New York State
Department of Health

Sexual Violence Prevention Plan:
Preventing Sexual Violence in New York State

2009-2017

EXECUTIVE SUMMARY

The New York State Department of Health (NYSDOH) entered into a new cooperative agreement with the Centers for Disease Control and Prevention (CDC) in 2007. The purpose of the agreement is to build and enhance capacity to prevent sexual violence from initially occurring by preventing first time perpetration and victimization. The Cooperative Agreement requires the following:

- development of a long-term statewide sexual violence prevention strategic plan that utilizes a public health approach to support comprehensive primary prevention program planning within the social-ecological model;
- building individual, organizational and community capacity for prevention using effective prevention strategies;
- applying the principles of and an evaluation of the prevention strategies and programs implemented as part of this plan.

The CDC Rape Prevention and Education (RPE) Program also requires the establishment of a Sexual Violence Primary Prevention Committee (SVPPC) to help assess the current state of sexual violence primary prevention activities and provide input to the state on the development of comprehensive primary prevention programming. The New York State SVPPC was convened by NYSDOH in February 2007. The committee is composed of key state and community partners involved in the prevention of sexual violence. The SVPPC met regularly to develop a sexual violence primary prevention plan for New York State (NYS) and has been an integral part of the comprehensive primary prevention program planning process. At these meetings, members reviewed pertinent documents and NYS data; identified opportunities for capacity building and prevention activities; and, developed and agreed on goals, strategies and outcomes for the plan.

The NYSDOH Sexual Violence Primary Prevention Plan (SVPPP) focuses on community and population-based prevention strategies including the social-ecological model developed by the World Health Organization (WHO) and adapted by the CDC to understand the origins of sexual violence and potential opportunities for prevention. This model looks at the complex interplay between individual, community, and societal factors that put individuals at risk for experiencing or perpetrating violence. Primary prevention focuses on the identification of these risk factors and the development of strategies to influence these factors. As most victims of sexual assault know their perpetrators, it is increasingly important for vulnerable populations, their families, and social support systems to know how to not only provide protection, but also to promote the intolerance of sexual exploitation and sexual harassment at the community and societal level.

To develop this plan, data were reviewed related to the incidence and prevalence of sexual violence in NYS and in the nation. A literature review was performed to understand the impact of sexual violence and identify best practices related to prevention of sexual violence. Risk and protective factors based upon personal and social characteristics that increase or decrease the likelihood of sexual violence are described, and prevention strategies are incorporated into the strategic plan. The plan also includes an overview of state and local primary prevention resources, along with an inventory of the available training and education programs. Finally, the plan includes a comprehensive set of goals, strategies and activities to guide the implementation process; a statewide infrastructure to support implementation of the plan; and a

plan to monitor and evaluate the plan's success, guided by a logic model and supported by ongoing program reporting.

The three key goals indentified in New York's plan are:

Goal 1: Foster leadership and strengthen coordination of programs at the state level to prevent sexual violence.

Goal 2: Increase the capacity of local organizations to effectively implement evidence-based and promising strategies to prevent sexual violence.

Goal 3: Create a respectful society changing social norms to empower youth and adults to intervene with peers when necessary to prevent sexual violence.

These goals are discussed in detail in Section VII below. It should be noted that the SVPP plan is a living document to guide the implementation of goals, objectives and activities over the next seven years. The plan will be adapted, as needed in response to changing needs and opportunities.

Table of Contents

Acknowledgements

The New York State Department of Health would like to acknowledge the contributions of the Sexual Violence Prevention Planning Committee to the development of the state Sexual Violence Prevention Plan. We appreciate the time, dedication and level of commitment of each committee member, which is reflected in this plan.

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II. PLAN DEVELOPMENT PROCESS

An integral component of the planning process was the development of the NYS SVPPC. The committee is composed of a diverse group of stakeholders from various backgrounds including representatives from State and New York City (NYC) public agencies, rape crisis centers, university and college officials and advocacy organizations. In addition to NYSDOH, key state agencies involved in the planning process include: NYS Office for the Prevention of Domestic Violence, NYS Developmental Disabilities Planning Council, NYS Division of Criminal Justice Services, and the NYS Office of Alcoholism and Substance Abuse.

The SVPPC has met regularly since its inception both in-person and via phone to develop a sexual violence primary prevention plan for NYS and has been an essential part of the comprehensive prevention planning process. At these meetings, members reviewed national and NYS data from a variety of sources; identified specific concerns related to primary prevention in NYS; reviewed best practices related to primary prevention; reviewed current primary prevention service capacity; and, agreed on goals, strategies and outcomes for the plan.

The SVPPC used a public health approach to address the prevention of sexual violence, focusing both on the health of an entire population and on the at-risk population of young people age 10-21 years, including high-risk youth (youth in foster care and in the criminal justice system, lesbian, gay, bisexual, transgender, and questioning youth and youth with disabilities). This approach included: using data to identify the incidence of sexual assault in the state; identifying and addressing regional, ethnic and cultural disparities; and, identifying and implementing best practice approaches to decrease the occurrence of sexual violence with the ultimate goal of eliminating sexual violence in NYS communities. This is consistent with the public health approach to sexual violence prevention defined by CDC, which contains the following four steps:

1) *Define the problem* - Data can provide answers to questions of how much sexual violence is happening, where it is happening, and who are the victims and perpetrators. Data sources may include the criminal justice system, emergency rooms, rape crisis centers, and general public surveys. To develop this plan, available data was reviewed to obtain as clear a picture as possible related to sexual violence in the State.

2) *Identify risk and protective factors* – Research has identified some of the factors that may put people at risk for sexual violence perpetration and/or victimization and protect them from harm. The research on sexual violence prevention was reviewed by NYSDOH in conjunction with the SVPPC to inform development of this plan.

3) *Develop and test prevention strategies*- Whenever possible, programs responsible for implementing the SVPPP should utilize curricula that have been evaluated and identified as evidence- based or as promising practices. When such curricula are unavailable for specific target populations or settings, data gathered from the experiences of practitioners working with various groups and through community assessments, stakeholder interviews, and focus groups may be useful for designing prevention programs that increase program acceptability among the intended audience.

4) *Ensure widespread adoption* - Once the evidence (e.g. data, outcomes, etc) supports an effective prevention strategy, the goal is to establish the prevention strategy as a standard in the field of sexual violence prevention. In NYS, prevention strategies known to be effective should be adopted and implemented in a variety of settings to the extent that resources permit and should replace ineffective strategies. The newly-established NYSDOH funded Centers of Excellence will provide technical assistance on primary prevention program development with all funded RCSVP Programs.

The SVPPC's public health approach included two complementary models which helped identify risk and protective factors and guided the development of prevention strategies. The Social-Ecological Model addresses cultural norms and beliefs as they relate to sexual violence. The Spectrum of Prevention provides prevention approaches that relate to the Social-Ecological Model. These models are complementary as they seek to challenge existing cultural norms and beliefs that may support sexual violence at multiple levels.

The Social-Ecological Model

The Social-Ecological Model considers the complex interplay between individual, relationship, community and societal factors. It provides a framework for addressing the factors that put people at risk for experiencing or perpetrating violence.[1] The core belief of the social-ecological model is that human behavior does not occur in a vacuum, and that behavior is a complex interaction between individuals, their families, their communities and the societies in which they live.

Prevention strategies should include a continuum of activities that address multiple levels of the Social-Ecological model. These activities should be developmentally appropriate and conducted across the lifespan. This approach is more likely than any single intervention to sustain prevention efforts over time.

The levels of the social-ecological model are described below:

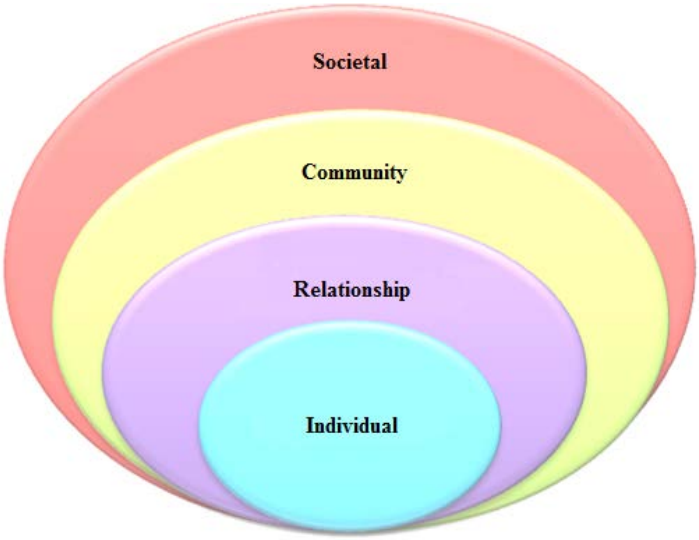
- **Individual** influences are biological and can include personal history factors that increase the likelihood that individuals will become victims or perpetrators.

- **Relationship** influences are factors that increase risk as a result of relationships with peers, intimate partners and family members. A person's closest social circle can shape the individuals behavior and range of experience.

- **Community** influences are factors that increase risk based on community and social environments and include individuals' experiences and relationships with schools, workplaces and neighborhoods.

- **Societal** influences are larger, macro-level factors that influence sexual violence such as gender inequality, religious or cultural belief systems, societal norms, and economic or social policies that create or sustain gaps and tensions between groups.

Figure 1: The Social-Ecological Model



Spectrum of Prevention Model

The Spectrum of Prevention model, which was originally developed in the 1980s by Larry Cohen and Susan Swift of the Prevention Institute, is another concept used when developing the goals and objectives of this plan. Since its development, this model has been modified to reflect the primary prevention of sexual violence. The Spectrum of Prevention provides a framework, complementary to the social-ecological model, for thinking about various categories of preventive approaches and shows that the elimination of complex social problems, such as sexual violence, requires more than one strategy.[2] Prevention efforts need to simultaneously occur on all levels of the Spectrum (Figure 2).

