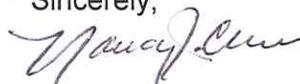
This letter is in support of the New Jersey Sexual Violence Prevention Plan being submitted by the Division on Women and the Prevention and Public Education Committee (PPEC) of the Governor's Advisory Council Against Sexual Violence. As a relatively new member of the PPEC, I have found the planning process to be highly informative and the commitment of its members to be quite impressive.

New Jersey's plan represents a major turning point in the field of sexual violence as those charged with intervening with victims/survivors now look toward enhancing their efforts to include primary prevention of sexual violence perpetration. The plan also strives to acknowledge the need for internal capacity building to be joined with efforts to affect social norms change—moving communities away from social norms which may act to support acts of sexual violence while helping them enhance those social norms that may help protect against it. The PPEC has invested many hours of work and debate and feels that this plan reflects its best effort to develop a comprehensive strategy to prevent sexual violence.

As a PPEC member, I will work in support of this plan as it moves from planning into active implementation. The key contributions that I can offer relate to helping teams develop comprehensive and affordable strategies across the goal areas. I have a special interest in the area of integrating sexual violence prevention into the work of those charged with helping develop empathy and attachment between young children and their caregivers, as well as supporting efforts designed to enhance healthy community connections for youth who have been exposed to intimate partner violence.

It has been exciting to witness the progression of the work of the PPEC and the subsequent plan for action. While the plan will surely evolve over the coming years, I have confidence that progress will be made and that the lessons learned will not only benefit the citizens of New Jersey but also hold valuable information for other communities undertaking similar prevention efforts.

Sincerely,



Nancy J. Cline
Project Manager
Sexual Violence Prevention Initiative

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State of New Jersey

DEPARTMENT OF EDUCATION
PO Box 500
TRENTON, NJ 08625-0500

JON S. CORZINE
Governor

LUCILLE E. DAVY
Commissioner

May 11, 2009

Karen S. Lang, MSW
Public Health Advisor
Centers for Disease Control and Prevention
NCIPC - Division of Violence Prevention
4770 Buford Hwy., NE, MS F-63
Atlanta, GA 30341-3717

Dear Ms. Lang,

This letter is in support of the New Jersey Sexual Violence Prevention Plan being submitted by the Division on Women and the Prevention and Public Education Committee (PPEC) of the Governor's Advisory Council Against Sexual Violence. As a member of the PPEC I have found the planning process to be highly informative and comprehensive.

The plan submitted represents the work of many stakeholders and future partners. While ambitious, it also represents a major turning point in the field of sexual violence and a realistic assessment of what is right for New Jersey at this time. We have tried to balance the need for internal capacity building with the actual social change efforts needed to change social norms in communities. The plan was carefully reviewed by the entire PPEC and I feel confident that it represents our very best effort on the subject of primary prevention.

I commit to ----

- remaining a partner in the implementation phase of the work
- advocating for formal support of the plan within my own organization
- sharing the plan with colleagues and community members

I see myself and the organization I represent supporting this work through the implementation of the core curriculum content standards in New Jersey public schools.

Sincerely,

A handwritten signature in cursive script that reads "James McCall".

James McCall, PhD
Coordinator – Health and Physical Education
New Jersey Department of Education
Office of Academic Standards

www.nj.gov/education



STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
Special Response Unit

Jon S. Corzine
GOVERNOR

PO BOX 700
TRENTON, NJ 08625-0700

Jennifer Velez
COMMISSIONER

**ADVISORY, CONSULTATIVE, DELIBERATIVE
AND/OR RISK MANAGEMENT MATERIAL**

Karen S. Lang, MSW
Public Health Advisor
Centers for Disease Control and Prevention
NCIPC - Division of Violence Prevention
4770 Buford Hwy., NE, MS F-63
Atlanta, GA 30341-3717

May 4, 2009

Dear Ms. Lang,

This letter is in support of the New Jersey Sexual Violence Prevention Plan being submitted by the Division on Women and the Prevention and Public Education Committee (PPEC) of the Governor's Advisory Council Against Sexual Violence. As a member of the PPEC I have found the planning process to be highly informative and engaging.

The plan submitted represents the work of many stakeholders and future partners. While ambitious, it also represents a major turning point in the field of sexual violence and a realistic assessment of what is right for New Jersey at this time. We have tried to balance the need for internal capacity building with the actual social change efforts needed to change social norms in communities. The plan was carefully reviewed by the entire PPEC and I feel confident that it represents our very best effort on the subject of primary prevention.

I commit to:

- remaining a partner in the implementation phase of the work
- advocating for formal support of the plan within my own organization
- full participation in the evaluation work of Empower II
- sharing the plan with colleagues and community members

I support and will encourage the organization I represent to support the work in protecting vulnerable populations as well as:

- building gender equity norms
- increasing bystander intervention
- integrating the work of sexual violence and empathy and attachment providers
- coordinating with the field of domestic violence on increasing community connectedness for at risk youth
- building local capacity for community organizing and community mobilization

Sincerely,

Vincent J. Giardina
Supervisor of Investigations



State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MENTAL HEALTH SERVICES
Special Treatment Unit
PO BOX 905
Avenel, NJ 07001

JON S. CORZINE
Governor

JENNIFER VELEZ
Commissioner

JONATHAN S. POAG
Acting Assistant Commissioner

JOHN E. MAIN
Chief Executive Officer
. (609) 633-0900

Karen S. Lang, MSW
Public Health Advisor
Centers for Disease Control and Prevention
NCIPC - Division of Violence Prevention
4770 Buford Hwy., NE, MS F-63
Atlanta, GA 30341-3717

June 1, 2009

Dear Ms. Lang,

This letter is in support of the New Jersey Sexual Violence Prevention Plan being submitted by the Division on Women and the Prevention and Public Education Committee (PPEC) of the Governor's Advisory Council Against Sexual Violence. As a member of the PPEC I have found the planning process to be well organized and extremely comprehensive.

The plan submitted represents the work of many stakeholders and future partners. While ambitious, it also represents a major turning point in the field of sexual violence and a realistic assessment of what is right for New Jersey at this time. We have tried to balance the need for internal capacity building with the actual social change efforts needed to change social norms in communities. The plan was carefully reviewed by the entire PPEC and I feel confident that it represents our very best effort on the subject of primary prevention.

I commit to ----

- remaining a partner in the implementation phase of the work
- advocating for formal support of the plan within my own organization
- full participation in the evaluation work of Empower II
- sharing the plan with colleagues and community members

I see myself and the organization I represent especially supporting the work in

- building gender equity norms
- protecting vulnerable populations
- increasing bystander intervention
- integrating the work of sexual violence and empathy and attachment providers
- coordinating with the field of domestic violence on increasing community connectedness for at risk youth
- building local capacity for community organizing and community mobilization

Sincerely,

Jennifer E. Schneider, Ph.D.
Special Treatment Unit
Ann Klein Forensic Center



State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MENTAL HEALTH SERVICES
ANN KLEIN FORENSIC CENTER
STUYVESANT AVENUE
PO BOX 7717
WEST TRENTON, NJ 08628

JON S. CORZINE
Governor

JENNIFER VELEZ
Commissioner

JONATHAN S. POAG
Acting Assistant Commissioner

JOHN E. MAIN
Chief Executive Officer
(609) 633-0900

Karen S. Lang, MSW
Public Health Advisor
Centers for Disease Control and Prevention
NCIPC - Division of Violence Prevention
4770 Buford Hwy., NE, MS F-63
Atlanta, GA 30341-3717

May 1, 2009

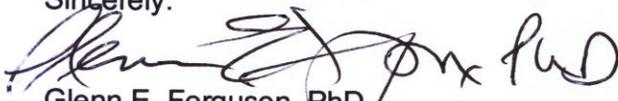
Dear Ms. Lang,

This letter is in support of the New Jersey Sexual Violence Prevention Plan being submitted by the Division on Women and the Prevention and Public Education Committee (PPEC) of the Governor's Advisory Council Against Sexual Violence. As a member of the PPEC I have found the planning process to be highly inclusive and comprehensive.