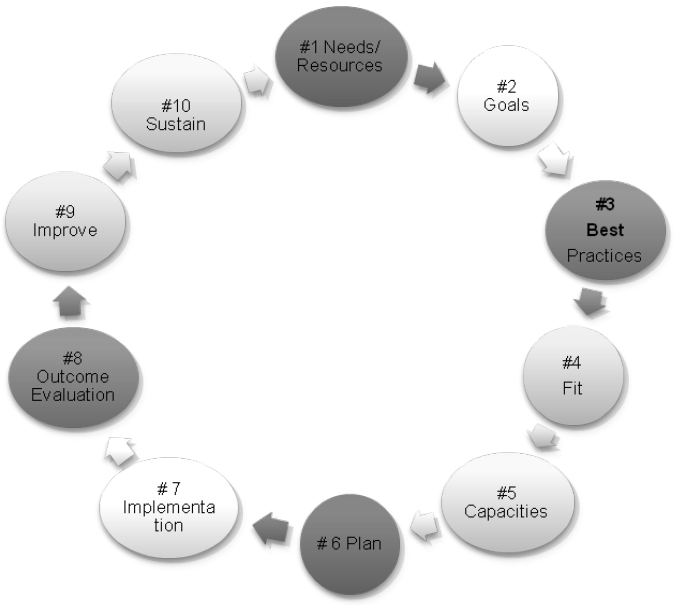
Figure 2: The Spectrum of Prevention

Strengthening Individual Knowledge and Skills	Enhancing an individual's capability of preventing injury or illness and promoting safety.
Promoting Community Education	Reaching groups of people with information and resources to prevent violence and promote safety.
Educating Providers	Informing providers who will transmit skills and knowledge to others and model positive norms.
Fostering Coalitions and Networks	Bringing together groups and individuals for broader goals and

	greater impact.
Changing Organizational Practices	Adopting regulations and shaping norms to prevent violence and improve safety.
Influencing Policies and Legislation	Enacting laws and policies that support healthy community norms and a violence free society.

The SVPPC utilized the Getting to Outcomes (GTO) planning process, which includes ten steps referenced in Figure 3. GTO is a program planning model designed to provide organizations with methods and tools to develop a comprehensive and systematic approach to accountability. GTO promotes user-friendly methods for planning, implementation, evaluation, and sustainability. Steps one through six of the model focus on planning, and steps seven through ten focus on implementation, evaluation and continuous improvement.

Figure 3: Getting to Outcomes



An initial step in the GTO planning process was to create a vision statement and a shared definition of sexual violence to ensure that all SVPPC members came to consensus on a

definition. A shared definition supports a consistent and integrated approach to primary prevention efforts across programs and settings. The NYS SVPPC adapted the World Health Organization's (WHO)[3] and CDC's definition[4] to emphasize the importance of consent.

The vision statement and shared definition of sexual violence adopted by the committee are as follows:

- SVPPC Vision Statement: Respect will be a foundation of our community culture leading to the elimination of all forms of sexual violence.

- Sexual Violence Definition: Sexual violence is defined as any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, acts to traffic, or other activities directed against a person using coercion by any person, regardless of their relationship to the victim, in any setting, including but not limited to home and work. The ability to give consent is an important consideration in any sexual act. A person who is unable to understand the nature or condition of the act in order to decline participation, or to communicate unwillingness to engage in the sexual act, e.g., because of illness, disability, age or the influence of alcohol or other drugs, or due to intimidation or pressure, is unable to give consent. [3, 4]

III. STATE PROFILE

A. Population

NYS is notable for its great diversity. According to the 2008 American Community Survey, NYS's total population was more than 19 million people (19,490,297), including 9.9 million (52%) females and 9.3 million (48%) males. The median age was 37.4 years. Twenty-three percent (23%) of the population was under 18 years, 10% were 18-24 years, 28% were 25-44 years, 25% were 45-64, and 13% was 65 years and older. NY is now the third most populous state in the nation, behind California and Texas with 6% of the U.S. population living in New York. NYC contains 43% of the State's population, with over 8 million people (8,363,710).

According to the 2008 American Community Survey, 67.2% of respondents reported their race as White alone, while Black or African American alone represented 15.9% of New Yorkers. 7.5% reported being Some Other Race. 7.0% stated they were Asian alone, and 0.4% reported they were American Indian or Alaska Native. Native Hawaiian or Other Pacific Islander accounted for only 0.03% of those reporting. Of New York State residents who selected Some Other Race, 93.4% identified themselves as Hispanic. Hispanics represent 16.7% of New York State's total population (Table 1).

In New York City, 28% indicated they were Hispanic. About 70% of Blacks and 43% of Hispanics/Latinos in the State reside in New York City. Among New York City residents, 45.7% reported their race as White alone, 25.6% reported Black or African American alone, 11.9% reported Asian alone, and 13.9% reported being Some Other Race. About 28% of New York City's population identifies themselves as Hispanic/Latino. Several counties outside of New York City have significant Hispanic/Latino population, as well. In Rockland, Nassau, Orange, Suffolk, Sullivan and Westchester Counties, Hispanics/Latinos make up at least 9% of the population.

Between 2000 and 2008, the Hispanic population increased from 13.9% to 16.7% of New York's total population. The percentage of Black or African Americans remained at 15.9% and the percentage of Asians increased from 5.5% to 6.9%.

Table 1: New York State Population by Race and Ethnicity 2008

Race Categories	New York Population		New York Hispanic Population			
	Number	% Total Pop.	Number	% of Total Population	% of Total Hispanics	% of Race Category
One Race	19,101,381	98.0	3,097,569	15.9	95.4	16.2
White	13,092,844	67.2	1,450,252	7.4	44.6	11.1
Black or African American	3,101,231	15.9	239,170	1.2	7.4	7.7
American Indian/ Alaska Native	72,575	0.4	21,745	.1	0.7	30.0
Asian	1,361,955	7.0	15,483	.1	0.5	1.1
Native Hawaiian/ Other Pacific Islander	5,908	.03	678	.00	.00	11.5
Some Other Race	1,466,868	7.5	1,370,241	7.0	42.2	93.4
Two or More Races	388,916	2.0	150,958	0.8	4.6	38.8
TOTAL	19,490,297	100.0	3,248,527	16.7	100.0	16.7

Source: 2008 American Community Survey

In addition to great cultural diversity, there is also great diversity in languages spoken in New York. According to the 2008 American Community Survey, of the estimated 18,285,349 New Yorkers over age 5, an estimated 12,977,510 speak only English at home, while 5,307,839 speak languages other than English. Of those speaking languages other than English at home, 2,443,942 speak English less than "very well." About 2,588,384 New Yorkers speak Spanish at home. In 2008, the New York State Education Department found that, of the 2.7 million students attending school in New York, 8.0% were identified as having limited proficiency in English.

B. Health Insurance and Overall Health

According to the United Health Foundation, the American Public Health Association and the Partnership for Prevention, which regularly assess the overall healthiness of the nation, New York ranked 24th in overall healthiness in 2010. Reasons for the ranking include: New York's ready access to primary care, high per capital public health funding and a low rate of cancer deaths in the state as compared to other states. The 2008 rate of uninsured New York State residents under the age of 65 was 15.8%, which compares favorably with the national rate of 17.3% without health insurance in 2008. In 2008, 49% of all obstetrical deliveries were paid for

by private insurance and about 2% were self-pay. The remaining 49% were funded by some type of government (47%) or other insurance (2%).

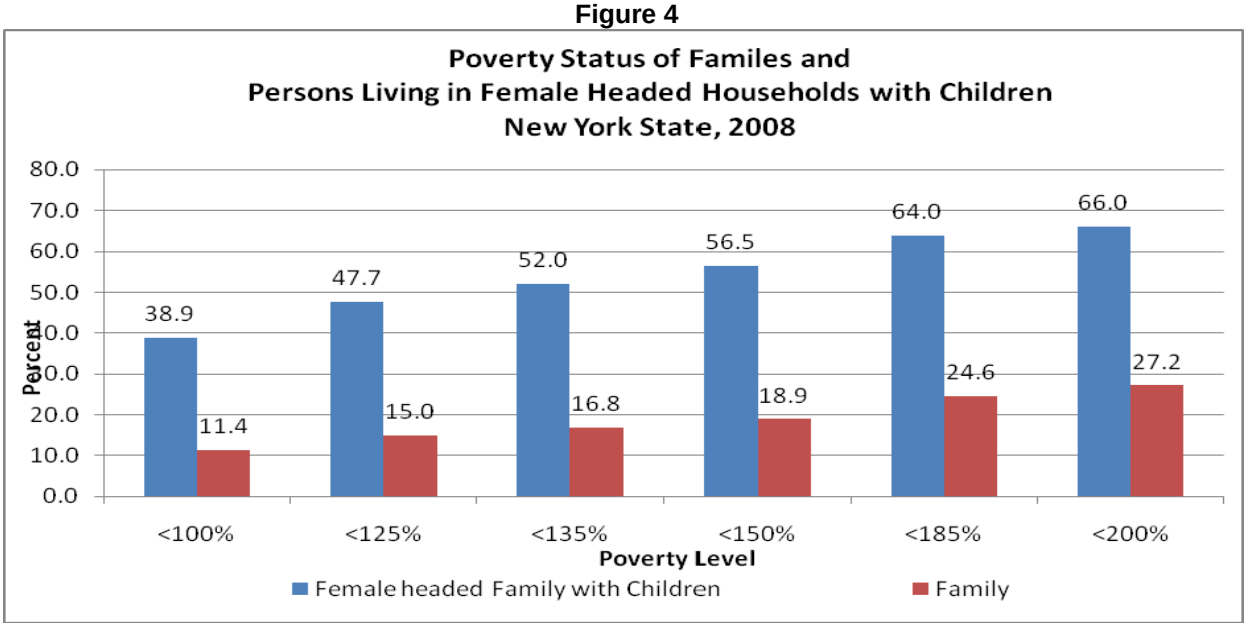
According to the Current Population Survey, in recent years the number and percent of children under the age of 18 in New York State who are insured has increased incrementally. More children under the age of 18 were insured in 2008 than in 1999 (92.9% vs. 89.8%). The percent of these children covered by government insurance increased over 20% since 1999 (increased from 30.6% in 1999 to 37.2% in 2008). This figure is expected to undergo even further improvement in the coming years, as coverage under Child Health Plus has been extended to children with incomes under 400% of the federal poverty level. Nationally, 9.4% of children under age 18 were uninsured in 2008, in NYS 9.9% were uninsured.