The plan submitted represents the work of many stakeholders and future partners. While ambitious, it also represents a major turning point in the field of sexual violence and a realistic assessment of what is right for New Jersey at this time. We have tried to balance the need for internal capacity building with the actual social change efforts needed to change social norms in communities. The plan was carefully reviewed by the entire PPEC and I feel confident that it represents our very best effort on the subject of primary prevention.

I commit to remaining a partner in the implementation phase of the work and advocating for formal support of the plan within my own organization. I see myself and the organization I represent especially supporting the work in protecting vulnerable populations and increasing bystander intervention.

Sincerely:


Glenn E. Ferguson, PhD
Deputy CEO/Clinical Services

Karen S. Lang, MSW
Public Health Advisor
Centers for Disease Control and Prevention
NCIPC - Division of Violence Prevention
4770 Buford Hwy., NE, MS F-63
Atlanta, GA 30341-3717

May 11, 2009

Dear Ms. Lang:

It was a pleasure meeting you and your colleagues in March at the CDC. This letter is in support of the New Jersey Sexual Violence Prevention Plan being submitted by the Division on Women and the Prevention and Public Education Committee (PPEC) of the Governor's Advisory Council Against Sexual Violence. As a member of the PPEC I have found the planning process to be extremely productive and comprehensive. I am writing to confirm my support and that of the Center on Violence Against Women & Children (VAWC) at the Rutgers University School of Social Work.

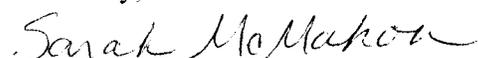
The plan submitted represents the work of many stakeholders and future partners. While ambitious, it also represents a major turning point in the field of sexual violence and a realistic assessment of what is right for New Jersey at this time. We have tried to balance the need for internal capacity building with the actual social change efforts needed to change social norms in communities. The plan was carefully reviewed by the entire PPEC and I feel confident that it represents our very best effort on the subject of primary prevention.

VAWC is committed to the following:

- remaining a partner in the implementation phase of the work
- advocating for formal support of the plan at VAWC and with our community partners
- full participation in the evaluation work of Empower II
- sharing the plan with colleagues and community members

We will especially support the work by building gender equity norms; protecting vulnerable populations; increasing bystander intervention; integrating the work of sexual violence and empathy and attachment providers; coordinating with the field of domestic violence on increasing community connectedness for at risk youth; and building local capacity for community organizing and community mobilization

Sincerely,



Jackson Tay Bosley, Psy.D.
55 Reinman Road, Warren, NJ 07059
(908) 222-9927

Karen Lang, Project Officer
Department of Health and Human Services
Center for Disease Control and Prevention
4770 Buford Highway, N.E. MS F-63
Atlanta, GA 30341

5/01/2009

Dear Ms. Lang,

The New Jersey Sexual Violence Prevention Plan represents the combined efforts of numerous stakeholders interested in reducing the incidence and prevalence of sexual abuse in our community. We looked closely at the organizations and services presently addressing these needs and envisioned a variety of planned interventions that are supported by research, efficient in their use of resources and are appropriate for our diverse populations.

As a sexual offender treatment provider, I hope that the need for my specific skills will diminish over time. We all hope that that will be the case. But hope is not enough, and this plan outlines the kinds of concrete action that will have the desired effect of making our communities safer. We will do this by protecting vulnerable individuals, empowering bystanders to intervene in helpful ways and increasing egalitarian gender norms.

I am committed to the eventual elimination of sexually offensive behaviors, and hope that the CDC will join in this commitment.

Thank you,

Jackson Tay Bosley, Psy.D.
Clinician Administrator
Community/Parole Supervision for Life Program
University of Medicine and Dentistry of New Jersey



Karen S. Lang, MSW
Public Health Advisor
Centers for Disease Control and Prevention
NCIPC - Division of Violence Prevention
4770 Buford Hwy., NE, MS F-63
Atlanta, GA 30341-3717

May 1, 2009

Dear Ms. Lang,

This letter is in support of the New Jersey Sexual Violence Prevention Plan being submitted by the Division on Women and the Prevention and Public Education Committee (PPEC) of the Governor's Advisory Council Against Sexual Violence. As a member of the PPEC I have found the planning process to be highly comprehensive.

The plan submitted represents the work of many stakeholders and future partners. While ambitious, it also represents a major turning point in the field of sexual violence and a realistic assessment of what is right for New Jersey at this time. We have tried to balance the need for internal capacity building with the actual social change efforts needed to change social norms in communities. The plan was carefully reviewed by the entire PPEC and I feel confident that it represents our very best effort on the subject of primary prevention.

I commit to ----

- remaining a partner in the implementation phase of the work
- advocating for formal support of the plan within my own organization
- full participation in the evaluation work of Empower II
- sharing the plan with colleagues and community members

I see myself and the organization I represent especially supporting the work in

- building gender equity norms
- protecting vulnerable populations
- increasing bystander intervention
- integrating the work of sexual violence and empathy and attachment providers
- coordinating with the field of domestic violence on increasing community connectedness for at risk youth
- building local capacity for community organizing and community mobilization

Sincerely,

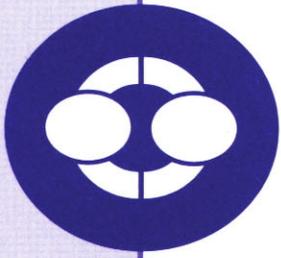
Jennifer DaCunha
Community Educator/Volunteer Coordinator

47 East Main Street | Flemington, New Jersey 08822 | Outreach Phone (908)788-7666 | Fax (908)806-4725

www.safeinhunterdon.org

24 Hour Hotline (908)788-4044 | **Toll Free Hotline** 1-888-988-4033 | **TTY** 1-866-954-0100

Member of New Jersey Coalition Against Sexual Assault | A United Way Member Agency | Member of New Jersey Coalition for Battered Women



Beyond Diversity Resource Center

Karen S. Lang, MSW
Public Health Advisor
Centers for Disease Control and Prevention
NCIPC - Division of Violence Prevention
4770 Buford Hwy., NE, MS F-63
Atlanta, GA 30341-3717

May 7, 2009

Dear Ms. Lang,

It is with pleasure that I write this letter of support for the New Jersey Sexual Violence Prevention Plan that is being submitted by the Division on Women and the Prevention and Public Education Committee (PPEC) of the Governor's Advisory Council Against Sexual Violence. As a member of the PPEC, I have enjoyed participating in the development process. The process was inclusive, highly comprehensive and productive. It represents the work of a committed, diverse group of stake holders and partners.

New Jersey's plan represents an important and timely turning point in the field of sexual violence in New Jersey. The plan was developed and reviewed by the entire PPEC and I believe that it represents our best effort to create a plan for primary prevention that is realistic and feasible.

I am committed to remaining a partner in the implementation phase of the work. I am also excited about participating in the evaluation work of Empower II. As a specialist in diversity and cultural competence, I see myself working to help ensure that the PPEC continues to be inclusive of all diverse populations as it moves forward with the implementation of its plan. As a volunteer consultant to the New Jersey Coalition for Battered Women, I also see myself working to build gender equity norms and to increase bystander behavior.

Sincerely,

Pamela Smith Chambers
Training Director



The College of New Jersey

Office of Anti-Violence Initiatives

PO Box 7718
Ewing, NJ 08628-0718

Karen S. Lang, MSW
Public Health Advisor
Centers for Disease Control and Prevention
NCIPC - Division of Violence Prevention
4770 Buford Hwy., NE, MS F-63
Atlanta, GA 30341-3717

P) 609.771.2272
F) 609.637.5107
E) deitch@tcnj.edu
W) www.tcnj.edu

May 4, 2009

Dear Ms. Lang,

This letter is in support of the New Jersey Sexual Violence Prevention Plan being submitted by the Division on Women and the Prevention and Public Education Committee (PPEC) of the Governor's Advisory Council Against Sexual Violence. As a long-time member of the PPEC I have found the planning process to be highly engaging and informative.

The plan submitted represents the work of many stakeholders and future partners. While ambitious, it also represents a major turning point in the field of sexual violence and a realistic assessment of what is right for New Jersey at this time. We have tried to balance the need for internal capacity building with the actual social change efforts needed to change social norms in communities. The plan was carefully reviewed by the entire PPEC and I feel confident that it represents our very best effort on the subject of primary prevention.

As the Coordinator for the Office of Anti-Violence Initiatives at The College of New Jersey, I commit to remaining a partner in the implementation phase of the work, advocating for formal support of the plan within my own organization, and sharing the plan with colleagues and community members.

I see myself and the organization I represent especially supporting the work in building gender equity norms and increasing bystander intervention. We will do so by being the first college to launch the Green Dot campaign and by serving as a pilot for colleges and universities statewide.

Sincerely,

Jacqueline M. Deitch-Stackhouse, MSS, MLSP, LCSW



New Jersey School Boards Association

413 West State Street • P.O. Box 909 • Trenton, NJ 08605-0909
Telephone: 609.695.7600 • Toll-Free: 888.88NJSBA • Fax: 609.695.0413

May 5, 2009

Karen S. Lang, MSW, Public Health Advisor
Centers for Disease Control and Prevention
NCIPC - Division of Violence Prevention
4770 Buford Hwy., NE, MS F-63
Atlanta, GA 30341-3717

Dear Ms. Lang,

This letter is in support of the New Jersey Sexual Violence Prevention Plan being submitted by the Division on Women and the Prevention and Public Education Committee (PPEC) of the Governor's Advisory Council Against Sexual Violence. As a member of the PPEC since its inception three years ago, I have found the planning process to be enlightening, educational, thorough, and very collaborative.

The plan submitted represents the work of many stakeholders and future partners. While ambitious, it also represents a major turning point in the field of sexual violence and a realistic assessment of what is right for New Jersey at this time. We have tried to balance the need for internal capacity building with the actual social change efforts needed to change social norms in communities. The plan was carefully reviewed by the entire PPEC and I feel confident that it represents our very best effort on the subject of primary prevention.

I commit to

- remaining a partner in the implementation phase of the work
- advocating for formal support of the plan within my own organization
- full participation in the evaluation work of Empower II
- sharing the plan with colleagues and community members

I see myself and the organization I represent especially supporting the work in

- building gender equity norms
- protecting vulnerable populations
- increasing bystander intervention
- building local capacity for community organizing and community mobilization

Sincerely,

Barbara Horl

Barbara Horl, Lobbyist
New Jersey School Boards Association



**Mental Health
Association
in New Jersey, Inc.**

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Karen S. Lang, MSW
Public Health Advisor
Centers for Disease Control and Prevention
NCIPC - Division of Violence Prevention
4770 Buford Hwy., NE, MS F-63
Atlanta, GA 30341-3717

June 1, 2009

Dear Ms. Lang,

I am writing this letter in support of the New Jersey Sexual Violence Prevention Plan being submitted by the Division on Women and the Prevention and Public Education Committee (PPEC) of the Governor's Advisory Council Against Sexual Violence. As a member of the PPEC I have found the planning process to be highly comprehensive, well thought out and exciting. It reflects the work of professionals from a variety of stakeholders from a broad range of disciplines and organizations, including those not usually engaged in this type of process.

The plan submitted represents the work of many stakeholders and future partners. While ambitious, it also represents a major turning point in the field of sexual violence and a realistic assessment of what is right for New Jersey at this time. We have tried to balance the need for internal capacity building with the actual social change efforts needed to effect social norms in communities. The plan was carefully reviewed by the entire PPEC and I feel confident that it represents our very best effort on the subject of primary prevention.

I commit to remaining a partner in the implementation phase of the work and advocating for formal support of the plan within my own organization. I see myself and the organization I represent especially supporting the work in protecting vulnerable populations and integrating the work of sexual violence and empathy and attachment providers.

It was exciting to work with such a highly motivated and visionary group of professionals on a project as vital as the primary prevention of sexual violence. I look forward to my continued involvement in the work to be done.

Sincerely,

A handwritten signature in blue ink that reads "Jennifer Miller".

Jennifer Miller, LCSW
Director of Communications and Marketing

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May 4, 2009

Karen S. Lang, MSW
Public Health Advisor
Centers for Disease Control and Prevention
NCIPC – Division of Violence Prevention
4770 Buford Hwy, NE, MS F-63
Atlanta, GA 30341-3717

Dear Ms. Lang,

This letter is in support of the New Jersey Sexual Violence Prevention Plan being submitted by the Division on Women and the Prevention and Public Education Committee (PPEC) of the Governor's Advisory Council Against Sexual Violence. As a member of the PPEC I have found the planning process to be highly comprehensive and inclusive.

The plan submitted represents the work of many stakeholders and future partners. While ambitious, it also represents a major turning point in the field of sexual violence and a realistic assessment of what is right for New Jersey at this time. We have tried to balance the need for internal capacity building with the actual societal change efforts needed to change social norms in communities. The plan was carefully reviewed by the entire PPEC and I feel confident that it represents our very best effort on the subject of primary prevention.

I commit to: remaining a partner in the implementation phase of the work; and to sharing the plan with colleagues and community members.

Sincerely,


Judith Chapman
Editor/Founder

"For you, the woman who is motivated to improve her life, Garden State Woman is an exciting, trusted media and events company that supports and encourages you to make a difference in your personal and professional life, your family and your community."