C. Poverty

Poverty is highly associated with poor health outcomes, especially for women and children. Poverty is most common in families headed by single females, and single-female headed households with children are more likely than other families to be living below poverty regardless of race or ethnicity (Figure 4). This is true regardless of race or ethnicity.

According to the 2009 Current Population Survey, during 2008, 38.9% of the people in female-headed households with children lived below the poverty level in NYS. For a female-headed household with two children, the Federal Poverty Level would be an income of $17,285 or less per year. Even at 200% of the poverty level, which includes 66% of female–headed families, the income level would be no more than $34,570. In 2008, 881,000 of New York's children (21.3%) were living below poverty. This is slightly higher than the nation as a whole (19%).

Figure 4



Source: Current Population Survey Annual Social and Economic Supplement, 2009

Poverty is associated with a greater likelihood of sexual violence; it can make individuals more dependent on others for survival and, therefore, less able to control their sexual safety, to consent to sex, and to meaningfully address their own victimization.[5] Sexual violence can jeopardize a person's economic well being, often leading to homelessness, unemployment, interrupted education and health, mental health, and other daily stressors and struggles.[6] Perpetrators of sexual violence target individuals who appear vulnerable due to gender, age, race, disability, sexual orientation, immigration status, income, or other reason. Poverty has a daily presence in the lives of many victims and survivors.

Persons with a household income under $7,500 are twice as likely as the general population to be sexual assault victims.[7] In a study of homeless women, 41% who were victimized as children did not complete high school. The same study found that 66% of homeless women were severely abused by their caretakers; 43% were sexually molested during childhood; and 60% of homeless women had been abused before the age of 12.[8]

D. Immigration

New York has always served as a major gateway for immigration and as an entry point for many new Americans. The 2008 American Community Survey collected information on the characteristics of legal native and foreign-born populations living in NYS. The following estimates are based on the American Community Survey findings:

- NYS had a foreign-born population of 4.2 million in 2008. This number represents 21.7% of the State's population, or about one in five people. Only California has a higher percentage (26.9%) of foreign-born residents. Nationally the foreign-born population is more than 304 million or 12.5% of the total population.
- There were approximately two million legal resident aliens and over two million naturalized citizens in NYS in 2008.
- NYS had more naturalized citizens than the country as a whole in 2008.
- NYS's immigrant population is diverse, with no particular region or country having clear dominance.

Immigrant women bring with them complex experiences from their countries of origin, including cultural patterns which both protect and make them vulnerable in their new environment. In many communities, immigrant women consistently face cultural and structural barriers in addressing domestic and sexual violence. In many cultures, violence against women has not been defined as a public problem. Domestic and sexual violence are still viewed as private matters, rather than societal concerns.[9] Poverty results in immigrant women being more likely to experience sexual violence.

E. Crime Victims Data

The true magnitude of sexual violence is difficult to assess because of the sensitivity of the subject. Violence against both men and women is greatly under-reported. Global estimates are that millions of people are experiencing violence or living with its consequences. Some of the most common and most severe forms of sexual violence include rape, sexual assault, trafficking, date rape, statutory rape, exploitation, child pornography, incest, intimate partner violence, prostitution, and drug facilitated sexual assault. Many forms of violence are ongoing rather than isolated incidents and can continue for decades.

Crimes involving sexual violence can result in severe physical and psychological problems, both immediate and long-term. The trauma associated with sexual violence crimes creates a significant health burden for survivors of sexual assault. Victims of sexual violence may experience a variety of long-term physical and psychological problems such as chronic pain, cardiovascular disease, gastrointestinal disorders, eating disorders, substance abuse, depression, risky sexual behavior, anxiety, low self esteem and suicidal thoughts and attempts. These health problems can lead to hospitalization, disability and death.

Crime related to sexual violence is a significant issue both nationally and in NYS. According to the U.S. Department of Justice, one of every six American women and one of every 33 American men has been the victim of an attempted or completed rape in his or her lifetime. It is estimated that 20% to 25% of college women experience attempted or complete rape during their college careers. About 44% of rape victims are women under age 18. Girls 15-19 are four times more likely than the general population to be victims of rape, attempted rape or sexual assault. Data collected by the National Crime Victims Survey and other sources indicate that women are more likely to report having been forced to have sex than males. Females reporting the first rape indicated the perpetrator was an intimate partner (30.4%), a family member (23.7%) or an acquaintance (20%).

Nationally, the lifetime rates of rape and attempted rape for women by race as of 1998 were: [10]

- All women: 17.6%;
- White women: 17.7%;
- Black women: 18.8%;
- Asian Pacific Islander women: 6.8%;
- American Indian/Alaskan women: 34.1%; and,
- Mixed-race women: 24.4%.

The NYS Division of Criminal Justice Services (DCJS) reported 2,767 forcible rapes in 2008. Since it is estimated that only 16% of sex crimes are actually reported, the numbers cited represent a small fraction of the sexual violence that may be occurring in NYS.

F. Domestic Violence and Sexual Assault

The Pregnancy Risk Assessment Monitoring System (PRAMS) is a surveillance project of the CDC and state health departments. PRAMS collects state-specific, population-based data on maternal attitudes and experiences before, during, and shortly after pregnancy. Initially, in New York State, the New York State Department of Health, through a grant from CDC, collected pregnancy related information from women who resided in areas in Upstate New York. In 2001, the New York City Health Department received a grant from the CDC to collect these data from women that resided in NYC. Table 2 presents a comparison of data related to domestic violence from the Upstate and New York City PRAMS surveys for 2004-2006 years.

Table 2: Domestic Violence

	2004		2005		2006	
Domestic Violence	Upstate	NYC	Upstate	NYC	Upstate	NYC
Abuse Before Pregnancy	4.3%	4.4%	3.3%	4.9%	3.2%	3.7%
Abuse During Pregnancy	3.2%	3.8%	2.8%	3.7%	5.1%	3.2%

Source: Pregnancy Risk Assessment Monitoring System, 2005-2007

A national study found that 2/3 of women who had been physically assaulted by their intimate partner had also been sexually assaulted by that partner.[11]

G. Adolescents

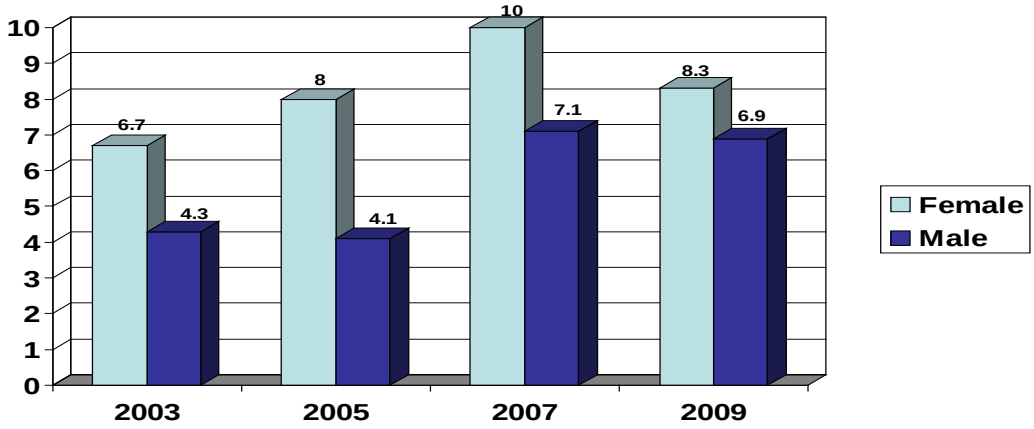
Sexual violence is a significant problem in the US affecting adolescents and adults. A national survey conducted in 2007 found that of those adolescents who experienced forced sex, 60.4% of females and 69.2% of males were 17 years old or younger at the time the first forced sex occurred. The National Crime Victims Survey and other national data sources indicate the following:

- In a national survey of high school students, 8% reported being forced to have sex. Females were more likely to report having been forced to have sex than males.
- Data from the National Survey of Children indicate that about 18% of women 17 and younger who had intercourse had been forced to do so at least once.
- The Bureau of Justice Statistics reported that in the 12 states with sufficient information to distinguish juvenile from adult rape victims, the majority (51%) of female rape victims were under age 18, more than twice their representation in the nation's population. In the three states that kept data on relationships between victims and offenders in rape cases with victims ages 12-17, a full 20% of perpetrators were identified as family members, while 65% were acquaintances or "friends" of the child victim.
- The Alan Guttmacher Institute reports that over 40% of mothers aged 15-17 had sexual partners three to five years older; almost one in five had partners six or more years older. With teen mothers in the 15-17 age range, 49.2% of the fathers were between ages 20 and 29.