APPENDIX V

EXCERPTS – VERA REPORT January 2008

From September 30, 2008 to November 3, 2008, the Vera Institute of Justice’s technical assistance team conducted onsite interviews with key staff from each of New Jersey’s 22 Sexual Violence Programs (SVP) and reviewed written program and agency materials provided by each SVP in order to gain insights into their readiness to develop a comprehensive strategy to prevent perpetration of sexual violence within their communities.

This memo includes sections on Readiness for Change, Community Engagement, Data Collection, and Possible Foundational Programs. Each section gives an overview, states issues impacting technical assistance, and lists questions and considerations for the SCBT.

I. Readiness for Change:

a. Overview

As shown in Graphic 1 below, the SVP sites’ readiness for change ratings ranged from Pre-Contemplation¹ to Action, with Contemplation² being the largest category (11 sites), and Preparation³ being the next largest (9 sites) with one site in Pre-Contemplation and one site in Action⁴. Looking strictly at the overall SVP ratings (not taking into account the work being done at the State level through the

¹ Has heard of shift toward primary prevention, but has taken no action toward learning more and is therefore under informed. Or site has tried to implement change in the past but failure is creating resistance to current change efforts.

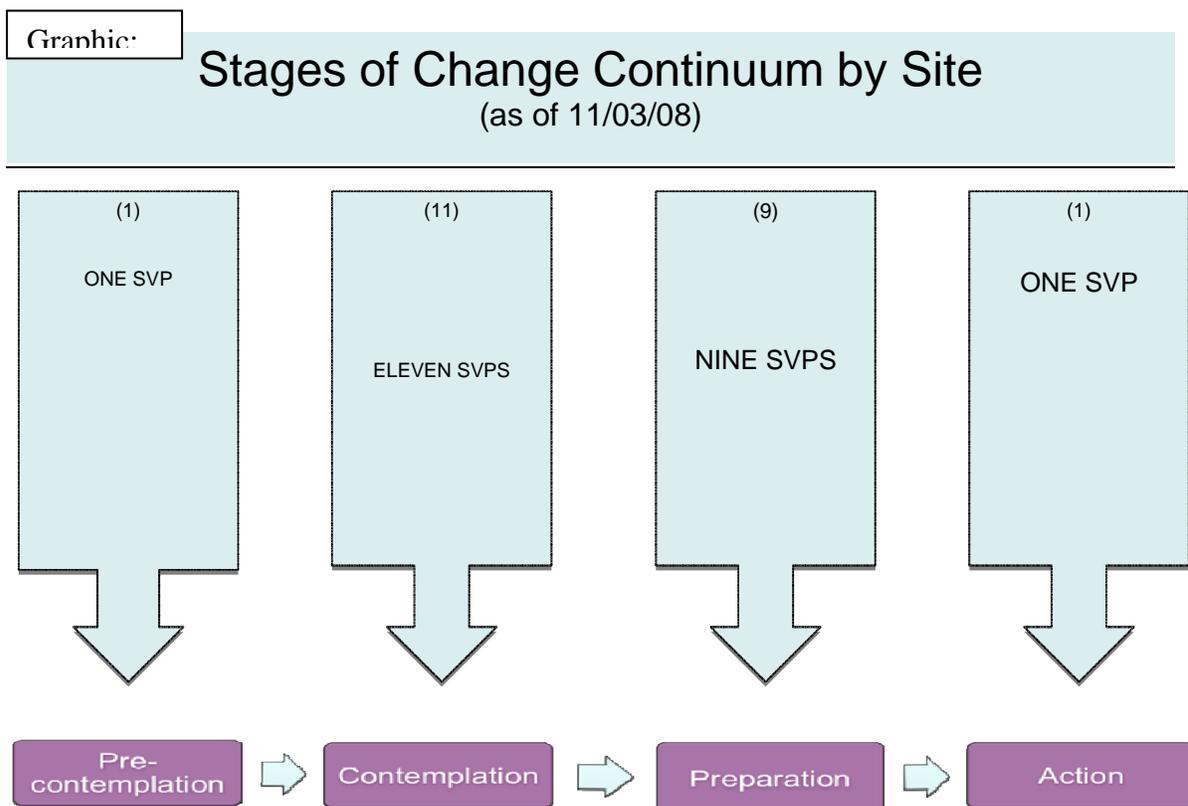
² Has made decision to commit to change, but are still weighing pros and cons and has not taken any concrete actions.

³ Site intends to take action in the immediate future, usually measured as in the next month. Examples of action: researching primary prevention curriculum, establishing a planning group/committee, or attending a primary prevention conference.

⁴ Site has made specific, overt modifications within the last six months, actions fall within state goals and meets at least five of the nine principles of effective prevention and is ready to enhance current efforts.

Prevention and Public Education Committee), our initial assessment places the SVPs for the state of New Jersey in the Contemplation stage as of the close of our initial assessment on November 3, 2008.

That said however, the overall rating is very close to shifting to the Preparation stage since there is only a difference of two sites between the Contemplation and Preparation stages. It is also important to remember that this rating is dynamic and only presents actions and impressions as of the date the Readiness Assessment was written. It is common for sites to move between stages in response to environmental changes such as increases and decreases in funding, staff turnover, and other motivators affecting individual and organizational attitudes and behaviors.



In our assessment, much of the weighing of pros and cons (the classic sign of the Contemplation stage) stems from site personnel’s concerns regarding: the money and time required to design start-up programs; the requirement for creating prevention programming by using a model of community consensus and decision making (Coalition Model); and the lack of clarity as to what exactly is expected as an outcome - each described in more detail below. Only a few sites expressed hesitancy related to “giving up” or “taking away” from services and attention to survivors. This seems a significant shift from the March 2008 survey results.

b. Assessment of Issues Affecting Change

i. Clarity of Expectations:

As the Prevention and Public Education Committee's (PPEC) priorities solidify, we believe that the sites that are in the Contemplation stage due to lack of clarity will be better able to commit to the primary prevention initiative and will do so with more confidence. For those in the Preparation stage, clarity is even more critical given that they are beginning to or continuing to engage communities and working to set local priorities. If the state's finalization process is not set before these sites move further, the sites will gain momentum on issues or strategies that run the risk of falling outside of the state's plan for action. This is only a problem if the PPEC's work on developing strategies is meant to be prescriptive in order to create a uniform response across the state. If the PPEC values creativity and diversity in the strategies selected to address the state goals and needs statements, this is less of an issue.

From Vera's perspective, if the strategies are not going to be prescribed, we recommend developing and distributing to the sites an outline for the "Primary Prevention Implementation Plan" before the end of January 2009. We believe this outline will allow sites to *work with the end in mind* and will help them to make decisions about when and how to engage the community.

ii. Funding and Staffing:

Funds and staffing will continue to be a challenge for sites. However, as long as levels stay consistent, our assessment is that progress can be made. If opportunities for funding increases arise, we recommend increasing staffing levels to include at least one full-time equivalent (1.0 FTE) and a half-time equivalent (0.5 FTE) for administrative support for primary prevention planning.

The other challenging staffing issues relate to retention, skill sets, and personality types needed for these differing roles. Community mobilizing skills⁵, curriculum/strategy development skills, program implementation, and evaluation skills are difficult to find all in one person. Sites attempting to use intervention specialists – counselors and crisis response personnel – to do prevention planning work would risk staff frustration and burnout due to the differing skill sets and personalities needed for these various roles.

⁵ Community engagement will be discussed in more detail under its own heading.

Also, situations where one staff person is splitting time between counseling/crisis response and developing a primary prevention plan means the prevention planning will take much longer to complete - especially if all sites are required to use a community consensus model of development that is not graduated (see “Community Engagement” below) to fit the site’s capacity. If no additional funding is available, sites will have to depend on volunteers and the good will of partnering organizations for their participation and involvement in the primary prevention planning process. Managing the community’s involvement and their respective expectations takes unique skills as well as a degree of political clout or personal persuasion skills. This requires proper staffing levels or that hosting agencies contribute in-kind time and resources to assure that the process moves forward with the best possibility for success.

Realities vary greatly across sites. Vera’s technical assistance will be tailored to each site’s realities, but it will take time to determine which sites or individual site personnel will be able to move the primary prevention process forward and to what degree. Having an outline of the Implementation Plan (mentioned in the previous section) can help with this process.

Questions and Considerations:

- Does the SCBT anticipate increases or decreases in RPE funds over the next 12 months?
- Does the SCBT anticipate that the SVP’s host agency’s budget will increase or decrease? Overall agency decreases may impact the staff whose salaries are paid for across programs. It may also mean that in-kind agency contributions to the new prevention initiative will suffer e.g. less access to in-kind supplies, meeting space, administrative support, moral support, time and attention of senior management and executive directors.
- Is the SCBT expecting to develop and support sites in securing new dollars related to implementation? Or, are sites expected to create plans that need to be supported based on existing funds or resources they secure on their own?
- If sites are expected to secure their own additional resources in order to implement their plans, NJCASA may want to prepare for a time when the SVP’s may end up competing with one another for foundation or federal funds.

II. Community Engagement:

Sites varied greatly in their readiness and ability to engage the community around primary prevention efforts by creating a coalition or other formal group. For example (Table One), six sites have begun a coalition specifically to address primary

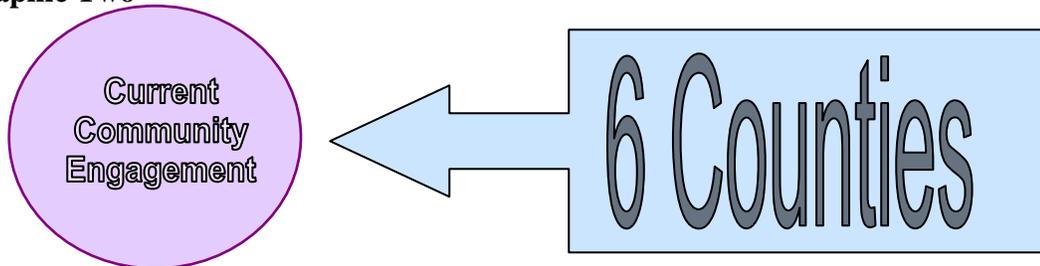
prevention, 15 have no existing/active coalition led by their agency, two stated that while they have no agency-led coalition, they could possibly use existing community groups (led by others) to create a subgroup or workgroup within the existing group to address primary prevention, and five indicated they have no desire to establish a community group.

Table One

Started:	6
None:	15
Other existing:	2
No desire:	5

For some who have not started a group, the expectation that sites broadly engage in community mobilization and/or broad-based community planning processes creates some challenges. Issues surfaced on several levels - some related to creating “another” coalition on top of existing community meetings that they already attend; some related to staff capacity to implement and manage a coalition or large planning group and; others related to confusion as to when or how to engage the community. It is also our assessment that some of this relates to language use and can be helped if we clarify terms and expectations as discussed in more detail below. Also, one site that had started a coalition is now facing a challenge because the staff person in charge of running it has left, placing the coalition in jeopardy until the staffing situation changes.⁶

Graphic Two



For those questioning when to start and for what purpose, some of this will be answered as the state-level decisions are confirmed: Should they start before the state goals and strategies are finalized or after? Should it be for the purpose of selecting a state goal or for deciding how to develop an implementation strategy in response to the State goal? Or, are they asking their community to pick among pre-set goals and strategies (those determined by the PPEC and set by the Governor’s Advisory

⁶ A member of Vera’s capacity team has stepped in to facilitate for the past 2 months but we are concerned that if the staffing issue isn’t resolved soon, then the site will be left without long-term capacity. We have agreed to continue this role until February 2009 and will reassess at that time.

Council) and then adapt/refine the prescribed implementation strategy to fit their community's values and needs?

Another level of attention to be paid is related to those sites that have started a process of community engagement before these questions are clarified (Graphic Two). For example, some may be wedded to a true/pure community driven process – calling the community together with a wide-open mandate to determine what goals and outcomes *they* want to achieve in relation to prevention. This open strategy of community engagement may, in the end, lead to locally defined goals and strategies which have little relation to the state-identified goals and strategies - an unintended consequence of having them start before the framework has been solidified.

Technical assistance recommendations for how to address these concerns vary according to the source of the resistance⁷ or confusion, and the degree to which the state needs to be prescriptive. For example, for those resistant to creating another ongoing coalition for the purpose of drafting the prevention plan and/or serving as the decision making body, we recommend giving sites options/models for gaining community input and buy-in, but that do so without requiring the monthly coalition meeting format. Or in other cases, a site with many existing coalitions could develop a workgroup on prevention within an existing structure. For sites without the capacity to run monthly coalition meetings, we would suggest a format in which they host a defined number of community forums to assess community priorities and values related to primary prevention (or in relation to vetting the State goals and needs statements) and then have a small working group (3-5 staff and volunteers) create a plan with these community priorities in mind. They could also develop feedback loops or check-in periodically with vested community members.

For use by all sites, we also recommend creating “operational” definitions for key terms such as Coalition and Community Mobilization. We believe that some of the resistance may be related to confusion about the difference between these terms and others (Steering Committee, Planning Group, Task Force).

It is our understanding that the SCBT is less concerned with what sites call their groups and more concerned that each site attempts honest efforts to include community input into the SVP's primary prevention efforts. One way to move attention away from jargon is to create behaviorally focused definitions outlining what actions and results the SCBT expects to see and then give people choices as to how to meet the expectation. For meeting the expectation of community engagement, we suggest creating a continuum of behaviors/actions checklist that represents a number of ways to engage communities from which the sites could pick and choose a set number, or score, that work best for their specific situation. This way, sites understand “what” level of community engagement is expected but have options for determining “how” the engagement occurs and what to call it. All sites would be

⁷ Resistance due to lack of capacity (staff, skill, personality type, support from host agency or executive director) would be addressed differently than resistance due to bad past experiences.

expected to engage their community, but they would not all be doing it in exactly the same way.

Questions and Considerations:

- Timing between local and state level decisions is a critical question for when the SVP should engage their communities as is defining the clarity of purpose for these groups.
- For sites that truly lack capacity (not desire) to successfully manage a large-community driven process, creating graduated expectations is vital - expecting their long-term prevention efforts to be equal to other sites that have more experienced staff and organizational support beyond RPE funds may set them up for failure. The point would be to encourage growth to whatever extent is realistic, but not put them at risk for failure.
- For sites with only a 0.5 FTE staff time for primary prevention and little agency in-kind contributions, off-the-shelf models or existing (or developed) products to guide their strategy will be needed.