There is a relationship between age of sexual initiation, number of partners, frequency of sexual activity, history of sexual abuse, and other risk factors particular to adolescents. In NYS, the 2009 Youth Risk Behavior Survey (YRBS) found the percentage of teens that have experienced sexual intercourse increases with age, from 28.0% of ninth graders to 62.6% of 12th graders. These numbers are comparable to the national average of 30.2% of ninth graders and 56.4% of 12th graders (2005 YRBS). Of New York students responding, 42% report ever having had sexual intercourse with 6.2% reporting having had sexual intercourse for the first time before the age of 13. 31.5% of high school students describe themselves as currently sexually active. Among students reporting that they are currently sexually active, 67.7% report using a condom at last sexual intercourse. In NYS, 9.6% of high school females and 11.2% of high school males

reported experiencing dating violence[1] with 8.3% of high school females and 6.9% of high school males reporting that they were ever physically forced to have sexual intercourse[2]. According to the 2009 New York State YRBS, one out of every eight female high school students and one out of seven high school males reported that they have been forced to have sex when they did not want to in their lifetime. Further information is needed to better understand the context of sexual violence for males and females, and to consider how to address violence, including any potential gender differences, through prevention programming. The Percentage of High School Students Physically Forced to have Sexual Intercourse by Year is presented for both male and females in Figure 5.

Figure 5: Percentage of High School Students Physically Forced to Have Sexual Intercourse, New York State, 2009



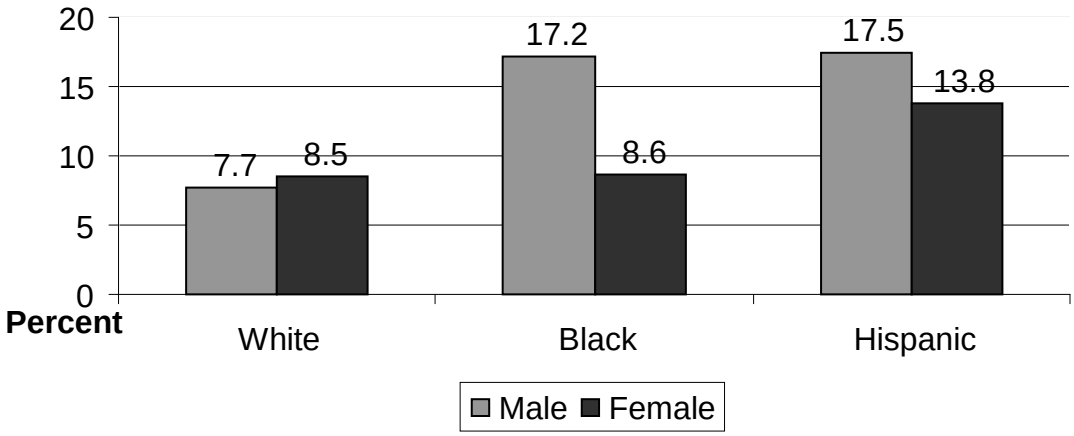
Source: NYS Youth Risk Behavior Survey

The 2009 YRBS also asked students about physical abuse. 10.6% of New York high school students reported they were physically hurt (hit, slapped or physically hurt on purpose) by a girlfriend or boyfriend in the past 12 months. The percentage of high school students physically hurt by a girlfriend or boyfriend by gender and race/ethnicity is shown is Figure 6. Rates were highest among Hispanic students (16.4%) compared to Black students (12.7%) and white students (8.1%). Males were more likely (11.2%) to report physical abuse by a girlfriend or boyfriend as compared to their female (9.6%) counterparts.

[1] During the past 12 months, did your boyfriend or girlfriend ever hit, slap, or physically hurt you on purpose?

[2] Have you ever been physically forced to have sexual intercourse when you did not want to?

Figure 6: Percentage of High School Students Physically Hurt by a Girlfriend or Boyfriend by Gender and Race, New York State, 2009



Source: NYS Youth Risk Behavior Survey

The New York City Alliance Against Sexual Assault, in collaboration with Columbia University Mailman School of Public Health's Center for Youth Violence Prevention, announced the results of a three-year, comprehensive research project on sexual and dating violence among NYC high school students, and the health impact of that violence. The NYC Department of Education granted researchers permission to anonymously enroll high school students with parental consent and the students' permission given the agreement of school principals and district superintendents. Students from four schools, reflecting a range of cultural groups, were asked to participate and over 1,300 high school students ranging in age from 13-21 were included in the analyses. The majority of participants were 15 or 16 years old. The study noted that NYC's young people are subject to sexual and dating violence at rates far higher than national average.

Results of the study are as follows:

- One in six participants (16.2%) reported having experienced sexual violence at some point in their lives, which is higher than the national average of between 7% and 10.2% of 12-17-year-olds who reported having experienced some form of sexual assault;
- 89% of those who have experienced sexual violence knew the person who perpetrated the victimization;
- 28% of those who reported having perpetrated sexual violence against their dating partner also reported having carried a weapon in the past month;
- 60% of youth who were physically violent with their dating partners also reported having engaged in other physical fights in the last year;
- Among those who experienced physical dating violence, more than one quarter (27.4%) reported having been pushed or shoved by a dating partner, and 17% reported having been slapped or hit;

- Almost 10% of students who reported having a dating partner in the last year said that their partner touched them sexually when they didn't want to be touched and 6.7% said they were forced to have sex against their will;
- Less than half (41.3%) of the students who self-identified as having experienced physical or sexual dating violence told someone about those experiences;
- NYC high school students are most likely to tell their friends about sexual or dating violence. 71.8% told friends first. Only 12.8% first told a parent about the violence; 11.5% first told another adult;
- Only 24.4% of youth experiencing sexual or physical dating violence sought help from a health professional, teacher or guidance counselor;
- Both victimization and perpetration of physical and sexual dating violence was linked with adverse health outcomes. Victims of sexual dating violence reported more frequent pain and illness symptom that results in high physical discomfort (31%) and higher emotional discomfort (28%) than teens who have not experienced sexual dating violence (20% and 18% respectively), and
- Victims of physical dating violence also reported poorer health status (28%) and lower self-esteem (25%) than youth who have not experienced physical dating violence (21% and 18% respectively).

Darkness to Light, an organization established to diminish the incidence and impact of child sexual abuse, reports the following on their website:

- Children who have been victims of sexual abuse exhibit long-term and more frequent behavioral problems, particularly inappropriate sexual behaviors.
- Women who report childhood rape are three times more likely to become pregnant before age 18.
- An estimated 60% of teen first pregnancies are preceded by experiences of molestation, rape, or attempted rape. The average age of their offenders is 27 years.
- Victims of child sexual abuse are more likely to be sexually promiscuous.
- More than 75% of teenage prostitutes have been sexually abused.

Some studies have indicated a strong link between early childhood sexual abuse and subsequent teenage pregnancy in industrialized countries. Up to 70% of women who gave birth in their teens were molested as young girls; in contrast, 25% of women who did not give birth as teens were molested.[12] Studies have indicated that adolescent girls are often in abusive relationships at the time of their conceiving.[13] They have also reported that knowledge of their pregnancy often intensified violent and controlling behaviors on part of their boyfriends.[14]

Persons with Disabilities

According to the Bureau of Justice Statistics, in the United States, nearly 730,000 nonfatal violent crimes were experienced by people age 12 or older with a disability in 2008. The violent crimes against people with disabilities included 40,000 rapes or sexual assaults. The rate of nonfatal violent crime against people with disabilities (40 per 1,000 persons age 12 or older, after adjusting for age) was about twice the rate for those without disabilities (21 per 1,000). The study generated age-adjusted criminal victimization rates for victims with disabilities, who are

typically older than victims without disabilities. In general, the age adjustment accounts for victimization rates that decrease as the age of victims increase.

Six types of disabilities were identified among persons who experienced criminal victimization: hearing, vision, cognitive, ambulatory, those unable to care for themselves, and those unable to live independently. A disability was defined as a sensory, physical, mental or emotional condition lasting six months or longer that makes it difficult for a person to perform activities of daily living. Among those measured, people with cognitive disabilities had the highest risk of violent victimization.

People with disabilities age 12 to 24 and age 35 to 49 were nearly twice as likely as people without disabilities to be victimized. Persons age 25 to 34 with and without disabilities experienced violence at about the same rate.

Females with disabilities (43 per 1,000 persons age 12 or older) experienced higher rates of violent crime than males with disabilities (36 per 1,000). About 27% of violent crime against females with disabilities was committed by an intimate partner (defined as a current or former spouse, boyfriend or girlfriend) compared to 1% of violent crime against males with disabilities. Nearly 15% of violent crime victims with disabilities believed they were targeted for violence due to their disability.

H. Violence in Schools

The following table shows data from the New York State Education Department (NYSED) on incidents at school, including forcible sex offences, other sex offenses and intimidation, harassment, menacing or bullying for the 2007-08 school year.

Table 3: Violent and Disruptive Incidents Reported in Schools by Region, 2007-2008

Incidents	NYS Total		Rest of State		New York City	
	N	%	N	%	N	%
Forcible sex	43	100	33	77	10	23
Other sexual offenses	2,872	100	1,115	39	1,757	61
Intimidation, harassment, menacing or bullying	25,158	100	19,459	77	6,699	23

Source: State Education Department

Note: Incidents reported under "Other sexual offenses" may not be consistently reported throughout the state.

A summary of the 2009 YRBS data on violence-related activities in schools documents the following:

- 13.9% of high school students reported carrying a weapon such as a gun, knife, or club on one or more of the past 30 days. Males were four times more likely to carry a weapon than females (21.4% vs. 5.7%).
- 6.4% of students reported that they had missed school because they felt unsafe at school or on the way to school, males at the rate of 5.9% and females at the rate of 6.6%.

- 7.5% of students reported being threatened or injured with a weapon while on school property. More males were threatened than females (9.9% vs. 4.7%).
- 29.6% of students reported being in a physical fight on school property one or more times during the past twelve months. 11.4% of students reported being in a physical fight on school property one or more times during the past twelve months.

I. Alcohol and Drug Abuse

Alcohol and substance use has been identified as a risk factor for sexual violence. Rates of drug, alcohol, and tobacco use are more than twice as high in girls who report physical dating violence or sexual abuse than in girls who report no violence. A summary of the 2009 NYS YRBS data on the use of substances (alcohol and drugs) indicates the following:

- 41.4% of students reported having had at least one drink of alcohol on one or more of the past 30 days; 20.9% had their first drink before age 13;
- 26.6% of males and 20.7% of females reported binge drinking (five or more drinks of alcohol in a row within a couple of hours, on one or more days in the last 30 days);
- 34.7% of students reported they had tried marijuana, males 37.9% vs. females 31.1%;
- 20.9% used marijuana one or more times in the last 30 days, males 24.7% vs. females 16.8%;
- 7.2% of students reported using cocaine, males 8.3% vs. females 5.4%;
- 10.8% of students reported they had sniffed glue or breathed the contents of aerosol cans to get high, males 10.3% vs. females 10.5%;
- 3.9% used heroin one or more times during their life, males 5.1% vs. females 2.3%;
- 4.8% reported using methamphetamines, males 5.9% vs. females 2.8%.

IV. RISK AND PROTECTIVE FACTORS

A. Risk Factors

Several important risk factors are associated with an increased likelihood of becoming a perpetrator of sexual violence. However, every individual who is identified as "at risk" does not necessarily becomes a perpetrator of violence. A complex interplay of individual, relationship, community, and societal factors are likely contributors to the risk of becoming a perpetrator of sexual violence. Risk factors for perpetration of sexual violence include[15]:

<u>Individual Risk Factors</u>

- Alcohol and drug use
- Coercive sexual fantasies
- Impulsive and antisocial tendencies
- Preference for impersonal sex
- Hostility towards women
- Hyper-masculinity
- Witnessed family violence as a child
- Childhood history of sexual and physical abuse

Relationship Risk Factors

- Association with sexually aggressive and delinquent peers
- Family environment characterized by physical violence and few resources
- Emotionally unsupportive familial environment
- Strong patriarchal relationship or familial environment (vs. family environments that are more egalitarian).

Community Risk Factors

- Lack of employment opportunities
- Lack of institutional support from police and judicial system
- Weak community sanctions against sexual violence perpetrators
- General tolerance of sexual violence within the community

Societal Risk Factors

- Poverty
- Societal norms that support sexual violence
- Societal norms that support male superiority and sexual entitlement
- Societal norms that maintain women's inferiority and sexual submissiveness
- Weak laws and policies related to gender equity
- High tolerance levels for crime and other forms of violence

Similarly, a set of risk factors, which place individuals at increased risk for sexual violence victimization have been identified. They are contributing factors and may or may not be direct causes. Not everyone who is identified as "at risk" becomes a victim of violence. Understanding these factors can help identify various opportunities for prevention.

Risk factors for sexual victimization include:

- Being young
- Consuming alcohol or drugs
- Having previously been raped or sexually abused
- Having many sexual partners

B. Risk Factors in New York State

The SVPPC assessed risk factors in New York State and assessed the correlation between known risk factors for rape, sexual assault and sexual violence by comparing county-level data from the Uniform Crime Reports, the Office of Alcoholism and Substance Abuse Services (OASAS) Prevention Risk Indicator Services Monitoring System (PRISMS) and Kids Count. The Uniform Crime Reports provided county-level information on the number of forcible rapes for 2004-2006. OASAS PRISMS identified community level or environmental risk factors that potentially impact all individuals, such as community disorganization, accessibility, adult alcohol and drug exposure, median family income, youthful arrests, drug outlets, teen pregnancy, being emotionally disturbed and drop-out rates. Data are provided for all of the counties in upstate and the boroughs of NYC. The information compiled from NYC is not as detailed as the other counties in the state. The Kids Count Data Book, which is released annually by the Annie E. Casey Foundation, profiles the well-being of America's children on a state-by-state basis and ranks states on measures of well-being. The data book provides state statistics on child death

rates, violent deaths of teenagers and juvenile violent crime. Kids Count is collected from various state organizations, compiled and presented for 65 regions: NYS, NYC, Rest of State (NYS minus NYC), and each of the state's 57 counties and five boroughs of NYC.

Using the Uniform Crime Reports for 2004-2006, the SVPPC calculated the average rate of forcible rapes per 10,000 females. Counties and boroughs were grouped into five categories of forcible rapes per 10,000 females as follows: <1, 1-2.99, 3-4.99, 5-6.99, and 7 or above. Using indicators from PRISMS and Kids Count, a statewide average was calculated for each risk factor using the county and borough rates. The county rates were compared to the statewide average for each risk factor to identify primary and secondary risk factors. Primary risk factors were characterized as those for which all counties in a forcible rape group had rates above the statewide average for that particular risk indicator. Secondary risk factors were characterized as those where all but one of the counties in a forcible rape group had rates above the statewide rate. Based on this methodology, primary and secondary risk factors for upstate and NYC are presented in Table 4. Data does reflect a difference in the number of respondents.

Primary and secondary risk factors identified through this analysis are characterized by upstate and NYC and presented in the following table. The majority of the risk factors in the upstate area were alcohol-related. Information about regional differences may help providers develop and target local strategies.

Table 4: Primary and Secondary Risk Factors by Region, NYS 2004-2006

Primary	Secondary
Upstate • Alcohol use • Drug use	Upstate • Poverty • Children in Foster Care
New York City • Other violent arrests • Youth arrest rate • Emotionally disturbed students	New York City • Poverty

Source: NYS Sexual Violence Prevention Plan Committee analysis

C. Protective Factors

Protective factors may lessen the likelihood of sexual violence victimization or perpetration by buffering against risk. These factors can exist at individual, relationship, community, and societal levels.

Limited research is available on protective factors for sexual violence in youth but it is thought that positive youth development (PYD) may help foster protective factors in youth. PYD is an ongoing process in which children and adolescents seek ways to meet their personal and social needs and build the skills and competencies to allow them to be successful in their daily lives. PYD recognizes the potential which children and adolescents possess and builds upon their strengths. Effective PYD actions are holistic in nature, using cross-system, multi-disciplined, collaborative and sustained community approaches.

The literature suggests that protective factors for youth include connectedness with school, having friends and adults in the community, and emotional health. The following protective factors occur at multiple social-ecological levels for all types of violence[16].

Multi-level protective factors include:

- Problem solving skills
- Sense of self-efficacy
- Good peer relationships
- Caring/respectful relationships
- Social support
- Support/belonging
- Availability of services
- Parental supervision

The Search Institute, an organization whose mission is to provide leadership, knowledge and resources to promote healthy children, youth and communities, has built a framework of developmental assets as an approach to positive youth development. Developmental assets represent the relationships, opportunities, and personal qualities that young people need to avoid risks and to thrive. The Search Institute conducted extensive research in youth development, resiliency, and prevention. Studies of more than 2.2 million young people in the United States consistently show young people are less likely to engage in a wide range of high-risk behaviors and more likely to thrive if they have more assets.[17] According to the Search Institute, the levels of assets are better predictors of high-risk involvement and thriving than poverty or being from a single-parent family. The average young person experiences fewer than half of the 40 assets. Boys on average experience three fewer assets than girls (17.2 for boys vs. 19.9 for girls).[18]

NYSDOH has infused the principles of positive youth development into all of its adolescent sexual health programs and funded initiatives. Using this approach, funded programs seek diverse opportunities for young people to learn, seek guidance, meet challenges, explore limits, experience consequences, develop self-confidence and self-control, help others, and improve their communities. A program that uses a positive youth development approach works with young people to help them realize their fullest potential.

V. CURRENT RESOURCES

As part of the planning process, the SVPPC reviewed NYS resources and assets to aid in sexual violence prevention. This is an important component of the state profile because of the need to build on existing infrastructure and create goals and strategies that complement or strengthen these resources so they are more useful in preventing sexual violence. The NYSDOH has devoted full-time staff to sexual violence prevention. Assets and resources are presented below: (it is important to note that this not an exhaustive list)

- NYSDOH-funded local Rape Crisis and Sexual Violence Prevention service programs across the state;

- NYSDOH-funded Centers of Excellence that support the Rape Crisis and Sexual Violence Prevention Programs
- Statewide and local advocacy organizations;
- Local coalitions that work to stop violence in all forms;
- Organizations working to prevent violence in all forms, such as rape crisis centers, child advocacy centers, domestic violence programs and shelters, local health departments and other public health programs;.
- Other NYSDOH-funded public health programs that serve children, youth, women and families, including adolescent pregnancy prevention and HIV prevention programs; home visiting and other community-based prenatal/postpartum programs for at-risk families and communities, clinical family planning providers, school-based health clinics and others;
- Faith-based organizations, youth clubs, civic groups, schools, colleges, hospitals and local law enforcement agencies;
- Other New York State agencies and their local programs, including the Office for Prevention of Domestic Violence, the Office of Alcoholism and Substance Abuse Services, the Office of Children and Family Services, and the New York City Department of Health and Mental Hygiene.

Since 1982, NYSDOH has supported direct services to victims of rape and sexual assault, as well as primary prevention efforts intended to reduce the incidence of these events. The goal of the NYSDOH Rape Crisis and Sexual Violence Prevention Program (RCSVPPs) is to reduce the incidence of rape, victimization and sexual violence utilizing a public health approach. Primary prevention strategies include shifting cultural norms, behaviors, and practices to create a community climate free from violence that will prevent sexual assault from occurring. The ultimate goal is to stop sexual violence before it begins. Efforts at many levels are needed to accomplish this.

A. Funded Programs

With 50 funded programs providing services in 72 sites, NYSDOH-funded Rape Crisis and Sexual Violence Prevention (RCSVPP) programs offer a variety of activities designed to prevent rape and sexual assault. The programs ensure that quality crisis intervention and counseling services, as well as a full range of indicated medical, forensic and support services, are available to victims of rape and sexual assault.