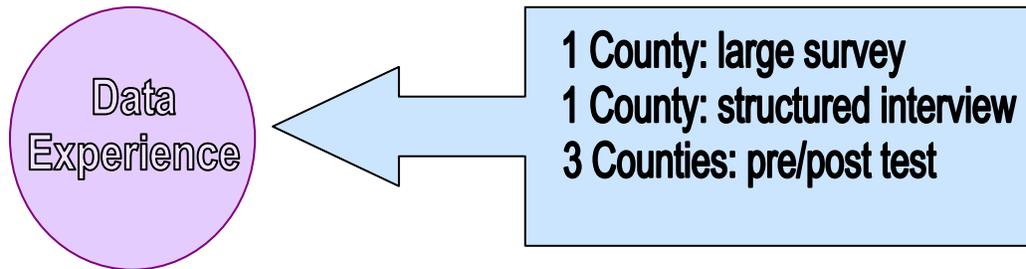
III. Data Collection:

The SVP's varied greatly in their understanding and capacity related to collecting and analyzing data - especially how to determine their specific community's needs in relation to which risk factors for sexual violence have the most relevance in their community. This is not surprising given the "newness" of the field of sexual violence primary prevention and the lack of secondary data sources related to this topic.

Where sites did collect data, it related mostly to counting program activities and numbers of clients served. Sites also varied in their use of data and evaluation related to current programming. Most sites doing outreach did not formally evaluate outcomes but focused more on satisfaction surveys. However, as shown in Graphic Three, some sites do have experience using pre- and post-test tools for some of their programs. While individual site's experience with data collection has implications for planning efforts, it will have special relevance during the implementation stage if individual sites are expected to do formal outcome evaluations at the local level.

Sites with the most expertise with data collection include: 1.) First county SVP just completed a large-survey related to their re-branding campaign (300 + surveys returned), but it was stressed that they lacked a consistent capacity to regularly analyze data that is collected; 2.) 2nd County SVP created pre- and post-test tools related to Expect Respect and completed roughly 30 structured interviews with community stakeholders regarding their opinions related to sexual violence prevention; 3.) University SVP has evaluation experience related to the original development of the SCREAM Theater and its access to academic resources on campus; 4.) 3rd County SVP reported that they regularly collect, analyze, and use data to make decisions and has used pre-and post-test tools; and 5.) 4th County SVP has used Middle School Student Attitude Survey © by Committee for Children, 2004 to test its pilot project. While all of these sites collected data, they varied in their consistency for data collection, analysis, and use in decision-making.

Graphic Three



To assist with data collection issues related to the planning phase, the Vera Team is drafting a “Frequently Asked Questions and Answers” sheet and a short handout containing places where data relevant to *prevention planning* can be found. We are also working to draft a list of questions for consideration before beginning a data search. In addition, we think it is valuable for sites to have a solid background of the process that the state used to get to this point. Thus, we will be editing a two-page overview document outlining this history to date (taken from the draft reviewed by Regina Podhorin and the email sent to the sites by Mary Giovinazzo).

Questions and Considerations:

- Most sites creating original programming will need extensive support if substantial expectations exist that the local site will be responsible for collecting outcome data.
- Because the document entitled: “Final Need, Goal, and Outcome Statements for Sexual Violence” (dated January 23, 2008) lists very specific outcomes to be reached related to each goal, sites are concerned that they are the ones expected to measure these outcomes. Clarifying the degree to which sites are expected to capture outcome data versus what outcomes that the State will measure will be needed as the goals and needs statements evolve.

IV. Possible Foundational Programs:

As shown in Graphic Four six sites have programs for which they have done extensive work to develop and which, with expansion, could be used as a foundational tactic from which to build a larger strategy⁸ should they decide that this direction is the most relevant for their community. We also believe that these programs speak to the site's capacity to develop and design new programs or adapt existing programs. Sites would need to develop complementary tactics to sufficiently address the nine principles of effective primary prevention and to address multiple levels of the social ecological framework. In addition, all sites would need to develop or adapt program evaluations to reflect the various new tactics of the selected strategy.

Graphic Four

Foundational Programs

Part of the Solution

Extensive men's campaign supporting pro-social messages for men and boys regarding violence against women. It includes a public pledge ceremony and has a broad-based community media distribution strategy.

Denim Day Plus

Awareness day plus follow-up freshman assembly (300+ students) followed by breakout workshops for discussion groups and art projects related to sexual violence.

Act It Out

Currently under development—a socio-drama program using skits and workshops run by student volunteers to teach other students skills for addressing sexual violence.

Peer Education Program Using Expect Respect & Choose Respect

Currently suspended to do prevention planning—Ocean had developed a two-day session with middle school aged students addressing healthy dating and relationships including prevention of sexual violence.

SCREAM Theater & SCREAM Athletes (see full report for analysis of 9 principles)

A freshman and athlete orientation program for college-aged students. SCREAM uses skits to demonstrate real-life scenarios for the purpose of education and awareness regarding responses to situations involving sexual violence.

Steppin' Into Manhood (see full report for analysis of 9 principles)

A day-long annual conference for young boys addressing issues regarding cultural expectations of manhood and providing knowledge and skills to develop healthy relationships and avoid domestic and sexual violence.

Interpersonal Violence Prevention Program (see full report for analysis of 9 principles)

An 8-week, multi-level, interactive pilot program encouraging healthy relationships and social competence in middle-school aged students. It included a component in which students participated in developing a program to address violence-related issues in their school community. It used program outcome measures including pre and post-tests.

⁸ Vera uses the word strategy to mean the overall plan of action. We anticipate that each strategy will contain a number of tactics addressing multiple levels of intervention.

V. Final Thoughts:

The SVP's, as demonstrated by Graphic One, are in varying stages of change that include their internal capacity for primary prevention efforts. As described above, site capacity encapsulates a variety of factors including agency support, funding resources and staffing levels, with all sites not being equal. While some sites may be able to overcome some of these challenges, it is important for the PPEC to recognize these differences and limitations as they relate to primary prevention efforts.

Whatever the state's final decision, general impressions drawn from these initial site visits are that any plan should include graduated expectations to meet the varying degrees of capacity, especially if the priority is to continue funding all sites and to do so at the same funding level. If this is the priority, then what may work best is to create an a la carte menu from which sites with high capacity can choose goals and take ownership over strategies and a prix fixe menu from which sites with less staff and fewer supports can choose a fixed frame of reference upon selection—requiring less up-front resources. Any plans would need flexibility to be adapted to fit the cultural context in which they are used.

Depending upon priorities—having all sites do something versus having a few sites doing something more comprehensive—another consideration is to think of the Primary Prevention Implementation Plans as a competitive process. Sites whose plans are judged to be most creative and feasible would be given more resources for implementation than sites whose plans seem unrealistic or whose planning process shows low interest. This strategy would mean fewer sites doing comprehensive primary prevention but would likely result in higher levels of innovation. This would also mean that additional funds would need to be available for those sites whose plans are rated higher—either new dollars raised or decreased funding for some SVP's and increased funding to others, which may or may not be politically feasible.