RCSVP programs ensure the provision of crisis intervention services to help eliminate the long-term effects that rape can have on an individual. These services include:

- 24-hour crisis hotline services
- client counseling
- medical and criminal justice accompaniment and advocacy
- referral for supports and services and confidentiality assurances to meet the needs of victims of rape and sexual assault
- training of professionals, including the medical and criminal justice professions
- sexual assault prevention and education programs.

In 2009-2010, RCSVP programs responded to 27,802 hotline contacts; provided an array of direct services (including hotline, counseling, advocacy and accompaniment) to more than 30,000 clients; and, provided counseling to 37,226 individuals, including 9,731 who were reported as new clients. RCSVP programs also provided 4,001 multi-session educational programs to 58,834 individuals.

In addition to rape crisis programs, beginning in 2010, the Department funded two Centers of Excellence, the NYS Coalition Against Sexual Assault (NYSCASA) and NYC Alliance Against Sexual Assault (the Alliance). These Centers provide training, technical assistance and expertise to NYSDOH-funded RCSVP programs and partner with the NYSDOH and other state agencies to improve direct services for victims of rape/sexual assault, and develop and implement primary prevention strategies that include sexual violence prevention and/or community mobilization activities.

In November 2006, the CDC implemented a new requirement that Rape Prevention and Education (RPE) funds that support rape crisis program contracts be used exclusively to support primary prevention education and the operation of hotlines, instead of the secondary or tertiary interventions to victims or one time outreach activities that many RCSVP programs previously provided to schools and community organizations. This led to a complete restructuring of the way prevention education services were delivered in New York State. The NYSDOH facilitated training and technical assistance for the RCSVP programs to assist them in the transition of the use of RPE funds for the development of primary prevention programs in conformance with CDC requirements. A number of train-the-trainer sessions were led by experts in evidence-based national programs to assist RCSVP programs in implementing primary prevention programs in their communities. Through a listserv developed by the Department, all RCSVP programs and the coalitions, the New York State Coalition Against Sexual Assault (NYSCASA) and the New York City Alliance Against Sexual Assault (the Alliance), have opportunities to share information and provide insight on effective strategies for rape prevention and education.

In April 2010, the Bureau of Women's Health and the Bureau of Child and Adolescent Health merged to form the Bureau of Maternal and Child Health. This enhanced the Department's ability to promote primary prevention efforts beyond rape crisis programs to other programs serving young people and adults including family planning, adolescent health, school-based health centers, etc. Supporting the development of collaborations between RPE funded providers with the Comprehensive Adolescent Pregnancy Prevention (CAPP) and Sexual Health Promotion Through Youth Leadership (SHPYL) providers within the Adolescent Health Unit has fostered a community-wide approach to address sexual health and sexual violence prevention across New York State.

The RCSVP providers are encouraged to collaborate on a community advisory council with the CAPP and SHPYL providers within their targeted community. This will ensure a system of integrated, and coordinated efficient resources, reduce duplication of services, and solidify a network of community services to increase community awareness regarding sexual violence. This network of collaborative community resources will help to create a sustainable local response in the targeted community.

RCSVP programs conduct age-appropriate prevention education for children and young adults in schools, colleges and other community locations. The RCSVP programs also provide education to community-based agency staff and professionals including law enforcement officers, district attorneys, physicians, other health care providers, crime lab personnel and others. RCSVP programs primary prevention and outreach activities include:

- Community outreach and education through which RCSVP programs provide general information about sexual assault and highlight the existence of rape crisis intervention and prevention services.
- Primary prevention education programs provided to the general public and students in schools, including colleges and in out of school settings. These multi-session programs are designed to increase knowledge and skills to prevent sexual violence from occurring.
- Community mobilization through coalition building or comprehensive programming to address community efforts to prevent sexual violence.

NYSCASA serves as the statewide sexual violence prevention coalition and coordinates and provides statewide training, technical assistance, and services to RCSVP programs and NYSDOH; serves as a clearinghouse for sexual violence prevention education and direct service resources to survivors of sexual assault. The New York City Alliance Against Sexual Assault (The Alliance) in conjunction with 11 of NYC's rape crisis programs is implementing a six-year citywide project to prevent sexual violence known as Project Envision. The goal of Project ENVISION is to change the social norms that promote and permit sexual violence in NYC through community mobilization, so that there is ultimately a reduction in the incidence of sexual violence.

Through collaborative relationships established with internal and external partners, NYS has addressed adult/youth sexual violence and child abuse through a number of programs and policies, including:

- The Sexual Assault Reform Act (SARA) enacted in February 2001 requires sexual assault forensic examiner (SAFE) programs in hospitals designated as 24-hour centers of excellence. As a result of the passage of SARA, the NYSDOH developed standards for approving SAFE hospital programs, approving programs that train individual SAFE examiners, and certifying individual SAFE examiners. NYSDOH-approved SAFE programs and specially trained health professionals ensure that victims of sexual assault are provided with competent, compassionate and prompt care, while providing the most advanced technology associated with DNA and other sexual assault forensic evidence collection and preservation. There are 39 SAFE Centers of Excellence, approximately 325 SAFE Examiners and NYSDOH approved SAFE training programs.

- New York enacted legislation in April 2005 known as the Forensic Payment Act which authorizes the State's Crime Victims Board to pay $800 per forensic exam directly to the hospital, allowing individuals to opt out of billing their insurance for these services to preserve their confidentiality. This legislation also provides funding to the State's Division of Criminal Justice Services to provide the sexual offense evidence collection kits to the state's hospitals at no cost.

- The Department of Health contracts with the Child Abuse Referral and Evaluation (CARE) program of the University Health Care Center in Syracuse to operate the Child Abuse Medical Provider (CHAMP) program, a network of medical providers specially trained to examine pediatric patients suspected of being physically and/or sexually abused. The goal of the CHAMP network is to improve access to quality medical care for suspected child abuse victims.

- The NYSDOH manages a Comprehensive Adolescent Pregnancy Prevention Services Program (CAPPS) with total annual funding of approximately $17.2 million. This initiative focuses on the prevention of pregnancy, reduction of racial and ethnic disparities in sexual health outcomes, and promotion of sexual health and positive relationships among male and female at-risk adolescents, age 10 to 21 years, through local community projects.

- The NYSDOH supports a statewide initiative entitled Lesbian, Gay, Bisexual and Transgender Health and Human Services Initiative (LGBT HHS). The initiative funds 45 community-based organizations located throughout New York State whose primary goal is to increase LGBT individuals' access to health and human services. Approximately half of the programs serve young LGBT individuals including homeless and street-involved youth. Many of the programs provide direct services to their target populations on sexual violence prevention and promote awareness about violence against LGBT individuals in their communities.

VI. ASSESSMENT OF NEED

Understanding the impact of sexual violence in NYS communities and the needs and resources related to the primary prevention of sexual violence was vital to effective statewide planning, and served as the basis for subsequent steps in the planning process. Needs were identified through a review of national and NYS-specific data regarding sexual violence and populations at-risk. Based on the needs identified through the planning process, the populations targeted for primary prevention of sexual violence includes adolescents, age 10-21 years, including high-risk youth (youth in foster care and in the criminal justice system, LGBTQ youth and youth with disabilities).

The SVPP incorporates the development and implementation of strategies and activities to foster collaboration across multiple sectors (state agencies, COEs, RCSVP Programs other state-funded programs and local communities) to promote sexual violence prevention. The NYSDOH in conjunction with SVPPC identified the impact of sexual violence in NYS communities and incorporated these findings as well as changes that are needed into the state plan. This information will be used to inform the work of the SVPPCs, which are funded in each county in the state. The NYSDOH in conjunction with the COEs and the SVPPC will continue to monitor and identify any needed changes to the plan. Through the strategies/activities in the plan, state and local agencies will seek to identify opportunities for presenting information, education and training on sexual violence and begin a dialogue to prevent sexual assault from occurring in the state.

VII. DEVELOPMENT OF GOALS, OBJECTIVES AND STRATEGIES

In conjunction with the SVPPC, the NYSDOH utilized the four-level social-ecological model, which looks at the complex interplay between individual, relationship, community, and societal factors that put individuals at risk for experiencing or perpetrating violence. Primary prevention focuses on the identification of these risk factors and the development of strategies to influence these factors. The committee developed three broad goals; each goal includes one or more objectives and strategies that collectively encompass all four levels of the social-ecological model (Individual, Relationship, Community and Societal) and address the needs of both the universal and selected populations.

GTO recommends defining the universal population as the entire population of the state without regard to risk when developing a statewide plan. By doing so, strategies that reduce the overall risk for sexual violence can be developed to target all groups, including those at risk of perpetrating sexual violence. This strategy may ultimately lead to overall reductions of sexual violence perpetration and victimization. As recommended in GTO, the universal population in NYS is the entire population.
In addition, the planning group identified a more specific target sub-population of youth age 10-21 years. This population was chosen because of the extensive data demonstrating early risk factors for, and experiences with, sexual violence among youth in NYS. By focusing on youth, NYS has a unique opportunity to impact beliefs and establish positive behaviors related to sexual violence during a formative stage of individual and social development.

This primary prevention plan reaches beyond the organizations currently working on sexual violence prevention and intervention efforts. Preventing sexual violence requires engaging the entire community, creating new partnerships, and coordinating efforts across multiple disciplines and sectors throughout the state. This plan establishes a course of action and provides a shared vision for sexual violence prevention in NYS. The goals, objectives, strategies, and activities outlined in this plan are derived from SVPPC members, research literature related to the prevention of sexual violence and existing evidence-based prevention approaches identified by the CDC and WHO.

The three key goals indentified in this plan are:

Goal 1: Foster leadership and strengthen coordination of programs at the state level to prevent sexual violence.

Goal 2: Increase the capacity of local organizations to effectively implement evidence-based and promising strategies to prevent sexual violence.

Goal 3: Create a respectful society by changing social norms to empower youth and adults to intervene with peers when necessary to prevent sexual violence.

These goals are discussed in detail below.

A. Goals, Objectives and Strategies/Activities

GOAL1: Foster leadership and strengthen coordination of programs at the state level to prevent sexual violence.

Objective 1-a: By July, 2013 and on-going, increase awareness, knowledge, and competency of state policymakers and program staff related to the problem of sexual violence, its causes, and implementation of effective prevention strategies.

Strategies/Activities:

a. NYSDOH will actively participate with the national network of CDC-funded RPE Coordinators to exchange information on best practices and emerging science, including attendance at national meetings associated with the CDC Cooperative Agreement.
b. NYSDOH will support two regional Centers of Excellence (COEs) to provide expert consultation and training to the Department and its funded local programs, including support for both core RCSVP program staff as well as state staff supporting other public health programs that focus on youth and high risk target populations. (*See also Objective 2-a below*).
c. NYSDOH will establish and/or strengthen strategic partnerships with sister agencies and external partners to expand working knowledge of available data and resources related to sexual violence in NYS, and to identify collaborative opportunities to advance the primary prevention of sexual violence.

Objective 1-b: By March 2013, at the state level, promote the integration of sexual violence prevention information, messages and effective strategies within other NYSDOH-funded programs, with an emphasis on programs that serve adolescents.

Strategies/Activities:

a. NYSDOH RCSVP staff will identify other NYSDOH programs that serve adolescents and other target populations, including: adolescent pregnancy and HIV prevention programs, family planning, school-based health clinics and home visiting programs.
b. In conjunction with the COEs, NYSDOH RCSVP staff will assess needs and assets of these potential partner programs related to sexual violence prevention and identify opportunities for collaborative strategies.
c. In conjunction with the COEs, NYSDOH RCSVP staff will provide outreach, training, technical assistance and materials/tools to partner programs to advance the principles of sexual violence prevention and community change within the existing infrastructure of those programs.

GOAL 2: Increase the capacity of local organizations to effectively implement evidence-based and promising strategies to prevent sexual violence.

Objective 2-a: By March, 2012 and on-going, **i**ncrease awareness, knowledge, skills and practice of sexual violence prevention among NYSDOH-funded local Rape Crisis/Sexual Violence Prevention (RCSVP) program contractors.

Strategies/Activities:

a. NYSDOH will provide funding and guidance to support local RCSVP programs to serve all 57 counties and the five boroughs of NYC.
b. NYSDOH will support two regional Centers of Excellence (COEs) to provide expert consultation, training and technical assistance to funded local RCSVP programs. (*See also Objective 1-a above*).
c. The COEs, in conjunction with NYSDOH, will assess the knowledge, capacity and training needs of local RCSVP staff and programs related to sexual violence prevention and the selection and identification of evidence-based/promising strategies.
d. The COEs, in conjunction with NYSDOH, will develop and implement training, materials/resources and technical assistance to address identified learning needs and support implementation of evidence-based/promising strategies by the local RCSVP programs. COEs will employ a variety of training modalities, including an annual meeting of local RCSVP providers.
e. The COEs, in conjunction with NYSDOH, will serve as a clearinghouse for information, resources and research related to prevention of sexual violence, including the establishment of a Web site for local providers and other stakeholders.
f. With guidance and support from NYSDOH and the COEs, local RCSVP programs will assess needs and assets within their communities to identify and prioritize specific target populations, risk factors, and protective factors related to sexual violence and prevention activities within their catchment areas.
g. With guidance and support from NYSDOH and the COEs, local RCSVP programs will identify and implement evidence-based or other promising interventions/strategies, including educational programming and/or community mobilization approaches, to address the needs and factors identified for the selected target populations to prevent sexual violence.
h. With guidance and support from NYSDOH and the COEs, local RCSVP programs will monitor and evaluate local interventions/strategies, and modify approaches as needed to achieve program objectives.

Objective 2-b: By September 2013, at the local level, mobilize community partners to promote effective sexual violence prevention strategies across community agencies, services and programs.

Strategies/Activities:

a. With guidance and support from NYSDOH and the COEs, local RCSVP programs will identify other local community providers and organizations in their service areas, with an emphasis on organizations that work with youth and families.
b. Local RCSVP programs that have chosen a focus on community mobilization will develop local coalitions to foster community-level collaboration among a broad spectrum of youth and family-serving organizations, appropriate state agencies and community partners.
c. Local RCSVP programs will work with coalition partners to develop and implement a community action plan to address sexual violence, targeting highest need groups and areas identified.

GOAL 3: Create a respectful society changing social norms to empower youth and adults to intervene with peers when necessary to prevent sexual violence.

Objective 3-a: By June, 2015 and on-going**,** increase awareness, positive norms, self-efficacy, and skill among youth to intervene with peers to establish respectful, healthy relationships and environments to prevent sexual violence/assaults**.**

Strategies/Activities:

a. With guidance and support from NYSDOH and the COEs, local RCSVP programs that have chosen a focus on educational programming will identify NYSDOH-approved evidence-based/promising programs for use with youth populations in target communities, including multi-session national curricula such as *Safe Dates*, *Girls Circle*, *Boys Council*, *Expect Respect*, *Mentors in Violence Prevention (MVP*), or the *Men of Strength Clubs* component of *Men Can Stop Rape*.
b. Local RCSVP programs will work with local partner organizations to recruit a variety of peer and interest groups and youth-serving agencies, such as Boy Scout/Girl Scouts, schools/alternative schools, after-school programs, athletic teams, fraternities/sororities, to participate in programming. RCSVP programs will ensure programs are available for youth including disenfranchised youth, foster care youth, LGBT youth and youth with disabilities.
c. Local RCSVP programs will conduct additional education activities to reach adults in the community, including families, teachers and other community leaders, to foster support for youth and a climate of nonviolence.
d. Local RCSVP programs will work with partners to implement and evaluate approved trainings and interventions.
e. With assistance from local RCSVP programs and the COEs, the NYSDOH will collect, review and catalog information to develop and disseminate a tool kit on bystander intervention for schools, colleges, workplaces and other institutions to use during student/employee orientation and training.

Objective 3-b: By March, 2013, identify and promote appropriate media messages to increase public awareness about sexual violence prevention and bystander intervention.

Strategies/Activities:

a. With input from COEs, RCSVP programs and the SVPPC, and building on initial work done during the planning phase by a NYS Carey Fellow in consultation with state and local partners, NYSDOH will convene an internal working group to develop and implement a new page on the NYSDOH Web site that focuses on sexual violence prevention, including links to a range of national, state and local resources.
b. NYSDOH, the COEs and the RCSVP programs will identify opportunities, including effective low-cost strategies to implement positive media messages statewide and within target communities.

VIII. IMPLEMENTATION OF THE PLAN

Successful implementation of this plan will require strong and sustained commitment from a large number of state, regional and local partners. The plan will be implemented largely through an existing state and local infrastructure. It is recognized that this plan is a living document that may be modified over time in response to changing needs, best practices, resources and opportunities.

At the state level, the plan will be implemented primarily through the Rape Crisis and Sexual Violence Prevention (RCSVP) Program, within the NYS Department of Health Division of Family Health, Bureau of Maternal and Child Health (BMCH). The BMCH was created in 2010 by the merger of the former Bureau of Women's Health and Bureau of Child and Adolescent Health. The merger brought together two bureaus that had similar provider communities, client bases and missions. In addition to the sexual violence prevention/rape crisis programs, other program initiatives that are now managed within one organizational unit include family planning clinics, school-based health centers, adolescent pregnancy prevention programs, regional perinatal centers, prenatal-perinatal networks, community health worker programs and adolescent HIV prevention programs. The merger presents numerous opportunities to incorporate sexual violence prevention messages and activities across a number of programs and service systems that may be serving victims and perpetrators of sexual violence, as well as strengthening local coalitions established to address community awareness and norms regarding sexual violence.

NYSDOH will continue to engage a number of state agency and non-governmental stakeholder partners directly and through the Sexual Violence Primary Prevention Committee (SVPPC). The SVPPC will continue to provide expert input and technical assistance to NYSDOH on the ongoing refinement, implementation and evaluation of the plan through regular meetings.
At the regional level, since 2010, NYSDOH has supported two regional Centers of Excellence (COE) to provide training, technical assistance and expertise to primary prevention programs and to partner in the identification of new and emerging evidence and research regarding approaches to prevent sexual violence, as described throughout the preceding Goals, Objectives and Strategies section. Training and education topics may include healthy relationships, bullying and sexual violence, dating violence, media advocacy, gender roles and expectations, consent/coercion, bystander interventions, drug facilitated rape, dating violence, peer norms that support sexual violence, or train-the-trainer sessions from any of the evidence-based curricula. The COEs will also work with the NYSDOH related to special projects that advance the primary prevention of sexual violence in NYS, including community mobilization to change social norms, and will serve as a focal point for information and research to promote the primary prevention of sexual violence. The COEs will facilitate and serve as an active member of the NYSDOH Sexual Violence Primary Prevention Committee to discuss ways to promote the prevention of sexual violence.

The Centers of Excellence will meet the wide-ranging needs and diversity of New York's funded programs at both the state and local level, including:

- Providing education, training and technical assistance to local RCSVP programs on primary prevention program development on a range of relevant topics, national evidence-based/promising curricula, and/or community mobilization approaches;

- Partnering with NYSDOH to work collaboratively with individual programs and state and national agencies and organizations to improve primary prevention efforts;
- Acting as a clearinghouse of information, resources and research related to preventing sexual assault, including collecting, reviewing, cataloging and disseminating information relating to sexual violence prevention;
- Developing and maintaining a Sexual Violence Primary Prevention Web site that includes current information on upcoming local and national conferences, funding opportunities, research, journal articles, links to other sexual assault primary prevention web sites and special events;
- Responding to NYSDOH requests to research issues and provide information on up-to-date evidence-based practice and research in the field of primary prevention of sexual violence;
- Collaborating with NYSDOH to facilitate an annual meeting of all primary prevention programs and periodic teleconferences to share information and updates regarding sexual violence prevention with local providers; and
- Participating in the statewide Sexual Violence Primary Prevention Committee.