As mentioned above, timing State and local decision making is key if the PPEC's objective is to be highly prescriptive. If local control in selecting strategies is preferred, timing PPEC decisions with local decision-making is less critical. If the latter is preferred, we recommend Vera's focus stay fixed on moving local sites toward their self-selected strategy. If the former is the case, we would recommend using some of Vera's resources to assist the PPEC to reach its objectives. Vera's objective is to promote a process that advances the tremendous work already accomplished by the PPEC and to do so in a way that respects the diverse realities of the SVP's and that ultimately leads us all to a world with less violence.

APPENDIX W

**February 2009 Presentation Evaluation Survey Results
Michael Haines Presentation on Positive Social Norms Marketing**

I am ...		
Answer Options	Response Frequency	Response Count
A member of the PPEC	29.0%	9
A local sexual violence provider	38.7%	12
Both	12.9%	4
VERA staff/consultant	16.1%	5
<i>answered question</i>		31
<i>skipped question</i>		0

2. We'd like to have your opinion on the effectiveness of the Feb 25th PPEC/RPE meeting content and your comfort with the material presented								
Answer Options	Strongly agree	Somewhat agree	Neither agree or disagree	Somewhat disagree	Strongly disagree	Can't answer	Rating Average	Response Count
The presentation on Positive Social Norms Marketing was an adequate introduction to the concept/strategy.	29	2	0	0	0	0	1.06	31
The written materials distributed before, during and immediately after the Feb 25th meeting were helpful in understanding this concept.	15	11	2	1	0	2	1.62	31
The Positive Social Norms Marketing approach should be an integral part of the Sexual Violence Prevention Plan	22	7	1	1	0	0	1.39	31

in NJ.									
Having both the PPEC members and local sexual violence providers learn about this strategy and discuss the implications together was helpful.	23	5	2	1	0	0	1.39	31	
Comments (as needed)								9	
								<i>answered question</i>	31
								<i>skipped question</i>	0

Comments on Question 2

- well organized and well presented. Mr. Haines did a good job of refocusing on how the strategies have been useful in other public service venues and how it might be used in the sexual violence field.
- I think it would have been more helpful for me to have been with my PPEC sub group to think about the way to utilize the approach. I found being with the SVPs limiting and that they had difficulty thinking outside of the box because they feel so overwhelmed with all they have to do.
- it is a good idea/ strategy, but is also expensive to do a good campaign. We also need more understanding on long term evaluation- we cannot use the same approach as a health model nor can we only use crime stats to determine effectiveness. It was clear that some members of PPEC do not understand sexual violence or the way our current SVPs work, so interaction together was not necessarily helpful, but didn't hurt...
- Excellent presentation. Very interesting and enlightening in many ways.
- I am concerned that the program staff has not had the benefit of the two years that the PPEC members have had to become completely familiar with the social norms concepts. I anticipate that the program will need a great deal of training on the concepts before they can implement them. The long history of focusing on victim services will make it difficult for some staff to make the shift.
- I didn't get pre-conference materials but did appreciate the PowerPoint handout. A 101 article would have been helpful too. Thought it was great that PPEC and SVP staff were together in one room. Think it would have been helpful for folks to have had a bit more orientation on the role of the PPEC and the context for how SNM fits into the overall vetting process going on at the state level. Some left with the impression that the state now wants them to do SNM at the local level -- despite the warning that Regina gave about don't run out and do this tomorrow. Maybe a visual graphic would be helpful to understanding

the overall process. Vera team is creating a handout on PPEC vetting process that we can share.

- His handouts didn't exactly match the powerpoint presentation, which made it more difficult to follow along.
- I think this was a great opportunity for local providers to see what the PPEC is doing and how this will affect them.
- Very Exciting concept

Which of the following implementation options for Positive Social Norms Marketing in NJ make the most sense:(check all that you agree with)		
Answer Options	Response Frequency	Response Count
The State Planning Team should pilot this approach in only a few targeted sites before considering expanding implementation	54.8%	17
Any local program that chooses to implement this strategy should be encouraged to do so.	51.6%	16
Our local Sexual Violence Program would like to implement this strategy but we need to build our capability first.	22.6%	7
The challenges expressed during the session outweigh the advantages of this approach/strategy. This strategy should not be implemented in NJ.	3.2%	1
The State Planning Team needs to do significant capacity building in NJ before implementing this approach either in pilot sites or more broadly	51.6%	16
Other (please specify)		8
<i>answered question</i>		31

3. Other (please specify)

- I am not sure whether it would be most beneficial for the planning team to build capacity for the whole state before piloting or working with programs that feel they have the capacity to use this in a pilot program while building capacity for other programs that might need more help.

- Part of the Social Norms Approach was beginning small and moving towards a larger goal and I think in order to get Prevention to really work we cannot work as effectively as we need to with a large statewide movement and we need real collaboration from the people who are leading the movement in the counties.
 - Capability is not a factor for us- we have the capacity, appropriate partnerships, but need the money to be able to implement.
 - Because SNM is new for the sexual violence field, crafting the messages (identification of what is the positive norm to be marketed) really needs to be developed and tested first. SVPs should play a role but should not be expected to be able to develop and test key messages on their own. Asking them to start from scratch is a bit like asking the doctor who practices medicine to develop the drugs that they prescribe—they need to play a role in the monitoring and testing but research & development needs to do its part first. Piloting with support from SNM experts and researchers together with local practitioners requires more resources than most SVP have at this time. Consideration about audiences outside of university settings also needs to be explored regarding saturation etc.
 - I believe the most efficient strategy would be a campaign developed at the state-level that can be altered and implemented at the local-level (with state support).
 - There needs to be a clearer understanding of how data would be gathered and aggregated by the local providers. Otherwise, I believe, most if not all programs should implement this strategy.
 - I think a lot of capacity building will be necessary to implement this strategy. Local programs are already in over their heads with the work they are doing, let alone adding primary prevention. This technique could be very useful in preventing sexual violence but has to be done strategically so the programs are prepared and have the capacity to do all the work involved in this strategy.
 - Ideally, the State Planning Team would develop the strategy and find funding for the evaluation, and implement on a statewide level with assistance from local sexual violence programs
- 4. Please tell us any specific uses of the Positive Social Norms Marketing strategy that you thought of during or after the Feb 25th session.**
- More messages promoting healthy sexuality and intimacy as opposed to anti sexual violence, more along the lines of the "my strength" ads.
 - Rather than solely addressing the risk factors we need to develop and research protective factors, reasons behind why some men are not committing sexual assault and determine what the scope of masculinity is as the youth define it. We need to begin talking and engaging the youth about their feelings and attitudes towards sex, power, masculinity, etc.

- With regard to the Empathy and Attachment goal, I thought there were several positive norming messages that could be utilized with parents ie; most parents don't hit their children, most parents spend at least 30 minutes each day in an uninterrupted conversation with their child, most parents.... addressing risk factors that contribute to a child becoming a perpetrator.
- This is something that my community is ripe for and so, I thought of many different groups to partner with or areas to focus on. If we end up using social norms marketing as part of our plan, we will continue to focus on bystander intervention
- I have reiterated the need to change the language of our movement from the language of deconstructing disease to the language of modeling health
- Getting positive message to boys and men is key to moving the work/field forward and a pro-social norm messaging is a good way to build allies. Working "for" something is more energizing then working "against" something.
- Not sure what you're asking here.
- I think it could be incorporated into some of the Green Dot work with college groups.
- I think this would work very well in specific school settings, and with small communities. It will be much harder to implement in larger communities considering the monetary restrictions we are up against. I can see this strategy working very well in the schools I am already presenting in.
- Gender Quality Norms, Bystander Intervention
- Use inside high schools to help students understand reality vs. perception when it come to sexual violence and the prevalence of
- sexual violence when coupled with risk factors such as alcohol.