An additional statewide asset available to the state RCSVP program is the NYS ACT for Youth Center of Excellence (ACT COE). The ACT COE, funded by the Department of Health, is also managed by staff in BMCH. The ACT COE provides training, technical assistance, resources and evaluation assistance to the Department's adolescent providers to support the provision of effective services to promote sexual health within a youth development framework, including support for selection and local implementation of comprehensive evidence-based programming. The ACT COE maintains an excellent long-standing web site for service providers featuring a variety of research-to-practice information and tools, and more recently launched a new web site (www.nysyouth.net) designed specifically by and for young people. This is a youth-friendly site where young people can get information about all aspects of sexual health and how to access sexual health services in NYS, with plans to further expand the site to address a broader range of issues important to youth. Specifically, information about healthy relationships, being developed with input from young people, will be available on the webpage in the near future, and can be further expanded with input from RCSVP providers and stakeholders.

At the local level, the funded community RCSVP programs, with support from NYSDOH and the COEs, will focus their primary prevention activities on young people with the goal of reducing first-time sexual violence among youth. As described in the preceding section, building strong state and local collaboration, integrating sexual violence prevention information and strategies across a range of youth-serving programs and services, and implementation of evidence-based educational programming are central aspects of NY's prevention plan.

Across all its youth-serving programs, the Department of Health has embraced a positive youth development (PYD) framework. The Department has provided extensive training to local providers, including adolescent pregnancy prevention and HIV prevention programs, about incorporating a PYD approach into their service programming and has added specific PYD goals and objectives into the programs' work plans. This approach will also strengthen and support local sexual violence prevention programs The main principles of PYD – strength-based, youth engagement, youth voice, youth/adult relationships, youth leadership, community involvement, and long-term involvement – all complement and strengthen the social-ecological

model used to develop this plan. Research has indicated that the more assets (internal and external) a young person has, the better his or her chances are for healthy, positive development and behaviors. Working to promote positive changes at the individual, relationship, community and societal levels, coupled with a youth development approach, the funded programs will have enhanced opportunities to achieve their goal of reducing sexual violence among young people.

As part of the SVP planning process, a NYS Carey Fellow conducted an extensive literature review of primary prevention programs designed to stop sexual violence from occurring. The curricula reviewed included: the *Safe Dates, Girls Circle, Boys Council, Mentors in Violence Prevention* and *Expect Respect.* A comprehensive summary of the information was done, including a general overview of each curriculum, the number of sessions, intended audience, and goals, the use of social ecological model and/or spectrum of prevention including community mobilization strategies. The summary will be used to inform NYSDOH and aid primary prevention programs in their selection of curricula appropriate for their target population.

In addition, information was compiled on existing toolkits used by schools, colleges, and work sites to inform the development of a sexual violence prevention/bystander intervention toolkit. Components of the toolkit may include: a definition of bystander intervention; related topics such as positive role modeling, positive youth development, consent in sexual relationships, and skills needed to intervene; how to change attitudes that allow hurtful, insulting and humiliating sexual behaviors to occur; the role of alcohol in sexual violence; definitions and laws related to sexual violence; model policies and practices; marketing campaigns; and public awareness materials.

IX. MONITORING AND QUALITY IMPROVEMENT EFFORTS

The NYSDOH in conjunction with the COEs will work collaboratively to monitor the implementation of the SVP plan at state, regional and local levels to assure that activities are conducted as planned, and that changes are made as needed to improve their ongoing effectiveness. This process will be guided by the Logic Model presented in Appendix 1, which outlines the anticipated outputs (process measures), outcomes (short, intermediate and longer-term) and impacts of the plan's strategies.

Each of the funded RCSVP programs has incorporated relevant project-specific process and outcome measures within their work plans to monitor and evaluate the success of local strategies. Local programs will summarize and report progress on a quarterly basis to NYSDOH. Progress reports will be reviewed by NYSDOH staff, and feedback will be provided through individualized follow-up and TA as needed. Comprehensive on-site assessments of each local program will be conducted to assure that all administrative and programmatic requirements are being met, and to provide more detailed feedback to providers on program strengths and opportunities for improvement. In addition, periodic conference calls will be held with all RCSVP providers to highlight common challenges and successful strategies among providers.

The ultimate goal of the state's RCSVP Program and plan is reduce the occurrence of sexual violence. More proximal outcomes include the reduction of risk factors known to contribute to the occurrence of sexual violence, and the increase in known protective factors. A priority for

the NYSDOH RCSVP over the course of the current 5-year program cycle is to develop a set of common outcomes and accompanying process and outcome measures related to changes in organizational capacity, awareness/knowledge, attitudes and behaviors that impact sexual violence. As resources permit, and with participation of the COEs and local RCSVP programs, NYSDOH will lead an effort to define such measures and develop tools (such as standardized pre/post surveys) to more consistently collect and analyze outcomes data across programs. In addition, NYSDOH will work with state agency partner to identify the most relevant data sources and measures, such as crime reports and specific YRBS data that can be tracked to monitor longer term impact of prevention strategies at the state and/or regional/local levels. Collectively, these programmatic and surveillance data can be used to develop a "dashboard" to monitor and communicate progress and continued challenges in preventing sexual violence in NYS.

X. SUMMARY

A Sexual Violence Prevention Planning Committee (SVPPC) was created to collaborate with the NYSDOH in developing a comprehensive sexual violence prevention plan. The goals, strategies and activities documented in the plan reflect the goal of the NYS Department of Health (NYSDOH) Rape Crisis and Sexual Violence Prevention Program (RCSVP PROGRAMS) to reduce the incidence of rape, victimization and sexual violence utilizing a public health approach. Primary prevention strategies include shifting cultural norms, behaviors, and practices to create a community climate that will lead to the prevention sexual assaults. The ultimate goal is to stop sexual violence before it begins. As evidenced by the goals, objectives and strategies in the comprehensive plan, to achieve this goal requires a multi-faceted and coordinated approach. The combined resources and efforts of the NYSDOH and the NYSDOH-funded Rape Crisis/Sexual Violence Prevention programs and Centers of Excellence, with the guidance of the SVPPC, creates a strong foundation for implementing the plan's strategies and activities and realizing the plan's goals and objectives.

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Appendix 1

Appendix 1

New York State Sexual Violence Prevention Plan Logic Model

Staff:
- NYSDOH RC/SVP Program staff
- NYSDOH Regional Office staff

Collaborative Partners:
- SVPPC
- DCJS, CVB, OPDV & other state agencies
- RC/SVP Centers of Excellence
- Local RC/SVP programs
- Professionals, schools, CBOs
- CDC
- Other DOH programs (Injury Prevention, Adolescent Health, SBHCs, etc.)

Resources:
- Evidence-based program models
- Federal, state and local funding
- State, regional and local program infrastructure
- CDC guidance & TA

Data & Evaluation:
- Vital records, SPARCS, criminal justice, YRBS and other data
- Provider reports

State Level:
- Participate in national RPE network
- Facilitate regular meetings of SVPPC
- Work with state agency partners to assess need and identify opportunities for collaboration
- Provide training and tools to integrate sexual violence prevention strategies across other DOH youth-serving programs.
- Review current and emerging information on available evidence-based/promising educational and community mobilization strategies to prevent sexual violence
- Develop and disseminate Bystander Intervention toolkit
- Design and launch new Web pages on SVP
- Identify opportunities for positive media messages

Regional Level:
- Support two regional Centers of Excellence (upstate/downstate)
- Assess knowledge, capacity and training needs of local RC/SVP programs
- Conduct training and materials to support implementation of effective local strategies
- Establish a clearinghouse for information, resources and research including Web site

Local Level:
- Support statewide network of local RC/SVP programs in all 57 counties and 5 boroughs of NYC
- Assess local community needs and assets and identify target populations and settings
- Select evidence-based/promising educational and/or community mobilization interventions to address local needs and priorities
- Identify and engage community partners including schools, colleges, businesses, community-based organizations, youth-serving agencies and fraternal organizations
- Convene local coalitions and implement community action plans
- Implement evidence-based/promising educational prevention curricula with selected target groups including youth and adults

Outputs (Process Measures)

- State and community partners are identified and actively engaged in meetings and other prevention activities
- State and local RC/SVP staff have timely access to data and practical information about current and emerging needs, trends, and evidence-based/best practice strategies to prevent sexual violence
- Trainings and TA are available, and local RC/SVP programs and other partners participate
- Web site launched and maintained up to date
- RC/SVP programs and other local partners implement evidence-based/promising educational and community mobilization strategies within target communities
- SVP messages and strategies incorporated across other partner programs and services
- Bystander Intervention toolkit completed and disseminated
- Positive media messages identified

Short & Intermediate Outcomes

- Increased stakeholder awareness of SVP and strategies to address
- Improvements in knowledge, attitudes and beliefs of state and local RC/SVP program staff
- Improvements in knowledge, attitudes and beliefs of other state & local partners
- Specific commitments from state and community partners to participate in or lead actions to prevent sexual violence
- Improvements in knowledge, attitudes and beliefs of youth and adults within target populations

Long Term Outcomes

- Increased evidence of community-wide awareness of and support for SVP
- Sustained and meaningful partnerships with other organizations and agencies to implement effective practices to prevent sexual violence
- Adults and youth intervene with peers to prevent sexual violence from occurring or continuing
- Increased respectful behavior/ decreased negative behavior including sexual harassment, bullying, sexual assault and rape within target groups and communities
- Policies that support prevention of sexual violence are in place/implemented in schools, colleges, businesses, community organizations and other institutions
- Changed social norms reflect a positive “culture” of SVP

Reduction in the occurrence of all forms of sexual violence in New York State