5. I feel: (choose one response)		
Answer Options	Response Frequency	Response Count
overwhelmed by the information provided on Feb 25th and the work ahead	0.0%	0
energized by the information provided on Feb 25th and the work ahead	38.7%	12

both overwhelmed and energized	51.6%	16
neither overwhelmed nor energized	9.7%	3
comment as needed		5
<i>answered question</i>		31

5. Comment as needed

- It was great to see the theory at work, but confusing and overwhelming to try to think about how to adapt it to something as secretive and shame-based for some as sexual violence is, it is different than smoking or binge drinking in that way. Not to say it can't be done, but that was what was overwhelming. I would love to see it happen!
- The Warren County Coalition is very energized and wants to implement a social norms strategy with the start of the September school year for high school students. I would love to have a DVD copy of Michael Haines' presentation to show them. So far they have only had my explanation and a copy of his material. It would be invaluable to show them the video.
- I love the approach, find it to be very effective and will finally address the issue with the goal of prevention.
- so many great opportunities but so little time
- I think this strategy could be implemented if coordinated at a state level with clear and concise information for how to be implemented at a local level.

6. Other than data collection and focus group facilitation, please specify any other training and/or capacity development you feel is necessary to implement a Positive Social Norms Marketing strategy

- Graphic design ideas, marketing ideas, guerilla marketing techniques, data analysis, market surveying skills – let’s face it, these things are all going to have to be done by the service providers, not professionals
- If this is an approach that the state really wants to pursue they might want to consider facilitating a group on the sociological concepts behind masculinity, power, norms, gender, etc. This is basically a sociological approach and you might want to make sure everyone understands the concepts behind this approach.
- Not sure
- I think there needs to be serious coalition building in the targeted areas. As many social service agencies, educational facilities, community and religious centers (e.g. churches) and state and local resources need to be brought together to maximize the success of the campaign.
- I think the program staff will need training that addresses how the theory works in particular for their programs.
- I think that sites needs more assistance working to find the best method for implementing this type of program and the ways by which to develop an effective campaign - all of which would benefit from data collection and focus groups.
- I think what would work best is to have a SNM development team [made up of PPEC members, an expert like Michael, a local researcher, a marketing firm rep, a development person, and 2-3 willing SVP pilot sites (preferably those a full-time staff member)]. The team could work together to develop a local campaign that other SVP sites could eventually use or adapt to their efforts/audiences. There would also need to be money to produce and reproduce “products” that develop out the pilot.
- I would assume that there needs to be a buy in process for the campaign on the local agency level.
- How to analyze and use the data that is collected.
- We will need more training for staff on marketing strategies. We are too far behind we are just beginning to collect data via focus groups. then we need to look at how our local programs can

target groups. We will need \$ and additional staff to offer successful norms change.

- I think some more training on creating positive messaging would be helpful. How do we get pictures and such? I know the messages will come from our audience but how do we go about producing those messages?
- Evaluation of impact
- Finalized goals.

7. The state prevention planning process is moving along at the right pace, considering the complexity of the issue and information.		
Answer Options	Response Frequency	Response Count
Strongly agree	17.2%	5
Somewhat agree	37.9%	11
Neither agree or disagree	20.7%	6
Somewhat Disagree	13.8%	4
Strongly disagree	0.0%	0
Don't know	10.3%	3
Comments:		12
	<i>answered question</i>	29
	<i>skipped question</i>	2

7. Comments:

- My response surprised me, but recently I've been invited to participate in a committee on homelessness, and the process they are using is clearly trying to address an outcome without first doing foundation work and it seems destined for failure. I think the time we have taken to research topics and inform our decision making has been tremendously helpful to developing interventions that are likely to be effective. I feel really good about what we've done.

- The concern is that the need and ability to provide victim service intervention is not going to go away for some considerable time and it is not likely that programs will abandon this mandate regardless of any other initiatives around prevention, which leads to a connected dilemma of funding sufficiency.
- It is very much a stop and go process and not well timed with what local programs are doing or are required to do.
- I'm not sure what the pace is as I don't seem to get any updates on their progress.
- While the PPEC might be moving at an adequate pace, it is difficult for sites to be moving forward when they feel that the state has only gotten so far and does not have all the answers/resources they need at the site level.
- I believe that state should have had a more solid plan before the SVPs started working, because to then go in and tell SVPs that they need to change their plans to fit the state's recommendations could mean SVPs are wasting time and resources.
- The TA team feels pressure to get answers to the sites about what exactly is expected of them but also understand that the work is complex and consensus takes time. I also think that when the time is right, the PPEC should consider investing in further developing what it is finding in the way of foundational programming – we are encouraging sites to think in terms of an overall strategy (one goal with multiple tactics across multiple levels = a comprehensive strategy) vs. just doing a “program.” We are calling most of what is being vetted “foundational programming” from which sites can build their own comprehensive strategy. Some sites will lack staff capacity to further develop foundational programming on their own so having the PPEC help with developing some products would be nice. See answer in number 6 above.
- As a PPEC member, there are times when I feel overwhelmed at the amount of work that is being requested from me.
- Feels like we're doubling our efforts on the state and local levels.
- This is a hard question for me to answer. I think it is foolish that some programs are choosing strategies or are doing their own strategies while the state planning team is still planning. I think some of the programs may be getting ahead of themselves because they need something to do. I just fear that they will be back tracking when the state planning team is done planning.
- The local sexual violence programs are being asked to develop a prevention plan for one of the state goals by July 2009, but the PPEC has not yet finalized the goals nor provided best practice strategies for each of the goals.
- I think it would be helpful if the state were farther ahead in the planning process than the individual centers, and therefore able to offer more concrete guidance.

8. Please tell us if there is something we can do to make future meeting times more productive and/or engaging...

- more meetings like 2/25
- I thought the meeting was extremely engaging and productive. I wish maybe we could have really collaborated about how this approach could work with SVP.
- Although the meetings often feel a little too long, I think the process has been productive.
- the TA meetings have gotten much more interesting/ worthwhile as the past year or two has gone on. so keep it up!
- give a clear outline of the next steps/phase of the process
- Speakers are a key, I think.
- This was a great meeting! Having the opportunity to hear different people speak about different programs is wonderful!
- Overall I thought the presentation was great. Thanks for inviting us to attend! Also, thanks for taping the session and please let us know how to tell sites about getting access to the footage in case they want to use it to educate their agencies and to keep their local coalitions motivated and "in-the-loop" about current thinking at the state/PPEC level. Nice meeting and meeting location.
- I think everything worked out great!
- More information on prevention strategies. This session was great.
- There needs to be some sort of forum for centers to share successes and challenges regarding the prevention process.